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Part 2

PART 2—APPENDIXES
DEVELOPMENTS IN AGING: 1980

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 353, MARCH 5, 1980

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

MAY 13 (legislative day, APRIL 27), 1981.—Ordered to be printed

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., May 13, 1981.

Hon. GEORGE BUSH,
President of the Senate,
Washington, D.C.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 353, agreed to March 5, 1980, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1980, Part 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 during 1980 by the Congress, the administration, and the Senate Special Committee on Aging which are significant to our Nation's older citizens. During the second session of the 96th Congress, Senator Lawton Chiles served as chairman of the Special Committee on Aging. The preparation and writing of this report was largely accomplished during 1980 under Senator Chiles' leadership. I deeply appreciate that extensive contribution and his continuing cooperation in completing this important publication.

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

Sincerely,

JOHN HEINZ, *Chairman.*

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PART 2—APPENDIXES
DEVELOPMENTS IN AGING: 1980

MAY 13 (legislative day APRIL 27), 1981—Ordered to be printed

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

REPORT
APPENDIXES

Appendix 1

ANNUAL REPORT OF THE FEDERAL COUNCIL ON THE AGING

JANUARY 29, 1981.

DEAR MR. CHAIRMAN: On behalf of the Federal Council on the Aging, I am pleased to submit a preliminary copy of the Council's 1980 annual report of the Federal Council on the Aging.

The report summarizes various positions taken by the Council on a number of legislative and other issues concerning the well-being of the elderly. We hope the Council's views will be considered as the 97th Congress convenes.

We appreciate the continuing support and 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,

MSGR. CHARLES J. FAHEY, *Chairman.*

Enclosure.

COUNCIL MEMBERSHIP

The Council is composed of 15 members appointed by the President with the advice and consent of the Senate so as to be representative of rural and urban older Americans, national organizations with an interest in aging, business, labor, and the general public.[1] Seven members of the Council are themselves older persons. The President designates the Chairman from among members appointed to the Council.

MEMBERS

Chairman, Rev. Msgr. Charles J. Fahey, director, All-University Gerontology Center, Fordham University, New York, N.Y.

Vice Chairman, James T. Sykes, director, public service, the Wisconsin Cheeseman, Madison, Wis.

[1] Legislation requires five members to be older persons.

Cyril H. Carpenter, president, Minnesota Farmers Union; and member, Governor's Council on Aging, Bloomington, Minn.
Jacob Clayman, president, National Council of Senior Citizens; president of the Industrial Union Department of AFL/CIO; and former member, Federal Advisory Council on Employment Security, Bethesda, Md.
Nelson H. Cruikshank,[2] former Counselor to the President on Aging; former president, National Council of Senior Citizens; former director, Department of Social Security, AFL/CIO, Washington, D.C.
Fannie B. Dorsey, director, Division for Aging Services, DHR, Bureau of Social Services, Frankfort, Ky.; chairperson (since 1974) State Institute of Aging with Kentucky Department of Human Resources, Owensboro, Ky.
Aaron E. Henry, Phar. D., pharmacist, chairman, board of directors, National Caucus on the Black Aged; and member, Mississippi State Legislature, Clarksdale, Miss.
Shimeji Kanazawa, member, Commission's Policy Advisory Board for Elderly Affairs; and vice chairman, University of Hawaii Gerontology Center Project's Steering Committee, Honolulu, Hawaii.
Mary A. Marshall, member, House of Delegates, Commonwealth of Virginia, Arlington, Va.
John B. Martin, legislative consultant, National Retired Teachers Association and American Association of Retired Persons, former Commissioner on Aging, Chevy Chase, Md.
Rev. Walter L. Moffett, director, Nez Perce Tribal Housing Authority; and former area vice president, National Congress of American Indians, Kamiah, Idaho.
Mary C. Mulvey, Ed. D., vice president, National Council of Senior Citizens; and president, National Senior Citizens Education and Research Center, Providence, R.I.
Bernice L. Neugarten, Ph. D., professor, Northwestern University; and Deputy Commissioner, 1981 White House Conference on Aging; past president, Gerontological Society, Chicago, Ill.
Jean J. Perdue, M.D., medical director, Office of Health Services; and member, Commission on the Ministry to the Aging of the Episcopal Diocese of S.E. Florida, Dade County, Fla.
Fernando M. Torres-Gil, Ph. D., professor, University of Southern California; former Special Assistant to the Secretary, HHS; former White House Fellow, Los Angeles, Calif.
Wesley C. Uhlman, attorney at law, former mayor, Seattle; and former chairman; Task Force on Aging, U.S. Conference of Mayors, Seattle, Wash.

1980 MEETING DATES

A. Council

The Council met four times during the year, as required by the Older Americans Act. All meetings were in Washington, D.C., on March 17, 18; June 16, 17; August 25, 26; and December 1, 2, 3.

B. Committees and Task Forces

Committee meetings were held as follows: Long-term care, January 18, February 28, April 15, June 24, all in Washington, D.C.; mandated study group, January 5, February 3, 4, May 19, July 28, November 17, December 17, all in Washington, D.C.; senior services, March 3, July 18, in Washington, D.C.; social security task force, March 3, Washington, D.C.; special aging populations, January 23–25, Louisville, Ky., August 5, New York, N.Y.

All Council, committee, and task force meetings were announced in the Federal Register and notices of the meetings sent to representatives of national organizations, to staff of various Federal agencies and to congressional members and committees with a special interest and responsibility in the field. Representatives of these groups and the general public usually attend Council meetings.

Documents pertinent to official actions are maintained in the Office of the Council and are available to the general public.

[2] Former Chairman.

COUNCIL MEETINGS SCHEDULED FOR 1981

March 9, 10, 1981
June 29, 30, 1981
August 31, 1981
September 1, 1981

(Note: All 1981 meetings are tentatively scheduled to be held in Washington, D.C.)

I. INTRODUCTION

LEGISLATIVE HISTORY AND MANDATE OF THE FCA

The Federal Council on the Aging (FCA) is the functional successor to the earlier and smaller Advisory Committee on Older Americans created in the 1965 Older Americans Act. The Council was created at a time, 1973, when there was concern within the Congress as to the adequacy of the then-existing Federal system arrangements for looking after the interests of older persons and as to the breadth of vision likely to be reflected in such oversight and assessment.

Having decided to upgrade (supplant) the existing advisory committee, the Congress found "model" legislative language readily at hand—in the legislative charter of the U.S. Commission on Civil Rights. That legislative language was simply adapted to define the powers of the FCA, but excluding the subpena power.

What the FCA was constituted to do was stated in section 205 of the 1973 Amendments to the Older Americans Act of 1965 and the subsequent 78 amendments as follows:

The Council shall—

(1) Advise and assist the President on matters relating to the special needs of older Americans.

(2) Assist the Commissioner in making the appraisal of the Nation's existing and future personal needs in the field of aging.

(3) 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) Serve as a spokesman on behalf of older Americans by making recommendations to the President, to the Secretary, the Commissioner, and to the Congress with respect to Federal policies regarding the aging and federally conducted or assisted programs and other activities relating to or affecting them.

(5) Inform the public about the problems and needs of the aging, in consultation with the National Information and Resource Clearing House for the Aging, by collecting and disseminating information, conducting or commissioning studies and publishing the results thereof, and by issuing publications and reports; and

(6) Provide public forums for discussing and publicizing the problems and needs of the aging and obtaining information relating thereto by conducting public hearings, and by conducting or sponsoring conferences, workshops, and other such meetings.

Having thus provided a legislative mandate for the Council that was broad enough to allow misinterpretation of congressional intent, members of the conference committee went on record as expecting a strongly proactive Council. They said of the FCA that:

—It "is intended to be the principal spokesman in the executive branch for America's older citizens and to provide the visibility, identification, and advocacy that have so long been lacking in the relations between the elderly and their Government."

—It "would provide valuable support for the President's efforts to mobilize the various agencies of the executive branch to meet the needs of older Americans."

—It "would serve to provide both the executive and legislative branches of our Government with a steady input of information regarding the problems of senior citizens."

The conference report tried to sum it all up by saying "It is the intention of conferees that this body function as more than a passive advisory body, and that it work to actively promote the interests of older Americans throughout the whole range of Federal policies and programs affecting them."

The Council is required by law to prepare an annual report which is submitted to the President by March 31 of the ensuing year. In addition to the legal requirement, the annual report probably represents the Council's most effective public relations tool. Each year approximately 7,000 copies are distributed to Members of the Congress, governmental agencies, aging organizations, private agencies, institutions of higher education, and to individual citizens throughout the United States.

Funds appropriated for the Council are a line item in the overall appropriation of the Department of Health and Human Services. These funds are used to underwrite meetings of the Council; to support the activities of a small professional and administrative staff in Washington, D.C.; to conduct special project activities; and to "contract out" for special research activities.

The Council has worked closely with both the administration and the Congress, and has shared with each the results of its public hearings, research, and special ana'yses of issues and policies affecting older Americans.

The President transmits each report to the Congress together with his further comments and recommendations.

The legislative authority for the Council will expire in 1981.

(Note: See appendix B for a description of the Council's functional operations and procedures.)

II. Recommendations of the Federal Council on the Aging

OVERVIEW

The seventh annual report of the Council consists of a number of recommendations to the administration, the Congress, and Federal agencies. The Council's primary focus of concern was initiating and completing the congressionally mandated study as authorized by Public Law 95–478, the Comprehensive Older Americans Act Amendments of 1978, section 205(g). Therefore, the number of recommendations made by the Council in 1980 pertaining to the immediate and future well-being of the elderly is a reflection of its commitment to the Congress mandate to study programs under the Older Americans Act.

A. NATIONAL POLICY FOR OLDER WORKERS

1. Age Discrimination in Employment

(1–a) The Equal Employment Opportunity Commission (EEOC) should change the current set of regulations on ADEA which permit employers to not credit years of service beyond age 65 in calculating a worker's final retirement benefit.

Background and Discussion

Whatever the reason which allowed employers not to credit years of service beyond age 65 for ultimate pension benefit levels, it is, of itself, wrong. A worker beyond age 65 who is able and meeting job performance requirements is entitled to the terms, benefits, and privileges of employment. Continued pension credit is among such benefits and privileges. Furthermore, employers surveyed in the studies mentioned above felt that the impact of extending credits for years beyond age 65 would be minimal. They expect relatively few workers to stay beyond that age, and those who do stay for relatively short periods of time. Extending pension credits for those workers, therefore, is no real problem since the cost factor associated with this action is minimal. In addition, many employers expect labor unions to bargain collectively in favor of extending pension credits beyond age 65 which becomes another reason to support the issue.

The principles and values associated with this study which were presented at previous Council meetings state that disincentives with a tendancy to inhibit the free choice of older and capable workers to remain employed or take on new jobs should be removed. The lack of crediting years of service beyond age 65 for purposes of final pension benefits constitutes such a disincentive. By making the recommendations, the Council supports the EEOC in revisions for the current regulations.

(1–b) Congress should remove the provision in ADEA (Public Law 92–256, 92 Stat. 189, 1978) which permits employers to refuse to hire or to terminate a worker if age, of itself, can be shown to be a bona fide occupational qualification (BFOQ) essential for the performance of a special job.

Background and Discussion

When exceptions to a regulatory law appear to become the rule, then serious reconsideration as to the purpose and validity of such an exception is in order. Under the ADEA, as that exception now stands age hiring limits and mandatory retirement rules can be set for police and firefighters in relatively arbitrary fashion. Refusal to hire after age 30 is common while forced retirement at age 45 or 50 is not uncommon. Furthermore, many older and some younger incumbents in these positions are challenging the age restrictions in the courts as they grow more aware of their rights.

The difficulty involved with BFOQ exception as it now exists is that it allows confusion between age, ability, and job performance. No one wants an incompetent police officer wielding a gun, or a marginal pilot flying an airplane. Functional criteria should be used in assessing both ability and job performance. When aging and health restrictions interfere in hiring and termination policies because of an exception in a law which intended to protect the rights of older workers. Then the time for change has come.

It is noteworthy that the removal of the exception would in no way saddle employers with substandard workers. Any such worker, regardless of age, race, or sex can be removed, or refused a job, when good cause is shown. Removing the BFOQ exception, however, would place the burden of proof squarely on the employers with substandard workers. Any such worker, regardless of age, race, perceived notion of older worker ability or limitation.

(1–c) The Department of Labor pursuant to the mandates of the ADEA, should develop and implement, in collaboration with other appropriate Federal agencies, a specific research, training, and information dissemination program directed at employers in order to highlight the skills and experience that middle-aged and older workers possess.

Background and Discussion

The statement of purpose of the ADEA includes positive directives as well as prohibitions. Thus, the act is intended "* * * to promote employment of older persons based on their ability rather than age and * * * to help employers and workers find ways of meeting problems arising from the impact of age on employment." The act further states that: "The Secretary of Labor shall undertake studies and provide information to labor unions, management, and the general public concerning the needs and abilities of older workers and their potentials for continued employment and contribution to the economy." The legislation continues to enumerate a number of steps which, regrettably, have never been carried out with any serious efforts. It is time to reexamine this aspect of the legislation and see how it can be implemented. Furthermore, clarifications are in order as to which agency, the Department of Labor and the Equal Employment Opportunity Commission, has responsibility for carrying out research and educational functions.

The ADEA does specify that the DOL should take positive steps to develop and disseminate information on older workers. However, this mandate should be viewed more broadly. The Administration on Aging is one agency which has an interest in developing and promoting research in areas that help older persons remain independent. Another agency, the Department of Commerce, through its Economic Development Administration, should be interested in the employment-related effects of its grants and how these affect job opportunities for older workers, especially in rural areas. The Social Security Administration, with a view toward conserving its resources, should also be interested in ways to promote productive, ongoing labor force activity for older workers beyond the conventional retirement age.

This effort should not be limited to Government alone. Private foundations should be encouraged to support research and develop information which can positively influence the utilization patterns of older workers. The recommendation, then, looks to Government to take a leading, stimulating role towards the ongoing effort of developing a positive base for older worker policy.

(1–d) The mandatory retirement limit, set at age 70 in the 1978 amendments to the ADEA, should be abolished.

Background and Discussion

In recommending the abolition of mandatory retirement the FCA remains consistent with the belief, values, and principles embodied in this study, namely that individuals be assessed and evaluated for job performance on ability rather than age. This, taken together with expected minimal effects of such action on

other younger labor force groups supports the recommendation. The Department of Labor is currently conducting a study on the effects of changed retirement age and likely effects of raising or abolishing the upper limit. It would be a more cautious position to wait the outcome of this and other studies. However, in its leadership role on behalf of older people, the FCA adopts the positive recommendation now.

2. Employment Programs

(2-a) The Department of Labor should direct regional administrators and local prime sponsors to comply with the specific CETA planning requirements, outlined under titles I and II of the act, directing that a special labor force analysis be completed on older workers and other targeted groups. The results of the analysis are to be used in formulating special service programs for these groups. Specifically, the Department of Labor should carry out appropriate procedures, including regional and local oversight hearings, if necessary, to assure compliance with the Age Discrimination Act (ADA) of 1975, as amended—especially as this statute applies to all CETA training programs.

Background and Discussion

This is the first that older workers have merited such specific planning and service requirements in CETA legislation. Each prime sponsor is not required to assess the older worker's need within his jurisdiction and respond to those needs in an equitable and positive manner. As statistics attached to the report show older persons tend to participate in CETA programs in declining percentage rates directly related to advancing age. The mainline training programs are almost entirely youth focused. However, questions may be raised if one group appears to receive more CETA program resources than another. In summary, the older worker shou d expect fairer treatment under CETA than in the past. In fact, if a prime sponsor neglects one particular group within the planning mandate, the individual may encounter sanctions.

There are many individuals who claim that CETA is a youth program especially focused on the needs of unemployed, underemployed, and disadvantaged young members of minorities. Sharing resources with older workers would only dilute the program. There exists also the assumption that training and employment investments should be made in the younger, as opposed to the older group, while the older ones will be, at best, leaving. The investment and payoff, then, can be viewed as tilting toward the elderly.

Regardless of such underlying considerations, congressional intent in the 1978 CETA amendments requires that planning and program services be allocated to older workers on the local level. Without expecting any great change of heart or miracles, participation rates of older persons in CETA programs should manifest an upturn over the coming years.

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in all major programs funded by the U.S. Government. The act admits to certain exceptions especially where age is specified as a statutory criteria for participation. Thus, the act does not apply to social security programs where age criteria for eligibility and participation are specified. Nor would the act apply to day-care programs for children where age criteria are also specified. In addition, the act does not apply to employment since Congress reasoned that the ADEA covered this area. But the act does apply to training programs funded by the Federal Government which can lead to employment.

Enforcement of ADEA is largely an oversight function of any Federal agency covered by the act with DHHS summing a larger coordinating and conciliating role. As applied to CETA, then, the Labor Department would be required to apply by reason of equity and ADEA requirements what is its mandate by the planning requirements of title I. The ADEA provides another mechanism to assure that older workers receive a fair share of the Nation's development of employment.

Both the law and the planning requirements noted above will offer group concerned with older workers more leverage to assure they receive a fair share. On the other hand, it is felt on a policy level that the Nation's disadvantaged youth needs the greater share of CETA resources, in this case; new programs and new appropriations must be developed for older workers. Extended employment opportunity for the able and willing older worker is no longer condescension, it is a protected civil right. Coupled along with a new approach to develop the productive older worker resource, new policies and new programs funded on a basis of need and equity are in order. In short, it is discriminatory policy to assert that billions of dollars will be allocated for one age group and only millions for another.

(2–b) Federal regulations which exclude workers from participating in apprenticeship programs funded by the U.S. Government solely on the basis of age should be abolished.

Background and Discussion

Ever since the inception of the Manpower Development and Training Act (MDTA) of 1962, apprenticeship programs funded by the U.S. Government and conducted by labor unions, have had age ceilings for acceptable applicants. In some cases, individuals over age 25 were denied access to these programs, not to speak of being over 30, 40, or 50. The assumption behind these age exclusions was, and still is, that training investment in older workers will not pay off, or that it will take too long for the older worker to gain the journeyman level of skil to really contribute to the trade or to the economy. Whatever the original policy behind each exclusion, the situation is different now. There are many women in the middle years who want and need to enter the labor force in a trade-skill capacity. They need the opportunity for apprenticeship training. Men and women in their 50's can look forward to at least 20 years of labor force activity if they are willing and able. Skill conversions through apprenticeship training is by no means out of the question. Changing demographics, changing interest on the part of workers, increasing challenges to age restrictions in the world or work and the raising of mandatory retirement age all suggest that restrictions on apprenticeship programs on the basis of age are unwarranted and should be abolished.

Recent discussion among members of the Equal Employment Opportunity Commission indicate Commissioners are concerned with the age-related restrictions on apprenticeship programs. Congressional staff interview in the key informant stage of the study also have expressed concerns over the issue. Some are considering introducing corrective legislation of the Federal agencies empowered to change the regulations do not take action. Whatever the type of action that occurs over the near future, the FCA should go on record in support of abolishing age restrictions.

(2–c) The Department of Labor should allocate at least $10 million in fiscal year 1981 to implement the middle-aged and older worker program described in title III, section 308, of the 1978 CETA amendments.

Background and Discussion

Section 308 of CETA provides for a wide variety of employment-related research and demonstration programs affecting the employment of middle aged and older workers. The legislation supports innovative approaches for retraining and utilization of these workers. Special research on the development of functional criteria for assessing skills and abilities of older workers, as opposed to formal tests, is encouraged. Second career training and the use of alternative work patterns, job redesigning, flexible scheduling for work, etc., are also suggested demonstration approaches. At present, no appropriation has been made to support any of the above activities. The whole title III program is discretionary as to fundings and it is up to the Secretary of Labor to make the allocations.

The Council has already made its views known in support of appropriations for section 308. The Chairman has met and discussed the issue with the Secretary of Labor. $10 million would appear to be a reasonable beginning amount for this new older worker program, especially in consideration of how poorly older workers have fared in the past.

In the 1950's the Bureau of Employment Security (BES) of the Department of Labor conducted extensive research of older workers in a number of major labor markets to assess such factors as numbers, sex of older persons seeking jobs compared to younger applicants, reported obstacles faced by older job seekers, employer attitudes on older workers including ability, productivity, motivation, their hiring practices, etc. The result of the studies indicated that older workers, defined by the Bureau as individuals over the age of 45, were encountered special problems when seeking employment and needed special assistance.

The BES then established a national older worker program which developed and implemented counseling and referral programs for older applicants, trained BES staff to carry out training and employer relation activities to assist older workers and established, in many States, a cadre of older worker specialists to implement the above functions.

For historical reasons, such as the changing of priorities of employment programs and the initiation of "Great Society" programs to help minorities, the older worker effort diminished. Some States have maintained services for older workers, but a concentrated program focus on the part of the DOL for this group no longer exists.

It would be inappropriate to suggest that the same older worker program be revived. First, with the inception of the decentralized CETA program, the changes that have occurred in the Employment Service and the availability in the communities of a host of agencies that are concerned with the elderly, a new design for the program is needed along with a sharing of program resources and collaboration among interested groups. Greater access to older persons and the assessment of their labor force interests and their needs is available through the area agencies on aging (AAA). However, AAA's staff needs training in detailing with and counseling the elderly. A number of older pilot programs financed from CETA 308 might prove to be the best first step. Given a careful development and evaluation period, there is no reason why effective older worker programs cannot be put in place over the coming years.

(2–d) The senior community service employment program under title V or of the Older Americans Act should be expanded on the basis of:

—An assessment of the proportion of workers in need of the program over the next 5 years; and

—An assessment of the impact and effectiveness of the program in terms of benefits to participants, services to agencies and people served, and the overall benefit to the economy and the Government.

Background and Discussion

The title V program has grown in numbers of participants and funding levels over the years. The program is currently (fiscal year 1981) funded at $265 million and provides work for over 52,000 older workers who meet specified poverty criteria.

Administratively, title V is managed by the U.S. Department of Labor which in turn, utilizes a number of national subcontracts, mainly agencies with a standing record of providing services to the Nation's elderly. These groups have been expanded recently to include State units on aging (SUA) and organizations with special concerns for the Nation's minority elderly.

Title V has been and remains very successful and popular. It puts older workers in a position of providing a variety of needed services and self-dependence gained by achieving earnings through employment. But a number of issues need to be considered:

—What is the true universe of need for programs in terms of older participants and the new kinds of work which they can, and are willing to perform?

—Given the double-digit inflation, are the poverty criteria for selection into the program realistic. Are participation criteria too restrictive?

—Should the program take on a greater job training emphasis and involve private sector and mainline Government agency employer in greater job development efforts?

—Can the basic program model which views participants as "aide" be changed so that seniors in every level of management, can be trained to become a major provider services to their own peers?

These many issues will be raised by the Council in its mandated study. In looking over the prospects and promises of the program over the coming decade, it might be helpful if the DOL would join in a major evaluational and development effort. The last assessment of the program was undertaken almost 10 years ago by a consultant group under contract with the DOL. The evaluation was sound, thorough, and positive. In fact, the model can serve as a point of departure for the FCA mandate study pertaining to the title V program and a supplemental effort made by the DOL which manages the program.

3. New Employment Opportunities

(3–a) The Department of Labor should develop an affirmative action program for middle-aged and older workers to assure that these individuals gain access to jobs made available through Federal contracts to major employers in the United States.

Background and Discussion

Since the passage of the Civil Rights Act of 1964, and especially title VII, which protects the employment-related civil rights of minorities, the Government has made efforts to enforce a series of affirmative action programs which are intended to guarantee a fair share of jobs and upward mobility on jobs to minorities covered by that legislation. Furthermore, in cases litigated under the act, the Federal courts have ordered, or otherwise arranged, for procedures whereby employers take direct action to restore any imbalances in their work forces that might have resulted from past discrimination.

Women have benefited from these arrangements especially through "consent decrees" whereby the Federal courts have withheld punitive actions against employers in lieu of specified steps to rectify promotion rates, salary and wage scales, etc., that might have been influenced by discriminatory actions on the basis of sex.

There is no reason why older workers should not benefit from an affirmative action approach. The principle at stake here is one which is fundamental to this policy study. What is a civil right for one subgroup of the U.S. labor force and population is a civil right for all. There can be no tradeoff on demographic characteristics of the population when it comes to the right to work by individuals who are willing and able.

In supporting this recommendation, the Council is supporting a principle and program of fairness. No one is asking for a special break for older workers or a special opportunity. We are asking for equity. Older workers are the only subgroup in the population who, at present, are not included in affirmative action programs.

(3–b) Congress should establish a special unemployment insurance and job retraining program for middle-aged and older workers to enable them to remain in or reenter the labor force when economic pressures force them to withdraw from the labor force involuntarily.

Background and Discussion

One of the most distressing labor force statistics which applies to workers over 40 is the continued pattern of duration of unemployment. The longer an over-40 worker is unemployed, and actively seeking work, the longer he/she tends to remain so. The duration of unemployment expands in proportion to the increased age of the older job seeker. This pattern has held for well over a 10-year period of reporting on such trends. But special studies involving plant shutdowns, mergers or other events which affect local areas also underscore the same phenomenon. Once out of a job, the older and not-so-old worker will look for reemployment and benefit from unemployment insurance for an interim period. After that period expires, the older worker is likely to leave the labor force completely and resort to some form of welfare dependency.

It would seem that if current retraining and relocation efforts, such as those provided through trade adjustment programs, were modified, the older worker would benefit and could remain in the labor force for longer periods. What seems unproductive is to neglect the older worker, or just sustain his unemployment insurance for a more extended period, and not build on that investment. Again, the Council is facing the underlying values of this recommendation. Invest in the older worker in terms of income maintenance and job retraining can pay off for the individual and for the economy. There is a healthy mix of humanitarian and economic motives involved in the focused development of the unemployment insurance resource and any added training efforts. Older workers can retain their status in the labor force including the power to earn income and benefit from other work-associated values. The economy benefits since the worker remains a taxpayer. Retirement systems benefit since the worker defers drawing upon these income resources.

Pilot demonstration efforts on this approach plus careful evaluation of costs and savings, both individual and economic, may be the best initial step for such a program.

(3–c) Congress should establish a retirement alternative employment program which would:

—Provide workers with incentives to defer retirement; and

—Provide employers with incentives to develop retention options for older employees.

Background and Discussion

Since the inception of the 1978 amendments to the ADEA which raised mandatory retirement to age 70, a number of employers have developed creative approaches toward retaining able older workers and hiring others. The general pattern has been to develop various lines of part-time jobs along with flexible work schedules. Employers have been pleased with the arrangement because they note that older workers are productive. Older workers are pleased with the arrangement also since they are able to continue earning and remain active. But there are problems. First, the benefit arrangement is not clear in all cases. Part-time work does not necessarily mean reception of partial benefit. Sometimes workers take reduced pay and still have to wait until retirement to receive pension benefits. Second, not all employers appear interested in such an approach. Those organiza-

tions with a long-standing value on older employees, and many which either raised or abolished mandatory retirement before the law set the age to 70, normally, are the ones which appear flexible and willing to develop differential work opportunity for individuals who would normally retire. What is needed, then is a retirement alternative program which would both educate and encourage employers in the public as well as in the private sectors to develop retention programs and hiring opportunities for older workers.

We already have the means to accomplish the programmatic aspects of such an effort. Title V, of the Older Americans Act, the senior community service employment program, provides an ample precedent in the design of part-time work for older workers. Translating that approach to a broader scale, especially in the private sector, would require careful demonstration. Providing incentives to employers to participate in and to develop retention programs would require adjustments in the system already used to encourage them to hire and to retain minority youth who come out of CETA training programs. Tax incentives, stipends, or salary wage maintenance for a period of time, maintenance of training and other job-related supports, are among the strategies that have worked. Designing a total package to facilitate older worker retention and the hiring is feasible.

(3–d) The Department of Commerce, Agriculture, and Labor should collaborate with the Small Business Administration and the Administration on Aging to develop and assess economic impact programs which will identify entrepreneurial, job, and other self-employment opportunities for middle-aged and older workers.

Background and Discussion

The Department of Commerce, through its Economic Development Administration, offers grants to a variety of economic development districts in order to achieve growth and stimulate developmental activity in those areas. Eligible organizations can build or expand facilities through the grants program which has the effect of creating jobs. It is important that this Federal resource, be shared equitably in the job creation aspect by all age groups. But it may be more important that the above Federal agencies collaborate in targeting training, employment, and developmental activities in a focused way to help older workers gain job opportunities in all areas including entrepreneurship and other self-employment activities.

The collaborative economic, manpower development is by no means new. It has been tried with various degrees of success in a number of settings. What is called for is a careful review, evaluation and planning approach which will build-on positive past experiences. It may well be that any effort that will succeed must be broad based, involving the maximum resources in terms of funding and agencies along with cross-generational sharing of the employment opportunities that arise from such economic development programs. It is unlikely that any economic development effort could, or should, benefit only one age group. All should benefit in an equitable manner—based on labor and job market analysis. Younger and adult workers may need full-time jobs. Older workers may prefer part-time work. Such analyses are complex, not to speak of the difficulties in program planning and coordinating. If areas eligible for economic development grants from Federal agencies are to utilize them effectively to support and stimulate local jobs, new efforts must be made to assure that all groups benefit fairly.

4. Retirement Policies

National retirement policy, as manifested through the social security system and regulatory laws affecting pensions, should be reassessed with a view toward encouraging continued, varied, and nontraditional employment opportunities for middle-aged and older workers.

Background and Discussion

This is a general, overall recommendation which takes into account previous recommendations. It is realized that making employment options a part of retirement policy may at first appear contradictory. It is, if we continue to review the life cycle in a segmented fashion that moves, inexorable from youth education to adulthood and work and to retirement in old age. But demographic factors, increasing longevity and improved health for older persons along with cloudy economic forecasts for this decade simply challenge static thinking about retirement policy. Key informants from the President's Commission on Pension Policy

noted, that retirement and employment issues for older persons are inextricably related. The Commission has consistently investigated alternatives to retirement along with its mission to rationalize the Nation's pension system. That focus is instructive to the Council and all others concerned with the economic well-being of older persons and their status as self-sufficient.

B. CONTINUING EDUCATION FOR OLDER ADULTS

Recommendation

In recognition that education is a basic right for all persons of all age groups, that it is continuous and hence one of the ways of enabling older people to have full and meaningful lives, and a means of helping them develop their potential as a resource for the betterment of society, the Federal Council on the Aging and the National Advisory Council on Extension and Continuing Education, a public statutory body established by Congress to aid in public policy development at the Federal level on matters relating to postsecondary education and learning opportunities for adults in the United States, have recommended to Secretary Hufstedler (Department of Education) that a Federal strategy for increased educational opportunities be developed and directed toward:

(B.1) The appointment of a coordinator for aging in the Department of Education to develop coordination with the Administration on Aging and other relevant Federal departments and agencies.

(B.2) The immediate establishment of an aging unit in the Department to initiate supportive educational services for older people as a necessary first step in any expansion of educational opportunities for older persons on a national scale.

(B.3) Coordination of education and aging networks at the State, area and local levels, including State departments of education, State offices on aging, area agencies on aging, public agencies which administer social security programs, voluntary organizations, postsecondary institutions (including technical institutes, community and junior colleges), local school districts, business and industry, and unions.

Background and Discussion

Education for older Americans is too often dismissed as a legitimate concern of the Federal Government, as is education for adults generally. There have been few national policies or stated purposes, and little adequate resources devoted explicitly to encourage education among the elderly. If sentiment does not change this condition, the reality of numbers may. A dramatic shift in demography is transforming us into a nation of older people.

In the past 10 years, enrollments by older and nontraditional students in postsecondary education have increased four times as fast as enrollments by traditional college-going youths between the ages of 18 and 22. In fact, education and training for adults, who tend to go to college on a part-time basis, is the most rapidly expanding segment of all postsecondary education.

This fact ought to be of special concern to the Department of Education. In the very near future, older learners are expected to outnumber and replace younger students as the "typical" undergraduates on our Nation's campuses. Once established, this pattern appears assured for the next two decades. In 1960, 4.3 million Americans were born. In 1978, only 3.3 million Americans were born. In short, the graduating class of the year 2000 has already been born and will, in all probability, be taught then by the same individuals teaching now.

There are three principles guiding Federal education policies. These are the principles of equity of access to education, equal educational opportunities, and the right of every American to expect and to receive quality instruction. These principles have been put into practice successfully for some Americans. There remains a serious question whether or not these principles have been universally extended to all learners, especially adults, and particularly older adults. With older Americans demonstrating a strong interest and need in continuing their education, it is important that the Federal Government have the legislation, the programs, and the commitment to encourage this interest, not discourage it by muted interest or arbitrary rules and regulations that discriminate against older Americans who wish to continue to learn.

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C. HOUSING FOR THE ELDERLY

Recommendation

That the Federal Council on the Aging, while realizing the importance of Federal budgetary efforts to combat inflation, recommend to the administration and Congress—

(1) That they urge an increase in the funding level for Section 202: Housing for the Elderly and Handicapped, to enable the construction of 30,000 units. The present budget for 1981 proposes loan authority for $830 million to support an estimated 18,000 units. Such housing is desperately needed by our elderly population and is a most cost effective way of preventing premature or inappropriate institutionalization.

(2) That the congregate housing and services program receive a fiscal year 1981 appropriation in the amount of $25 million since the $10 million appropriated in fiscal year 1980 will only provide services for 60 housing projects.

(3) That sufficient funding be provided for assisting 600,000 units of public housing (section 8) including 400,000 units of HUD section 8 and 200,000 units of Farmers Home Administration and HUD section 235.

Background and Discussion

For a period of time the Council has had an unending commitment to a Federal policy that would improve housing conditions for a significant portion of the Nation's elderly. The essential problem faced by the elderly in housing is income. If older people had enough income they would probably buy adequate housing.

Historically, the Department of Housing and Urban Development (HUD) has concentrated its energies on the construction of housing units, but presently is coming to the realization of the important social role to be played in solving the problem of the poor; that provision of a house, by itself, is not enough to solve these problems.

While the funding levels required for the above-mentioned housing units may seem high, appropriations to complete these units will provide shelter for only a small portion of the elderly individuals and households in greatest need of these services.

III. Council Activities

During 1980, the Council worked in a number of areas of special concern as well as inviting attention to emerging issues of importance to the elderly of the present and future. Specifically, the largest portion of the Council's agenda was the congressionally mandated study (to be described elsewhere in this report).

The 1980 Council activities were centered around the following committees and/or task forces:

A. LONG-TERM CARE

Activities of the Federal Council on the Aging in long-term care date back to 1975. At that time, the Council initiated development of its first report on recommendations for a national policy on services to the frail elderly. This publication, entitled "Public Policy and the Frail Elderly," was made available in 1979. The Council then turned its attention to delivery system and in 1979 disseminated a paper identifying the key issues in long-term care. The Council's Long-Term Care Committee convened a work group composed of 18 representatives from seven Federal departments with policymaking and program responsibilities impacting on long-term care. This group provided expert advice to the committee in the development of its key issues paper.

This work group also provided expertise on the most pressing areas of inquiry. One result of the work sessions is the chartbook to be published by the Council in early 1981. The chartbook presents information and issues on the need for long-term care. The committee convened a data task force of persons knowledgeable in various aspects of long-term care to develop the specific topic areas for the chartbook. The task force included members from national associations and consulting firms as well as from Federal agencies.

The purpose of the chartbook is to present information and issues in determining current and future need for long-term care. It brings together four mainstreams of information on the need for long-term care by America's elderly; data on demographics, health status, use of health services and informal supports. A fifth section discusses the impact of Federal policies on the delivery of long-term care. The information represents a mosaic of diverse pieces which combine to provide a better understanding of the complex issues concerning the need for long-term care.

In many of the charts, data on the past and projections for the future are presented along with current information. This perspective in three time frames is important to understanding the need for long-term care because it sheds light on where we were yesterday, shows how we got where we are today, and forecasts where we are going. The data point to interrelationships that have important impact on the need for long-term care—ties between age and disability, education and income, minority status and longevity, living alone and being female.

The chartbook was prepared with many users in mind—delegates to the 1981 White House Conference on Aging, policymakers, program planners, legislators, and all others concerned with the aging of the American people.

Chairperson: Charles J. Fahey. Members: Mary A. Marshall, Jean J. Perdue, M.D.

B. MANDATED STUDY WORK GROUP

The FCA mandated study work group had the major responsibility for identifying and framing the issues relevant to the congressionally mandated study. The work group worked with and advised the consultants who authored FCA conceptual papers on age as a criterion for focusing public programs, targeting under the Older Americans Act and policy development and advocacy. Additionally the work group helped to formulate and define the problem focus and advise on methodology with respect to the contracted studies undertaken by the Council in 1980. In short, the work group provided the overall leadership for the Council toward achieving the objectives of the congressionally mandated study.

Chairman: Wes C. Uhlman. Members: Mary C. Mulvey, Bernice L. Neugarten, Charles J. Fahey, James T. Sykes, Fernando Torres-Gil, Bill Holland (FCA study director).

C. SENIOR SERVICES

The primary focus of the Senior Services Committee in 1980 was its study on the employment of older workers (see discussion of this topic in the section on recommendations). Second, the committee participated in the development of an interagency agreement to provide small business enterprise and employment opportunities for the older worker. (Note: Some of the principals involved in this effort other than the Council were the Administration on Aging, the Small Business Administration, the Farmers Home Administration, the Economic Development Agency, the the American Bar Association, and the U.S. League of Savings Associations.) Finally, the committee proposed, as a beginning toward developing a work plan in the housing area, a resolution which was adopted by the full Council on increased funding for section 202 and the congregate housing and services programs (see full text of resolution in section on recommendations).

Chairperson: James T. Sykes. Members: Aaron Henry, Mary C. Mulvey.

D. SOCIAL SECURITY TASK FORCE

The social security task force studied specific issues involving gender-based inadequacy and inequity in the social security system. Topics under consideration included divorce, disability, dependency, poverty among widows, and dual entitlement. The Council received the task force's efforts as work in progress; therefore, no specific recommendations for action were made.

Chairperson: Mary Marshall. Members: Aaron Henry, Mary Mulvey, James T. Sykes.

E. SPECIAL AGING POPULATIONS COMMITTEE (SAPC)

The Special Aging Populations Committee followed up on recommendations emanating from the committee's report on "Policy Issues Concerning the Minority Elderly." The followup was accomplished by sending letters to the various Federal agencies having direct or indirect responsibility for aging programs.

With respect to its commitment to the needs and problems of both urban and rural elderly residents the committee engaged in the following activities:

1. On the Rural Elderly

(a) In January, the committee met with State and local officials, service providers as well as grass roots in Louisville, Ky. While in Kentucky, the SAPC members visited some rural and urban senior centers and shared with the center's participants their differing needs.

(b) Also in January, the committee was represented in a title VI hearing in Anchorage, Alaska. The major concerns pointed to the difficulties in obtaining services in the isolated, culturally unique, and poverty-stricken Indian villages.

(c) In April, the committee was represented and testified at a hearing on the "Plight of the Rural Elderly," sponsored by the Senate Special Committee on Aging, in Las Vegas, N. Mex.

(d) In April, the committee was also represented and participated at various workshops on the rural elderly during the National Council on the Aging Conference, in Washington, D.C.

(e) In May, the committee participated in the annual conference of the National Caucus/Center on the Black Aged in Philadelphia.

2. On the Urban Elderly

The committee worked closely with the National Urban League in planning a workshop on "Inner City Elderly Living Facilities." The workshop was held in conjunction with the National Urban League Annual Conference in New York on August 5, 1980.

Prior to the workshop, committee members visited with staff from the New York Office on Aging, toured areas with heavy congregation of boarding homes, and single room occupancies.

Committee members explored with residents, SRO operators, providers of services and researchers, the major problems and alternatives.

Chairperson: Fernando Torres-Gil. Members: Fannie Dorsey, Cyril Carpenter, Walter C. Moffett.

IV. 1981 Work Plan

During 1981, the Council will continue working in a number of areas which have occupied much of its time as well as devoting attention to emerging issues of importance to the elderly of the present and future. The Council's agenda will also be affected by actions concerning the elderly by a new administration and changes in the composition of the legislative branch of government.

To follow is an indepth discussion of some of the major Council concerns in 1981 and a listing of others including a time schedule depicting the percentage of time to be given per topic.

EMPLOYMENT

In 1980 the FCA approved a series of recommendations regarding the public sector's responses to the needs of older workers. These recommendations were developed in the FCA report entitled, "Toward a National Policy on Older Workers." In 1981 the FCA will pursue the second phase of its study on older workers. This task will continue throughout the calendar year, and will include: (1) Monitoring public debate on older workers (congressional hearings, President's Commission on Pension Policy, etc.); (2) presentation of testimony representing the FCA's position on the older workers issues; and (3) participation in a joint initiative with public and private organizations that will test various mechanisms for including older workers in our economic system both as entrepreneurs and as employees.

It is expected that the outcome of this phase of the study will allow policymakers to form a more focused opinion on the issue as well as generating new questions for public debate.

The FCA will spend 5 to 10 percent of its time pursuing these activities.

TARGETING OF RESOURCES FOR THOSE IN GREATEST NEED

It is clear that government has assumed the responsibility of ameliorating inequality in our society. This responsibility is reflected in a variety of policies and programs. Yet, a large number of these direct themselves specifically to income inequality. Under these programs, assets and income are used to judge the eligibility of a person or household for participation in a particular program. The present method of "means testing" is a weak surrogate for "needs testing," i.e., identifying economic and nonèconomic needs. It is becoming increasingly clear that, in society where public dollars for social programs are not unlimited, more efficient and equitable methods for identifying the real "in need" groups must be devised and implemented.

Various new approaches to the general problems surrounding the targeting of resources for those in greatest need have surfaced recently and are the source of intense debate. It is clear that the debate will continue into the future.

A large number of older Americans are served by "needs tested" programs. The FCA will, in 1981, formulate a conceptually sound and programmatically acceptable policy position on the issues surrounding targeting after considering the size and direction of the tradeoffs in equity, target efficiency, and program costs resulting from variations in approach.

The FCA will employ its role as convenor by bringing together those knowledgeable in this area.

Approximately 10 percent of the FCA's time will be spent in this area.

SOCIAL SECURITY

The current financial outlook for the OASDHA program indicates several problems. The OASI program is running out of funds as automatic benefit increases exceed the growth in revenues. It is clear that additional financing will be needed throughout the 1980's. The possible forms that the revised financing scheme could take are of extreme interest to the FCA because social security is the most important national program affecting the well-being and economic security of both the present elderly and those who will retire in the future.

In the past the FCA has urged that short-term financing problems be corrected. This was especially true with the decoupling issue. In 1981, the FCA will study, review all proposed mechanisms for returning OASDHA to a sound financial footing. Congressional debate will be monitored and testimony will be given as the FCA deems appropriate. The FCA will spend 5 to 10 percent of its time pursuing these activities.

MANDATED STUDY

The study is to be presented to Congress in March or early April 1981. Prior to that time the study will be the major FCA activity. This involves review and comment on findings and a decisionmaking process on options and recommendations. Until completed, the study will involve 70 to 80 percent of FCA time. Following completion and throughout the remainder of 1981, followup activities on the study will take 10 to 15 percent of FCA time. These include meetings with congressional committees, national aging organizations and presentations at major meetings and conferences. Decisions will be made for followup facets of the study that are timely and priority areas for followup be established and pursued.

LEGISLATION

Reauthorization of Older Americans Act—here the FCA has the opportunity to develop a short-range position and a long-range position (possibly based on findings from mandated study)—the short-range position, paper on the position and testimony will take 5 to 10 percent of FCA time. The long-range position and paper another 5 to 10 percent of FCA time.

Other legislative concerns—5 to 10 percent of FCA time. These include new programing, energy, income, health care, and positions on existing programs. The FCA will decide the most appropriate methods to use to be engaged in the legislative process.

WHITE HOUSE CONFERENCE ON AGING

This is a major FCA activity through 1982. A major block of FCA time (30 percent) will go into direct support by members and staff of the conference. After the conference of major portion of FCA time (20 percent) will go into followup activities aimed at maximizing the results of the conference process. The FCA will priorit ze and categorize the Council agenda in light of conference outcomes.

UPDATING FCA STUDIES

Many recommendations in FCA studies are relevant and have not been implemented. A review will be done of studies and a plan on implementation or further promulgation of recommendations will be presented to the FCA. The studies include: Formula study, benefits study, tax study, minority elderly study, assets study, public policy and the frail elderly. Five percent of FCA time will go into this activity.

A Study of Living Arrangements of Older Persons

This long-range policy study (2 to 3 years) will build on findings from prior FCA work—frail elderly, long-term care, minority elderly, benefits study. The study will attempt to develop policy that will lead to the most appropriate range

of community based living arrangements in a system for all older persons that is based on need and acceptability. Ten percent of FCA time for this activity.

A Study on the Future Role of the Family, Informal Supports, Other Mediating Structures and the Elderly

This intermediate range policy study is complementary to the living arrangements study. Questions to be addressed include:

(1). What do present policies encourage on the role of the family and the elderly?

(2). Is dependency on family a desired social goal?

This activity will take 10 percent of FCA time.

A Study of the Feasibility of Developing Reports on Measures of the Status of the Well-Being of Older Persons

This long-range policy study would determine the ability to measure the status of older persons in society and would include health status, economic status, and other social indicators of well-being. This activity will take 10 percent of FCA time.

V. The FCA Congressionally Mandated Study

The 1978 amendments to the Older Americans Act require that the Federal Council on the Aging undertake a thorough evaluation and study of the programs conducted under the act. The law requires the study to include at least three parts:

(1) An examination of the fundamental purposes of such programs, and the effectiveness of such programs in attaining such purposes.

(2) An analysis of the means to identify accurately the elderly population in greatest need of such programs.

(3) An analysis of numbers and incidence of low-income and minority participants in such programs.

Separate funds were not appropriated for this purpose. To achieve a useful, focused result, the FCA obtained help in the Department of Health and Human Services from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and from the Administration on Aging (AoA).

The expected level of effort is approximately 8 to 10 person years. The Administration on Aging authorized a transfer of $500,000 of 1 percent evaluation funds to the FCA for these purposes.

KEY DATES AND EVENTS TOWARD ACHIEVING THE OBJECTIVES OF THE FCA CONGRESSIONALLY MANDATED STUDY

The following represents a chronology of the important dates and events germane to framing the issues and achieving the objectives of the mandated study.

January 5, 1980

The FCA Mandated Study Group met on Janaury 5, 1980, to consider the implications of the AoA exploratory evaluation for: (1) Its formulation of conclusions regarding the fundametal purposes and effectiveness of programs conducted under the Older Americans Act, and (2) for additional special analyses and short-term evaluations of the efficiency, effectiveness, and responsiveness of programs conducted under the Act.

The work group decided to:

(1) Incorporate the results of the AoA exploratory evaluation and of all others relevant ongoing AoA program evaluation studies into its report to Congress (the latter will take the form of evaluation summaries based on readily available date).

(2) As a part of the short-term evaluation of the AoA program based on evaluation studies in progress, Commission policy papers on six to eight topics related to the values and parameters underlying programs conducted under the Older Americans Act. Finally, after further deliberations, the study group decided on hiring consultants to develop the following policy and/or conceptual papers:

Policy paper I: Age as a Criterion for Focusing Public Policy.

Policy paper II: Policies and Program Strategies for Reaching. Those in Greatest Need.

Policy paper III: Achieving Effectiveness in Policy Development and Advocacy in Aging at the National Level.

Policy paper IV: AoA Program Strategies for Community Service System Development.

The purpose of this aspect of the study was to obtain expert advice regarding potential program improvements of the programs conducted under the act. This advice will be an input to the Council to help it formulate its policy recommendations to the Congress and to the Department.

(3) Undertake a limited series of new special analyses and evaluation studies designed to:

—Identify the best means of identifying those in greatest need (a congressionally mandated analysis).

—Determine what is known about current low-income and minority group participation levels in programs conducted under the Older Americans Act (a congressionally mandated analysis).

—Assess the effectiveness of the Title V: Community Service Employment Program; and

—Answer a series of specific questions about AoA's effectiveness in fostering community service system development and to define exemplary community service systems. (Note: this study will provide information on evaluation design options for assessing community progress in developing systems of services for the elderly and for assessing the progress of State units on aging and area agencies on aging in fostering the development of such systems.)

May 18, 1980

Between January 5 and May 18, request for proposals (RFP's) were developed for the special analysis studies including the identification of potential contractors. Also, the requirements for the policy option papers were developed and the identification and hiring of writers (consultants) for the papers were completed.

The FCA study group met on May 18 with the paper writers and reviewed the outline of each paper. Also, a status report on the overall progress of efforts toward achieving the objectives of the mandated study was presented. Additionally, special assignments were given to each member of the mandated study group and FCA staff to monitor each paper and contracted study.

May 21, 1980

An overview of the FCA congressionally mandated study was made to the Hill staff by the mandated study director and FCA staff.

June 16, 17, 1980

The major issues of the mandated study were reviewed with the full Council.

July 28, 1980

The Council met informally with the leadership council of aging organizations for the purpose of seeking their input on the issues being addressed and the process being used by the Council in responding to the mandated study.

August 24, 1980

The FCA mandated study group met with a paper writer and explored in depth the issues on "Age as a Criterion for Focusing Public Programs."

August 25, 26, 1980

The full meeting of the Council on August 25 and 26 featured an intensive and provocative discussion of the mandated study with the full Council focusing on the issues and concerns of the policy papers and studies to be undertaken. The overall discussion on the mandated study was led by Wes C. Uhlman, chairman of the mandated study group.

November 16, 17, 1980

A comprehensive review and analysis of options and positions were presented to the mandated study group by the study director and FCA staff.

December 1, 1980

A briefing on the progress of the policy options papers, and contracted studies was made before the full Council. Also, preliminary findings, conclusions, and recommendations were discussed reflecting both the papers and contracted studies.

December 17, 1980

The mandated study group and FCA staff met with members on the leadership council of national organizations to receive their comments relative to the FCA findings and recommendations on:

(1) Title III, grants for State and community programs on aging—services development and system building under the Older Americans Act.
(2) Targeting under the Older Americans Act.
(3) Policy advocacy at national level.
(4) Title VI, research and training programs.

The target date for the delivery of the report to the Congress is March 31, 1981. (Note: See appendix E for a listing of the critical issues pertinent to the mandated study.)

APPENDIXES

Appendix A

1981 White House Conference on Aging

Throughout 1980, the Council made the 1981 White House Conference on Aging one of its primary agenda items. Of primary concern was the role of the Council relative to the White House Conference on Aging. A consensus among the White House Conference on Aging Advisory Committee members seem to be that the Council assume a major role in the Conference process and, most importantly, in the followup period of implementation of the recommendations which will come from the December 1981 meeting.

At its December 1–3 meeting, the Federal Council on the Aging took formal action on this matter and passed a resolution which outlined FCA plans to undertake major responsibility for monitoring and cooperating with others to implement recommendations to emerge from the 1981 White House Conference on Aging.

The Council believes that this role is in keeping with the legislative authority and function of the Council, namely: "(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."

The seven members of the Council (Charles J. Fahey, Cyril Carpenter, Jacob Clayman, Aaron Henry, John Martin, Bernice Neugarten, and James Sykes) who also share dual status of membership on the White House Conference on Aging advisory body will serve as the Council committee that would determine and coordinate the role of the Council, its members and staff in relation to the 1981 White House Conference on Aging.

Appendix B

FCA Operations and Procedures

The Council is required by law to conduct a minimum of four meetings per year. Therefore, it is the policy of the Council to conduct a minimum of four regular meetings per year, and to provide sufficient time during each meeting to allow for reasonable review, discussion, and resolution of Council business.

The purpose of the Council meeting is to provide a forum for orderly discussion among the membership and for deliberation and determination of issues related to the Council's legislated mandate.

All meetings of the Council must be open to the public and reported in the Federal Register 30 days prior to the meeting. It is the staff's responsibility for submitting all legal notices and for advising other interested agencies and individuals as appropriate.

Conduct of all Council meetings requires a quorum of the membership to be present. A quorum is the simple majority of current appointees for a regular Council meeting. Occasionally Council members may have to leave the meeting room briefly; the quorum is officially maintained for the purpose of conducting the day's business.

Council meetings normally consist of 1½ or 2 full, consecutive day sessions. The opening session includes approval of previous meeting minutes. The closing session includes discussion of tentative items to be placed on the next meeting agenda.

Items to be listed on the meeting agenda can be suggested by Council members and/or staff. These items are submitted to the special assistant to the chairman who has the responsibility for developing the agenda in consultation with Council chairman and executive committee. It is necessary and legally required, that major items on the agenda be determined and the public notified of issues to be considered.

At least 1 week to 10 days prior to each meeting, the staff mails the agenda to the entire Council membership and a selected mailing list of government and nongovernmental agencies and officials. Also, specific background materials are mailed to acquaint Council members with specific agenda items, when appropriate. The staff compiles all other meeting documents, papers, and related materials into a portfolio or folder for each Council member.

For purposes of accurate recording of the proceedings of a Council meeting, a professional stenorecorder is hired to record verbatim all formal proceedings. This record is made in compliance with the Federal Advisory Committee Act and is available to the public upon request at the Council staff office. A synopsis of major discussion and decisions of a meeting is distributed to the members in the form of minutes prepared by Council staff, principally by the executive assistant.

Federal legislation has established broad and complex responsibilities for the Council. To this end, the Council recognizes the intent of the legislation to provide a means for including a variety of representation from throughout the populace in the policymaking process of the Federal Government. In order to best utilize the specialized knowledge and expertise of all of its members, the policy of the Council is to apportion specific activities among its members, reserving ultimate review and approval authority for the vote of the entire membership.

Furthermore, the Council has established a policy of conducting apportioned activities through the operation of task forces which correspond to distinctly identifiable responsibilities.

The Council recognizes that although the legislated, broad responsibilities of its mandate remain constant, the means for accomplishing specific goals, and the recognition of current, relevant issues, may fluctuate. Therefore, task forces are established on a temporary, as-needed basis to conduct a specific program of work as a means of accomplishing an identified goal(s) and/or objective(s).

Once a committee or task force is established, a member of the professional staff will be assigned to be responsible for coordinating staff activities and to be the principal contact between the committee or task force chairman and other Council members.

Committee or task force members are expected to attend all the meetings of that committee or task force and to review all documents and other materials pertinent to the work of the task force. In addition, staff is responsible for:

(a) Keeping abreast of documents, issues, and legislation related to the work of the committee or task force and advising members as appropriate.

(b) Making committee and task force meeting arrangements including preparing the meeting agenda, securing speakers and facilities, writing and disseminating appropriate notices, and preparing materials.

(c) Writing progress reports and keeping committee members informed.

(Note: Copies of all correspondence, progress reports, and related documents are routinely provided by staff to the Council chairman.)

Appendix C

TIME CHART FOR WORK PLAN (STAFF MEMBERS)

Topic	January	February	March	April	May	June	July	August	September	October	November	December
Mandated Study	80% FCA time				20% FCA time						25% FCA time	
White House Conference on Aging		20% FCA time										
Employment	0				5-10% FCA time							
Targeting	0				Part of 20% Mandated Study Follow-up							
Social Security	(as needed reactive)				5-10% (proactive) FCA time							
Legislation	(as needed reactive)				5-10% (proactive) FCA time							
Update FCA Studies	0				5% FCA time							
Living Arrangements	0				10% FCA time							
Family Informal Supports, Other Mediating Structures	0									10% FCA time		
Well Being of Older Persons	0									10% FCA time		

Appendix D

FCA Mandated Study Issues

POLICY TOPIC I: AGE AS A BASIS FOR SOCIAL POLICY

Issue: What role should age play as a criterion for focusing public policy and social programs?

Discussion Questions

(1) How meaningful is age as an eligibility condition of program participation?
(2) How meaningful is age as a basis for targeting services? How meaningful is age as a proxy for need?
(3) Should the government promote age-integrated or age-segregated service systems?
(4) What are the major policy implications of an aging society for the design of programs funded under the Older Americans Act?
(5) What role should factors other than age play in rationing public benefits and services for the aged population?

Conclusions

(1) "From its passage (then) and embodied in the Declaration of Objectives, Older Americans Act services were to be available to any person aged 60 and over, under the presumption that if old, one had *need* for such services." (Kutza)
(2) "One—at every age—has need for services that enhance one's social well-being. Society has an obligation to provide generally for those needs—e.g., parks, theaters, safety, life-enhancing opportunities. (Sykes) How a society decides collectively to finance such services is a separate question."
(3) Chronological age *as such* is an arbitrary rationing device.
(4) Chronological age is a weak indicator or proxy for need.
(5) Resolution of this issue requires a careful delineation of the uses that chronological age and age classifications might have in relation to public policies and programs. (E.g., chronological age might be used as an eligibility foundation to ration the benefits of a program; it might serve as a general presumption or proxy for need for some service; or it might simply serve as the condition defining the client group for outreach, program development, or other similar purposes.) The reasonableness of age classifications has to be judged on the basis of their intended use in serving legitimate State interests. Because uses and interests vary widely with the particular program or government function to be served, such judgments require careful consideration of the specific context in which the classification is to be used.
(6) Because of these complexities, general conclusions have limited usefulness apart from a specific context defined in terms of the use to be made of age, the type of program or government function, and the State interest to be served.

POLICY TOPIC II: RESOLVING THE APPARENT DILEMMA OF WHO SHOULD BE SERVED

Issue: Who should be served by Government programs funded under the Older Americans Act?

Discussion Questions

(1) Is the dual focus justified or should it be changed?
(2) What justifies a dual focus? (a) The nature of the problems facing older persons; (b) the diversity of programs authorized and funded.
(3) Is the answer different if the financing question is separated from the issues of *what* programs and *what* services are needed? E.g., *personal* social services versus social action programs; *or*
(4) Is the answer different if the focus is on different types of Government responsibilities or roles? E.g., law enforcement versus publicly financing social services; or access services versus other social services?
(5) What are the implications of the need and service data?
(6) Does raising this issue really constitute another way of asking what the Government's priorities ought to be? E.g., economic security first, jobs, housing, and health care next?

Conclusions

(1) The legislative intent of the act is clear in generic terms. Specifically, the act authorizes activities and programs intended to serve all older Americans

while targeting social and nutrition services toward those with special social or economic needs; title III also requires preference for those in greatest need.

(2) The universe of unmet need for services and programs is reasonably well-understood in general terms; it is not, however, defined with precision and specificity for each social service or even for nutrition services. Needs, wants and preferences are not easily distinguished. The resolution of this question is actually accomplished in the reauthorization and appropriations process which is not always very rational. There is a fairly clear consensus about the general need for some services (e.g., legal services and certain access services) but not others.

(3) There is a need for a reasoned basis to establish long-range policy goals and priorities for program development under the Older Americans Act. At the present time, the active disagreement about priorities regarding such broad policy areas as economic security, jobs, housing, health care, and social services for older persons appears to hamper effective program development, especially under title III of the Older Americans Act.

POLICY TOPIC III: THE ELDERLY AS A NATIONAL RESOURCE

Issue: How can the Congress and the Departments of Labor and Human Services establish effective programs to achieve the best use of the elderly population as a national resource?

Discussion Questions

(1) (a) Are some of those responsibilities on an age-specific basis? (b) Should some of those responsibilities be met on an age-specific basis? (c) Should efforts directed at employment or employability of the elderly be targeted to those who are identifiable as "traditionally disadvantaged"?

(2) Should Federal efforts directed at employment of the elderly be means-tested?

(3) (a) Are there Federal laws which prohibit or act as disincentives to gainful employment? (b) Are those regulations which prohibit or act as disincentives to gainful employment? (c) Are there barriers to entrancing employability which the Federal Government could reduce or remove?

(4) (a) Are present efforts adequate? (b) What approaches are most effective? (c) What new programs might be needed? (d) How are positive results measured? (e) How are negative results measured?

Conclusions

(1) The Federal Government has a responsibility to enhance the potential for usefulness of each of its citizens to assure their autonomy and control over as broad a range of individual options as possible for as long as possible.

(2) The independence guaranteed by self-support is an important contribution to an individual's array of options and personal autonomy.

(3) Employment and employability are both conditions affected directly by Federal policies, processes, and programs.

(4) There is a Federal responsibility to affect positively, and not to affect negatively, the employability and opportunities for the employment of the elderly population which otherwise competes at a disadvantage against other citizens in the labor market.

POLICY TOPIC IV: FEDERAL POLICY TO ACHIEVE EFFECTIVE TARGETING

Issue: What policies should the Federal Government employ to promote effective targeting of services to those in greatest economic or social need?

Discussion Questions

(1) How can existing targeting strategies be improved?

(2) Should targeting goals be established on a national level or on the State/area/local level?

(3) Which strategies should be used in identifying target populations?

(4) Which approach to targeting is preferable: (a) A technical assistance and monitoring strategy, or (b) an enforcement strategy?

(5) What are the possible advantages of targeting resources to meet the needs of specific populations? More and better services to those most critically in need?

More flexibility to focus on the unique problems of the elderly subpopulations at individual State levels? E.g., large subpopulations of minority elderly in poverty? More flexibility to alter service delivery strategy to meet changing needs of various subpopulations, e.g., older women?

(6) What are the possible disadvantages of targeting resources to serve the needs of specific populations? Increase the size of subpopulations of elderly needing more costly services, e.g., nursing homes, hospitals, etc.? Carried to an extreme, would targeting be counter productive? Place a stigma on the image on programs for older Americans?

(7) Which incentives might work to improve targeting? One based on using broad dissemination regarding what is known about best practices? One based on discouraging program utilization by those elderly with other resources?

POLICY TOPIC V: FEDERAL POLICY FOR SERVICES DEVELOPMENT AND SYSTEMS-BUILDING UNDER TITLE III OF THE OLDER AMERICANS ACT

Issue: For national policy purposes, what policies and principles should guide priority-setting for services development and system-building under the Older Americans Act?

Discussion Questions

(1) What type of systems should be promoted? What kind of service system should AAA's try to build at the local level?

(2) How should priorities for services be established—by statute, by regulation, by Federal administrative decision, by State and local decision?

(3) How can reasonable expectations be defined for State government in its role in implementing Older Americans Act programs?

(4) Under the Older Americans Act, what substantive policy should be used by the Federal Government in promoting local service systems? Specifically, should AoA focus on all community services, primarily on health and social services, or primarily on the problem of long-term care? What policy should guide such priority-setting?

(5) What functions should AAA's perform to foster the development of desirable service systems?

(6) What relationships should AAA's have to HSA's, to title XX agencies and other similar State and local community planning organizations?

(7) Should the Federal Government promote consolidated intergovernmental management structures for the planning and delivery of health and human services to the elderly?

(8) Can AAA's provide services directly and also serve effectively as information gatherers, and planning agencies stimulating program development and assuring the quality control of services and service delivery?

Conclusions

(1) At the national level, the accountability for services development and system-building at the State and local levels has been defined largely in process, activity, and input terms. AoA's management's long-range developmental objective is to establish local aging service systems that insure access to care, treatment, and other social services, adequate community based social and nutrition services, adequate in-home services and adequate services in care-providing facilities. AoA's strategies for achieving such program development have been focused selectively on certain services such as transportation services, legal services, and the long-term care ombudsman program.

(2) Expectations regarding the development of comprehensive, coordinated local service systems need clarification, especially in the light of known resources constraints.

(3) There is a need to document successful services development and system-building as a basis for future program development and program evaluation. (The Federal Council has undertaken a short-term study to determine the feasibility and cost of such program development and future full-scale evaluation.)

(4) Past evaluations show that the Administration on Aging, and the State and area agencies on aging have made some measurable progress in achieving appropriate developmental objectives under title III of the act. On the basis of readily available information from such past evaluations and a selected number of other relevant studies; the Council reached *no* general conclusions regarding the effectiveness of the "network" at the State and substate levels as vehicles for

services development and system-building. There are studies—such as the 1976 Steinberg study, the Westat study and (perhaps) the Estes-Newcomer study that document some success—as well as room for improvement. (Note: The GAO will be in a position to illuminate the performance of State units on aging and the area agencies on aging after the results of their national survey are ready in the spring 1981.)

(5) There are fundamental policy issues regarding services development and system-building under the Older Americans Act. Specifically, it is unresolved whether the Government should develop a fully comprehensive categorical system of services for the elderly or should provide services to older people through a more generic human services delivery system. Relative priorities among social services are debated periodically in the authorization and appropriations process. Usually the debate is highly contentious and not very rational. It would be useful to have a more clearly defined general strategy for such program development.

POLICY TOPIC VI: PUBLIC LEADERSHIP IN POLICY FORMATION—ADVOCACY UNDER THE OLDER AMERICANS ACT

Issue: Are redirections and improvements needed at the national level to clarify and upgrade AoA's and the FCA's advocacy role in the agency policy formation process?

Questions We Have Addressed

(1) Are expectations realistic and sufficiently well-defined? If not, how can expectations be clarified and made realistic?

Options to consider

(A) *Define expectations regarding the advocacy function in terms of* (1) the quality of brokering and negotiating for change; (2) the degree of apparent influence of advocates on decisionmakers (executive and legislative); (3) the specific results achieved in legislative, budgetary and administrative processes; or (4) specific types of major reform of Federal policy in aging (e.g., expect successful leadership in achieving a coherent national manpower policy in aging, or a coherent Federal policy for long-term care services for the elderly).

(B) *Develop measures around* (a) coherence of national level policy in selected policy areas; (b) extent of rights, benefits, and entitlements protected; and (c) extent of new rights, benefits, and entitlements created for the elderly.

(2) Are radical changes needed? Should the policy-oriented advocacy function be separated from AoA's other basic functions.

(A) *Maintain the advocacy and policy development framework established under the 1978 Older Americans Act Amendments.*—Involved here is an assessment of the advocacy record, potential and limitations of the Administration on Aging, the Federal Council on Aging, the National Institute on Aging, the Center for Studies of the Mental Health of the Aging, and the White House Conference mechanism (as currently organized, charged, and interrelated) in light of the criteria developed in part II.

(B) *Maintain the existing Older Americans Act advocacy framework, but substantially reorganize and strengthen it by:* Elevating AoA within HEW; increasing AoA's policy review staff and capacity; increasing staff and policy development capacity of the Federal Council on Aging; clarifying roles and expectations among AoA, OHDS, the Federal Council, and NIA in order to maximize positive and complementary interaction vis-a-vis advocacy.

(C) *Consolidate the broader advocacy functions of the Administration on Aging into the responsibilities of an enlarged Federal Council.*

(D) *Create a new Federal aging agency with Older Americans Act advocacy and program responsibilities under a Presidentially appointed commission.*

(E) *Eliminate the Federal Council on Aging and create a citizen advisory group to a more advocacy-oriented Administration on Aging.*

(3) Are process changes needed?

(A) Are improvements needed in policy agenda setting, information gathering and synthesis, collaboration to solve problems and improve policies?

(B) How does the AoA see the Council's relationship to older Americans as a potential FCA/AoA client group or constituency?

(C) Is the Council's role in the long-term care policy area a possible model for a Council relationship to the AoA, the Department, the Congress, and the clientele?

(D) What role should State and substate level advisory councils play in relation to the Federal Council's role?

Conclusions

(1) At present, expectations are poorly defined and the program design is implausible.

(2) A more coherent national policy in aging is needed to resolve the apparent dilemmas caused by the generic and broad mandates of the Older Americans Act.

(3) Current expectations regarding AoA and FCA's roles in national aging policy formation are not realistic—given their structure, other basic functions, staffing, and other resources, and the wide distribution of responsibilities throughout the executive branch, the Department and the Congress.

(4) The advocacy role needs to be defined to permit: (a) Agreement on its appropriate role, (2) appropriate expectations, (c) agreement on objectives against which to measure its effectiveness, and (4) clear directions on which to base management decisions regarding actions and resources.

(5) Methods are needed to clarify the roles of AoA, OHDS, NIA, OASPE, OS, and the FCA and to establish a process that will consistently produce topics for data collection, data synthesis, policy discussion, and followup action.

(6) More systematic and visible use should be made of the State and area agencies, and the voluntary nonprofit sector as vehicles for policy agenda-setting, information gathering and synthesis and other actions.

(7) AoA still lacks the organizational capacity to manage actively for leadership in aging policy formation in the Department and in the executive branch. A design change may be needed.

(8) The results of effective advocacy are best measured by the growth of strength and status and diminution of the needs and vulnerabilities of the advocate's client or constituency.

POLICY TOPIC VII: KNOWLEDGE BASE FOR POLICY AND PRACTICES IN AGING—AOA'S RESEARCH AND TRAINING PROGRAMS

Issue: Should AoA's research and training programs be more visibly integrated into AoA's other major program elements to achieve more support of its mission?

Discussion Questions

(1) What direction has AoA given the overall R.D. & E. program? (a) Has it supported advocacy satisfactorily? Has it supported services development and system-building satisfactorily? (c) Has it supported the research in social gerontology and the related aging policy sciences satisfactorily? (d) Has it supported the evaluation function satisfactorily? (e) Has it accomplished any results? (f) Has its impact been felt?

(2) What initiatives can AoA management take to shape a research program as an integral part of AoA's activities supporting its key mission elements? (a) What are the constraints on centralized priority setting? (b) What are the limitations of the resource levels? (c) What are the in-house skills needed to operate a research program? (d) Can a process be developed to operate a multipurpose program economically? (e) Which audiences are most difficult to satisfy with research information? (f) Can AoA identify the purposes of its mission which are supported by meeting the needs of a given audience?

(3) Is the evaluation function organized as a program at the Federal level? (a) Has it identified objectives of the respective subprograms? (b) Has it differentiated the constituencies and clientele of the respective subprograms? (c) Has it developed means of identifying and measuring impacts of the subprograms? (1) At the State and/or local level? (2) At the project level? (d) Can it institutionalize feedback of its findings?

(4) Have there been useful results generated by AoA research efforts? (a) In development of skills? (b) In development of delivery techniques? (c) In development of administrative or enforcement process? (d) In development of evaluative measures?

(5) Has constructive learning been generated by AoA research efforts? (a) Have information gaps been filled? (b) Have useful institutions, individuals, or programs been supported? (c) Have useful questions been generated? (d) Have data been refined or made more reliable? (e) Have casual questions been validated and/or answered? (f) Has policy changed direction or degree of control as a result of research? (g) Have State, local, or service delivery personnel indicated use of AoA products? (h) Have the elderly reflected interest in a satisfaction with any AoA research products?

Conclusions

(1) Titles II and IV in combination, authorize a multipurpose program intended to support all elements of the AoA mission.

(2) The title IV program is intended to build a knowledge base for long- and short-range policy formation in aging. Research, demonstration, and evaluation activities have a major role to play in:

—Developing new knowledge for tomorrow's services for future generations of aged.

—Advocacy in the public policy formation process; and

—Services development and system-building.

(3) There is evidence that AoA's research has made a contribution to the field of social gerontology, to constructive policy formation regarding issues of concern to older Americans, to services development and system-building.

(4) The existing program design for determining the impact, effects, cost, replicability, and transferability of demonstrations is implausible.

(5) The existing program design for achieving utilization of research in the public policy formation process is likely to produce inconsistent results.

(6) The existing program design for AoA's support of the evaluation function throughout the network is implausible.

(7) Staffing and intramural capacity in research, demonstration, and evaluation, education and training program management is a serious problem at AoA.

(8) Continued progress in research, demonstration, and evaluation planning is needed, so that the role of both in support of all of AoA's mission elements can be made more demonstrable.

(9) Concentration of title IV research and training funds is also a significant issue. (Measures of investment adequacy are needed; as are appropriate strategies for concentrating resources sufficiently to achieve visible results.)

Appendix 2

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1. DEPARTMENT OF AGRICULTURE

FEBRUARY 23, 1981.

DEAR MR. CHAIRMAN: Thank you for your committee's letters to Secretary Bergland and Mr. Alex P. Mercure requesting an update of the U.S. Department of Agriculture (USDA) activities in the fiscal year 1980, affecting older Americans.

We are pleased to submit the following report. Enclosed is input from the following USDA agencies for inclusion in the "Developments in Aging" report: (1) Science and Education Administration; (2) Forest Service; (3) Economics and Statistics Service; (4) Rural Electrification Administration; (5) Farmers Home Administration; (6) Food and Nutrition Service, and (7) Office of Equal Opportunity.

We hope this information will be helpful both to the committee and to others concerned with the welfare of older Americans Thank you for giving us the opportunity to be included in the annual report, "Developments in Aging" of the Senate Special Committee on Aging.

Sincerely,

JOHN R. BLOCK, *Secretary.*

Enclosure.

SCIENCE AND EDUCATION ADMINISTRATION

It is estimated that approximately $18 million (25 percent) of all resources in Extension family education programs directly or indirectly provide program activities regarding the elderly.

Extension, Science and Education Administration, USDA, is a party in two of AoA's working agreements for older people: (1) *Working agreement on information and referral for older people;* (2) *working agreement on energy conservation actions for the elderly.* Extension, in addition, has a (3) *memorandum of understanding with AoA to improve the quantity and quality of nutrition, health, and other supportive services to older persons.* (4) *Educational programs* to meet the above needs and the myriad other needs and interests of the elderly are provided by national, State, and county Extension professionals, Extension Homemaker Club members and 4-H and other youths.

At State levels these are goals for programs aimed especially to the elderly: Knowledge of laws and regulations affecting the family/household (i.e., credit, consumer protection, property descent, divorce, employment, day care, social security, medicare, death and burial, etc.); knowledge of where health services are available and how to use these services appropriately; helping people participate in health services and continue to learn what constitutes and contributes to wellness, referral for available health services; developing programs for persons facing major economic and/or social adjustments, such as divorce, displacement, death of a spouse, or family abuse; providing programs that help develop skills for remaining self-sufficient in the retirement years; and increasing involvement by families in public decisionmaking which impact directly on designated populations.

Extension staff members cooperate with many other agencies and organizations in efforts to meet the interests and needs of the elderly. At the national level, major coordination is with AoA, National Endowments for the Arts and Humanities, AARP–NRTA, NCOA, the National Safety Council, the National Extension Homemakers Council, and the White House Conference on Aging scheduled.

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HUMAN NUTRITION PROGRAM IN AGING

A major new national facility for the study of human nutrition in aging is being constructed at a cost of $23 million on land donated by Tufts University. Construction is scheduled for completion in 1982. At that time research will be conducted into the ways in which diet, alone and in association with other factors, can delay or prevent the onset of the degenerative conditions commonly associated with the aging process. Research programs developed in the center will identify nutrient requirements during aging and the ways in which an optimal diet, in combination with other factors—heredity, constitutional, psychological sociological, and environmental—may contribute to health and vigor over the lifespan of people.

During fiscal year 1980 the Human Nutrition Research Center on Aging at Tufts University was appropriated $2 million. Using facilities made available by Tufts University, an interim research program is developing. Studies to determine the significance of dietary protein in maintaining tissue function as aging takes place, as well as more fundamental studies of the effect of nutritional status on individual cells through life, are in progress. In addition to these studies, significant progress has been made in developing a program of nutrition evaluation of older Americans.

FOREST SERVICE

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The U.S. Department of Agriculture, Forest Service in cooperation with the Department of Labor sponsors the senior community service employment program (SCSEP). The SCSEP provides part-time employment, work experience, and skills training to economically disadvantaged seniors, aged 55 and older, who reside primarily in rural areas.

Program participants are involved in projects on national forest lands such as construction, rehabilitation, maintenance, and natural resource improvement work. Enrollees receive at least the minimum wage to supplement their personal incomes. A major benefit of the SCSEP program is the opportunity participants have to regain a sense of involvement with the mainstream of life through meaningful work. Additionally, valuable conservation projects are completed on national forest lands.

Our July 1, 1979 through June 30, 1980, interagency agreement (for fiscal year 1979) with the Department of Labor provided funding of $14.5 million to conduct the SCSEP in rural areas within 40 States and the Commonwealth of Puerto Rico. The SCSEP served approximately 3,947 seniors who accomplished approximately 2,208 person-years of conservation work valued at $20 million. During this program year, 28 percent of the enrollees were women and 17 percent of the enrollees were minorities. For each dollar invested in the SCSEP, an estimated $1.38 worth of conservation work was accomplished.

Our July 1, 1980 through June 30, 1981, interagency agreement (for fiscal year 1980) with the Labor Department provided funding of $15.4 million which maintained the program at the previous year's level. We anticipate serving 4,200 seniors; we expect that 32 percent will be women and 19 percent will be minorities. These senior workers should accomplish 2,250 person-years of conservation work valued at more than $21.2 million. For each dollar invested in the program, we anticipate reaping $1.38 worth of conservation work.

ECONOMICS AND STATISTICS SERVICE

The Economic Development Division, Economics and Statistics Service, for several years has had at least one study that considered the elderly directly. Several studies (those with relevant age categories as a set of variables) involved consideration of age along with other variables. Direct consideration has involved mainly the following individuals and reports:

E. Grant Youmans, Ph. D., EDD, ESCS, USDA. Stationed at University of Kentucky. Retired 1978.

E. Grant Youmans and Donald K. Larson. "Health Status and Needs: A Study of Older People in Powell County, Ky." Dept. of Soc., Univ. of Kentucky, cooperating with EDD, ESCS, USDA, RS–52, April 1977.

Donald K. Larson and E. Grant Youmans. "Problems of Rural Elderly Households in Powell County, Ky." EDD, ESCS, USDA, ERS–665, January 1978.

E. Grant Youmans. "Age Stratification and Value Orientations," Internat'l J. of Aging and Human Dev., vol. 4, No. 1, 1973, pp. 53–65.

E. Grant Youmans. "Age Group, Health, and Attitudes," the Gerontologist, vol. 14, No. 3, June 1974, pp. 249–254.

E. Grant Youmans. "The Aging: Needs and Services," Yearbook of Agriculture, 1971, pp. 197–200.

Mary Jo Grinstead-Schneider, Ph. D. Employed by University of Arkansas and working with Bernal L. Green, Ph. D., EDD, ESCS, USDA.

Doyle Butts, Mary Jo Schneider, et al. "Programs for the Aged in Western Arkansas: A Cost Analysis." Ark. Agr. Exp. Sta. cooperating with Western Ark. Area Agency on Aging and EDD, ESCS, USDA, Bul. 847, September 1980.

Michelle Davis Fryar, Mary Jo Schneider, and Donald E. Voth. "The Impact of Nutrition Programs on the Health Status of Elderly Arkansans." Ark. Agr. Exp. Sta. cooperating with EDD, ESCS, USDA, Bul. 839, October 1979.

Ann Tippitt, Mary Jo Grinstead-Schneider, and Bernal L. Green. "Problems and Adjustments to Loss of Spouse Among the Elderly: Fort Smith and Waldron, Ark." Ark. Agr. Exp. Sta. cooperating with EDD, ERS, USDA, Bul. 823, 1977.

Alan May, et al. "An Evaluation of Congregate Meal Programs and Health of Elders: Scott County and Fort Smith, Ark." Ark. Agr. Exp. Sta. cooperating with EDD, ERS, USDA, Bul. 808, July 1976.

Alan May, et al. "Attitudes Toward Nursing Homes and Other Facilities for Meeting Health Care Needs After Retirement: Scott County and Fort Smith, Ark." Ark. Agr. Exp. Sta. cooperating with EDD, ERS, USDA, Bul. 800, June 1975.

Nelson LeRay, Ed. D., EDD, ESCS, USDA. Stationed at University of New Hampshire. Retired 1980.

Nelson LeRay and Donn A. Derr. "Community Service Convenience and Satisfaction of the Elderly in Nonmetro Areas of the Northeast," J. of the Northeastern Agr. Coun., VI, April 1980, pp. 67–80.

Nelson LeRay, et al. "Community Services for Older People in the Rural Northeast." Northeast Reg. Ctr. for Rur. Dev. Pub. 14, Ithaca, N.Y.: Cornell Univ., July 1978, pp. 135–144.

Nelson LeRay, et al. "Elderly Households in the Nonmetropolitan Northeast and Their Satisfaction With Community Services." New Hampshire Agr. Exp. Sta., Univ. of New Hampshire, cooperating with EDD, ESCS, USDA, Res. Bul. 646, March 1977.

Nelson LeRay, et al. "Household Income Status of the Elderly in New Hampshire." New Hampshire Agr. Exp. Sta., Univ. of New Hampshire, cooperating with EDD, ERS, USDA, Res. Rpt. 23, April 1972.

James R. Bowring and Nelson LeRay. "The New Hampshire Older Poor." Coop. Ext. Ser. Univ. of New Hampshire, Ext. Cir. 398, June 1969.

Robert A. Bylund, Nelson LeRay, and Charles O. Crawford. "Older American Households and Their Housing 1975: A Metro-Nonmetro Comparison." New Hampshire Agr. Exp. Sta. Univ. of New Hampshire, cooperating with EDD, ESCS, USDA. AE and RS 146, January 1980.

Nelson LeRay, et al. "The Older Population of New Hampshire." New Hampshire Agr. Exp. Sta., Univ. of New Hampshire, cooperating with EDD, ESCS, USDA, Res. Rpt. 66, July 1978.

Robert Bylund, Charles O. Crawford, Nelson Leray, and Elinor M. Caravella. "The Rural Elderly in the United States and the Northeast: A Statistical Report." Northeast Reg. Ctr. for Rur. Dev. Pub. 14, Ithaca, N.Y.: Cornell Univ., July 1978, pp. 14–31.

Janet W. Coffin and Nelson LeRay. "Older Farm Operators and Their Farms." EDD, ESCS, USDA, Working Paper 7910, December 1979.

Nina Glasgow, M.A., EDD, ESS, USDA.

Andrew J. Sofranko, Frederick C. Fliegel, and Nina Glasgow. "Older Urban Migrants in Rural Settings: Problems and Prospects," Internat'l J. of Aging and Human Dev. (forthcoming 1981).

Nina Glasgow. "The Older Metropolitan Origin Migrant as a Factor in Rural Population Growth." Rebirth of Rural America: Rural Migration in the Midwest.

Ed. Andrew J. Sofranko and James D. Williams. Ames, Iowa, North Central Reg. Ctr. for Rur. Dev., Iowa State Univ. 1980, pp. 153–169.

Donald K. Larson, Ph. D., EDD, ESS, USDA.

Donald K. Larson. "Elderly Americans: Emerging Economic Issues," Proceedings of Science and Aging, 1976.

Donald K. Larson. "Rural Elderly: Needs, Problems, Satisfactions," Rural Development Perspectives, No. 1, November 1978, pp. 21–22.

For coauthored reports, see Youman's publication list.

Rural Electrification Administration (REA)

REA-financed electric and telephone systems must provide service to all residents of the areas they serve. Upon request REA does provide the REA borrowers with information about Federal financing and technical assistance available to help the elderly.

The most recent community development survey reveals that a number of the electric and telephone systems which are financed by REA are working with other community leaders on various projects for the elderly, i.e., housing, medical, transportation, and food distribution.

Although REA does not have the exact number, many elderly citizens are receiving home energy audits and other assistance from the electric cooperative to help save energy.

Farmers Home Administration (FmHA)

1. SECTIONS 502 AND 504 RURAL HOUSING LOANS

Section 504 rural housing loans are available to qualified low-income applicants to make basic repairs necessary to remove health and safety hazards. This includes such items as roof repair, storm windows, and doors, insulation, water systems, and waste disposal systems. The maximum loan is $7,500 and the interest rate is 1 percent. For the fiscal year 1980, $24 million is available for 504 loans. For elderly applicants who do not have repayment ability for a 1-percent loan, grant funds may be available for necessary improvements; $24 million is available in fiscal year 1980 for the grant program. This compares with $19 million available in 1979.

Elderly applicants may also be assisted under the section 502 loan program. Such loans are available to build, purchase, or rehabilitate modest homes that are adequate to fit the needs of the applicant. The interest rate on section 502 loans is currently 13 percent, with a maximum repayment period of 33 years. For low-income applicants, reduced interest rates are available to as low as 1 percent depending on income, number of people in the household, amount of loan installment, real estate taxes, and property insurance. Seventy-two percent of $3,080 billion available for section 502 loans in fiscal year 1980 is allocated to applicants who will qualify for the reduced interest rates.

Farmers Home Administration regulations are currently in process of revision to clarify the provision to allow for adequate space to include elderly family members, such as parents or grandparents, as a part of the household.

2. SECTION 515 RURAL RENTAL HOUSING

Rural Rental Housing

The section 515 rural rental housing program provided approximately 31,000 units for $868 million in loan obligation during fiscal year 1980. Of this amount, it is estimated that 30 percent was expended to house the elderly. Many of these units were subsidized with FmHA rental assistance or by Department of Housing and Urban Development (HUD), section 8 assistance payments. As of this writing, FmHA has not completed its program evaluation relative to assistance impact. Therefore, the figures given are solely estimates and should be considered as such. Under these programs, low-income elderly households pay up to 25 percent of their adjusted income for housing, including utilities. If their adjusted income is too low for them to pay the established rent, these subsidies make up the difference.

For fiscal year 1981, FmHA has budgeted $918 million for rural rental housing coupled with an additional $403 million for rental assistance. FmHA also expects to receive from HUD 10,000 units of section 8 set-aside funds to be used with the rental housing program.

The FmHA State Directors will be working on a State-by-State basis with their HUD counterparts to determine the ratio of elderly units to family and large family units to be subsidized by section 8 assistance.

Congregate Housing for the Elderly and Handicapped

Farmers Home has authority under the section 515 rural rental housing program to build congregate housing for the elderly and handicapped. Congregate housing is an alternative for the elderly who need an assisted residential living environment. It offers the functionally impaired or socially deprived but not ill elderly residential accommodations with supporting services to assist them in maintaining, or returning to independent or semi-independent lifestyles to prevent premature or unnecessary institutionalization as they grow older. The regulations provide for the establishment of the following mandatory services: Meals, personal care and housekeeping services, transportation, and social and recreational activities. Developers who apply to Farmers Home for loans to build congregate facilities must demonstrate their ability to provide these minimum services. In most instances, developers are coordinating with social service agencies to obtain support in the provision of services.

The congregate housing for the elderly and handicapped program has been launched through a joint demonstration effort with the Administration on Aging of the Department of Health and Human Services (HHS). Farmers Home set aside $12 million for the construction of a congregate facility in each of the 10 HHS regions and two Indian reservations and the Administration on Aging provided up to $85,000 per facility for the support services named in the regulations. Sites were chosen based on the percentage of persons 60 years of age and older, income factors, and poor housing conditions. Housing will be constructed in Port Gibson, Miss., Mayville, N.Y., Baldwin, Mich., Onancock, Va., Truth or Consequences, N. Mex., Lamoni, Iowa, Wagner, S. Dak., Beaumont, Calif., Baker, Oreg., Carroll County, N.H., Turtle Mountain Tribe in North Dakota, and White Earth Tribe in Minnesota. Funding from the Administration on Aging for services will be available each year of the 3-year demonstration period after which the appropriate area agencies on aging have made commitments to continue the established services.

Farmers Home and the Administration on Aging have received technical assistance from the International Center for Social Gerontology (ICSG) through training and consultation to national and field office staffs. Farmers Home has funded ICSG to evaluate the project through a subcontract to the American Institute for Research. The Administration on Aging has provided funds for ongoing technical assistance to the projects over the demonstration period.

States such as West Virginia and Missouri have begun to replicate the demonstration effort through cooperative activities between social services agencies, FmHA State offices, and the developers.

3. POLICY COORDINATION AND TRAINING UNIT

An interagency agreement was signed by Alex Mercure, Under Secretary of Agriculture for Small Community and Rural Development, U.S. Department of Agriculture on August 1, 1980, for the purpose of conducting rural miniconferences in connection with the 1981 White House Conference on Aging. The purpose of the agreement was to provide for the orderly transfer of funds to the U.S. Department of Labor, Employment and Training Administration, in order to provide for the conducting of six rural miniconferences.

National Green Thumb, Inc., a title V Older Americans Act contractor with the Employment and Training Administration of the U.S. Department of Labor, was designated by Jerome Waldie, Executive Director of the 1981 White House Conference on Aging, as the convener for one or more rural pre-White House Conference "miniconferences" for the rural aging. The conferences were held in Owensboro, Ky., East Hartford, Conn., Jacksonville, Fla., Sioux Falls, S. Dak., Oklahoma City, Okla., and Sacramento Calif. These conferences in-

volved older, rural citizens in meaningful discussions of their problems and concerns, and to enable these individuals to contribute policy and program recommendations for consideration in the 1981 White House Conference on Aging. The reports of the miniconferences will be submitted to the White House Conference on Aging Committee in Washington, D.C., as well as to the members of the technical committees which will be developing position papers on the issues to be discussed at the 1981 Conference. In addition, the White House Conference Committee will provide a copy of the rural report to the Conference delegates in order to stimulate an awareness of rural concerns prior to their meeting.

The miniconferences were funded by six Federal agencies. The following Federal agencies provided funds to support the miniconferences and the specific amounts by each are as follows:

Appalachian Regional Commission	$5,000
Department of Health and Human Services, Health Care Financing Administration	15,000
Department of Health and Human Services, Health Services Administration	15,000
Department of Housing and Urban Development	20,000
U.S. Department of Labor	40,000
U.S. Department of Agriculture	40,000
Total	135,000

Report of the National Strategy Conference

A national strategy conference on improving service delivery to the rural elderly was held in Des Moines, Iowa, on January 28 to February 2, 1979. This week-long conference was funded by FmHA and coconvened by the Iowa Lakes Area Agency on Aging and the National Association of Area Agencies on Aging. Its primary objective was to "identify not less than 50 persons with expertise in the various areas of rural service delivery and to bring these individuals together for an extended period to develop a strategy and working plan for improving service delivery mechanisms."

The conference attendance was limited to one delegate and one alternate from each State, plus representatives of Federal agencies and national associations. More than 118 persons participated at some point during the week.

Presently, FmHA is distributing the report of the national strategy conference which summarizes the problems that were discussed at the Des Moines conference and the primary strategies that were developed. It is organized around the seven fundamental subject areas—transportation, health, housing, nutrition, outreach, income/employment, and management/administration that were highlighted in the conference agenda.

The report of the national strategy conference will be distributed to the 1981 White House Conference delegates and State coordinators for consideration and deliberation. In addition, copies of the report are being distributed to Administration on Aging network and the participating organization of the conference.

Community Facilities Loan Division—Loan Payments That Impact on the Elderly

Community facility loans are made to public entities and nonprofit corporations in rural areas and towns not to exceed 10,000 people.

These loans are made to construct, enlarge, or improve hospitals, clinics, nursing homes, community buildings, fire stations, or other community facilities that provide essential service to rural residents and to pay necessary costs connected with such facilities.

Loans are made at 5 percent and may be amortized up to 40 years.

Nursing Homes

In fiscal year 1980, approximately 23 loans were obligated for nursing homes for some $24 million. These loans were in approximately 15 to 20 States. Nursing homes directly impact on the elderly in that they are almost wholly occupied by the aged.

Hospitals

Approximately 60 loans were made in fiscal year 1980 for hospitals. This amounts to approximately $70 million, and represents loans in almost 30 States.

Health Clinics

During fiscal year 1980, 102 loans were made for health clinics. These clinics were either for medical or dental services. The amount of funds loaned amounted to $37 million. Of the 102 health clinics, 83 were made under a joint agreement with the Department of Health and Human Services (HHS). These clinics are located in rural communities that are medically underserved. The HHS grants cover only operating expenses of rural health care projects, while FmHA loans cover the cost of construction, enlarging, extending, or otherwise improving and equipping of community nonprofit health facilities.

Miscellaneous Projects

Miscellaneous projects include those facilities such as medical rehabilitation centers, nutritional centers, and vocational rehabilitation centers. During fiscal year 1980, 26 such loans were made for approximately $7 million.

Interagency Agreement

In the State of Missouri, FmHA and the Missouri Division of Aging have entered into an agreement which encourages and fosters coordinated efforts between the two agencies to provide better service to the elderly in this State.

The objectives of this agreement are: (1) "Development of a facility for a comprehensive delivery of services to the elderly, located in a rural area." (2) "Joint initiatives and coordinated efforts to develop better coordinated services and more innovative programs to meet the needs of rural elderly."

There is also an agreement between one of the regional agencies on aging and FmHA district office in Missouri. Such efforts are also carried out in most other States on a less formal basis.

RURAL HOUSING SEC. 502 SENIOR CITIZENS, EMERGENCY, AND SELF-HELP LOANS OBLIGATED, FISCAL YEAR 1980 THROUGH SEPT. 30, 1980

State	Senior citizens loans				Emergency loans				Self-help loans			
	Initial		Subsequent		Initial		Subsequent		Initial		Subsequent	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount
U.S. total	858	23,688,080	351	2,202,130	15	465,330	2	5,250	1,122	36,791,500	191	1,581,190
Alabama	59	1,474,830	14	59,110	0	0	0	0	18	438,840	17	27,910
Alaska	0	0	0	0	0	0	0	0	0	0	0	0
Arizona	7	228,500	3	41,420	0	0	0	0	69	2,209,240	7	22,130
Arkansas	65	1,526,370	22	124,530	0	0	0	0	41	1,105,680	11	12,680
California	30	1,088,250	9	112,660	0	0	0	0	217	8,371,100	31	987,840
Colorado	9	262,830	1	3,500	0	0	0	0	64	1,929,100	13	39,020
Connecticut	2	90,000	0	0	0	0	0	0	22	871,600	0	0
Delaware	0	0	0	0	0	0	0	0	0	0	0	0
Florida	21	667,800	4	22,800	0	0	0	0	109	2,814,870	6	5,130
Georgia	8	158,910	12	78,960	0	0	0	0	0	0	1	593
Hawaii	28	1,254,120	0	0	0	0	0	0	0	0	0	0
Idaho	5	182,470	2	20,500	0	0	0	0	8	239,550	4	8,800
Illinois	1	27,400	6	28,770	7	268,880	0	0	1	5,890	1	1,000
Indiana	3	80,250	3	16,250	0	0	0	0	0	0	0	0
Iowa	21	667,130	10	55,100	0	0	0	0	0	0	0	0
Kansas	4	48,400	2	4,310	0	0	0	0	0	0	0	0
Kentucky	28	798,270	9	52,040	0	0	0	0	0	0	0	0
Louisiana	45	1,460,200	7	19,710	0	0	0	0	0	0	0	0
Maine	1	3,230	3	19,550	0	0	0	0	0	0	0	0
Maryland	1	40,000	2	1,870	0	0	0	0	0	0	0	0
Massachusetts	2	33,900	0	0	0	0	0	0	57	1,816,610	0	0
Michigan	5	150,030	11	79,240	0	0	0	0	12	360,950	2	2,540
Minnesota	1	30,500	3	23,350	2	63,000	0	0	7	292,490	8	13,480
Mississippi	150	4,070,480	33	174,000	1	30,000	0	0	52	1,468,050	10	18,350
Missouri	23	549,220	10	54,650	1	20,000	1	4,500	11	372,600	2	3,600

Montana	1	9,150	1	2,200	0	0	0	0	0	0	0	0
Nebraska	5	108,920	1	3,000	0	0	0	0	0	0	0	0
Nevada	0	0	0	0	0	0	0	0	0	0	0	0
New Hampshire	0	0	0	0	0	0	0	0	31	1,264,000	1	40,000
New Jersey	1	29,000	0	0	0	0	0	0	0	0	0	0
New Mexico	7	210,610	2	8,000	0	0	0	0	43	1,256,300	6	115,250
New York	0	0	15	106,210	0	0	0	0	0	0	1	900
North Carolina	25	732,180	21	129,700	0	0	0	0	23	633,860	7	14,490
North Dakota	2	20,350	1	5,600	0	0	0	0	0	0	0	0
Ohio	6	194,700	1	2,300	0	0	0	0	0	0	0	0
Oklahoma	25	543,820	29	140,610	2	44,000	0	0	77	1,856,340	28	98,790
Oregon	13	515,880	11	125,810	0	0	0	0	21	934,540	12	127,130
Pennsylvania	2	6,400	1	1,200	0	0	0	0	5	172,300	0	0
Rhode Island	0	0	3	14,090	0	0	0	0	0	0	0	0
South Carolina	26	746,340	11	43,980	0	0	0	0	0	0	1	4,550
South Dakota	2	2,500	2	16,400	0	0	0	0	59	2,122,350	2	35,570
Tennessee	38	832,710	11	34,050	9	0	0	0	3	86,100	0	0
Texas	91	2,267,410	8	44,360	0	0	0	0	28	676,530	1	24,810
Utah	4	123,500	1	17,500	0	0	0	0	0	0	0	0
Vermont	0	0	0	0	0	0	0	0	0	0	0	0
Virginia	41	1,124,010	32	190,670	1	950	1	750	7	225,100	9	30,930
Washington	7	188,460	7	111,370	0	0	0	0	79	2,846,000	7	19,300
West Virginia	30	785,310	10	73,690	0	0	0	0	0	0	0	0
Wisconsin	2	53,430	3	15,940	1	38,500	0	0	57	2,332,410	3	26,500
Wyoming	4	157,900	2	15,570	0	0	0	0	1	39,200	0	0
Puerto Rico	3	72,910	0	0	0	0	0	0	0	0	0	0
Virgin Islands	1	10,000	12	107,570	0	0	0	0	0	0	0	0
Western Pacific Territory	3	59,500	0	0	0	0	0	0	0	0	0	0

RURAL HOUSING SEC. 504 GRANTS OBLIGATED, FISCAL YEAR 1980 THROUGH SEPTEMBER 1980

State	Total amount	Rural housing sec. 504 grants			
		Initial		Subsequent	
		Number	Amount	Number	Amount
U.S. total	23,999,990	8,013	23,301,350	576	698,640
Alabama	692,860	302	662,880	24	29,980
Alaska	33,170	8	33,170	0	0
Arizona	256,390	56	252,360	1	4,030
Arkansas	670,240	310	644,530	26	25,710
California	709,480	171	687,260	24	22,220
Colorado	225,480	67	214,360	9	11,120
Connecticut	79,240	19	77,840	1	1,400
Delaware	140,930	32	140,930	0	0
Florida	657,560	180	651,050	7	6,510
Georgia	899,270	231	876,010	21	23,260
Hawaii	137,610	64	133,900	3	3,710
Idaho	150,210	55	150,210	0	0
Illinois	776,010	325	725,310	42	50,700
Indiana	396,260	136	379,540	11	16,720
Iowa	403,160	236	381,440	23	21,720
Kansas	295,730	116	292,810	2	2,920
Kentucky	873,040	286	860,860	8	12,180
Louisiana	812,120	279	801,360	7	10,760
Maine	425,030	142	404,390	15	20,640
Maryland	523,650	139	504,430	13	19,220
Massachusetts	233,080	69	221,890	7	11,190
Michigan	583,230	199	562,090	17	21,140
Minnesota	331,130	99	326,860	3	4,270
Mississippi	1,072,860	626	1,019,090	45	53,770
Missouri	788,590	406	747,860	38	40,730
Montana	85,600	22	83,660	2	1,940
Nebraska	228,850	97	220,630	9	8,220
Nevada	74,350	22	71,580	2	2,770
New Hampshire	145,120	44	130,680	9	14,440
New Jersey	267,980	83	255,320	11	12,660
New Mexico	496,130	121	490,440	5	5,690
New York	551,810	197	528,430	20	23,380
North Carolina	902,320	279	876,540	20	25,780
North Dakota	253,170	70	249,090	5	4,080
Ohio	632,830	147	611,680	16	21,150
Oklahoma	517,170	198	502,630	11	14,540
Oregon	418,980	123	394,820	21	24,160
Pennsylvania	868,160	237	846,820	16	21,340
Rhode Island	80,370	19	72,680	6	7,690
South Carolina	513,170	147	501,120	7	12,050
South Dakota	181,120	67	179,020	2	2,100
Tennessee	681,450	185	680,520	3	930
Texas	1,193,740	370	1,180,220	10	13,520
Utah	96,150	44	94,310	2	1,840
Vermont	247,630	59	242,620	4	5,010
Virginia	504,590	124	503,990	1	600
Washington	302,340	69	293,420	8	8,920
West Virginia	466,480	180	449,860	16	16,620
Wisconsin	516,860	134	493,650	15	23,210
Wyoming	60,300	19	60,300	0	0
Puerto Rico	1,314,220	336	1,302,120	8	12,100
Virgin Islands	17,210	4	17,210	0	0
West Pacific Territory	215,560	54	215,560	0	0

Food and Nutrition Service

The most recent tabulated data indicates that at least 1.350 million elderly persons (age 65 and older) are participating in the food stamp program. This figure is from November 1979. It is expected that participation by the elderly has increased since then, but studies to confirm this or indicate the extent of the increase are still in progress. Participation by the elderly has been increasing substantially since January 1979, when the food stamp purchase requirement was removed. Studies done since the elimination of the purchase requirement show that participation by households headed by the elderly increased by 32 percent from February 1978 to April 1979, while that of nonelderly households increased by 14 percent.

It is estimated that elderly persons received about $487 million in food stamp benefits in fiscal year 1980. This represents 5.6 percent of the total amount spent for benefits, approximately $8.69 billion. The average food stamp allot-

ment per person, per month, was $34.11 as of September 1980. We do not have current figures for the average allotment which elderly persons or households receive.

We estimate that some 3.2 million elderly are eligible to receive food stamps. This rough estimate is actually the number of elderly who were below the poverty line in 1978 as given in the U.S. Census Bureau document, "Characteristics of the Population Below Poverty Level, 1978" (published June 1980). This number should be viewed cautiously for several reasons. First, it is based on 1978 data. Second, the Census figure does not count assets which can disqualify for food stamps, applicants otherwise eligible by income. Third, it does not subtract the number of elderly people in SSI cash-out States, who are categorically ineligible for food stamps. (SSI cash-out is explained later.)

Last, some elderly persons whose gross income is above the poverty line are eligible for food stamps because certain deductions can be subtracted from their gross income during the certification process. However, 3.2 million is as good an estimate as we presently have.

Especially in recent years, Congress and food stamp program administrators have been actively encouraging the elderly to participate in the food stamp program. Laws passed in 1977, 1979, and 1980, contained a number of special provisions aimed at easing participation for elderly persons and offering extra aid to households containing elderly members.

EASING APPLICATION

States must provide out-of-office interviews for *elderly* households who cannot or do not want to visit a certification office. Out-of-office interviewing can be done by telephone or by a prearranged home visit by an eligibility worker. Applicants may also designate an authorized representative to be interviewed for them, to obtain their food stamp coupons and to shop with their food stamps. Also, some project areas arrange transportation to certification and issuance offices as part of their outreach programs.

Elderly persons applying for or receiving supplemental security income can apply for food stamps at their Social Security office instead of at a welfare office. (*All* persons in the household must be applying for or receiving SSI or be processed at an SSA office.) SSI/food stamp joint processing is one of several attempts to make food stamps more familiar, acceptable, and available to the aged by coordinating the food stamp program with more widely used elderly aid programs. State agencies are also required to inform SSI and social security households about food stamps. This has most often been done through enclosures sent with SSI and social security checks and notices.

SPECIAL ELIGIBILITY CRITERIA

Elderly households can have twice the countable assets other households can before becoming ineligible for the program. Most households are permitted $1,500 in resources; a household of two or more persons which contains at least one person 60 years of age or older, however, can have assets up to $3,000 and still be eligible for food stamps.

Persons 60 years of age and older are not required to register for work.

Special deductions for medical and shelter costs are available for elderly people.

(a) All nonreimbursed medical expenses of a person 60 or older, which are over $35 per month (excluding costs for special diets), may be deducted from a household's income. (The threshold will be lowered to $25 and medical expenses of spouses of the elderly will be deductible in October 1981.)

(b) There is no limit placed on the excess shelter deduction which elderly households may claim. A household containing someone 60 or older may deduct all costs for shelter, which exceed 50 percent of its income after all other deductions. Other food stamp households may claim shelter costs over 50 percent of net income which, when combined with dependent care costs, do not exceed $115.

Households consisting entirely of elderly persons with very stable income can be certified for up to 1 year; the normal certification period is 3 months.

SPECIAL PROVISIONS FOR COUPON USE

Elderly persons and their spouses can use their food stamps to purchase meals at congregate eating facilities. Food stamps can buy meals served in senior

citizens centers, senior citizen occupied apartment buildings, public or private nonprofit schools, and any other public or private nonprofit establishment that feeds senior citizens. Food stamps may also be used for meals at private establishments—including approved restaurants—which contract to sell meals to the aged at "concessional prices."

The elderly can use food stamps to buy prepared meals delivered to their homes by meals on wheels and similar organizations.

SPECIAL PROGRAMS

Two projects are being operated in conjunction with the SSI program in a number of sites to offer special aid to the elderly in obtaining nutritious diets.

An SSI "cash-out" program has been running in a few States since 1974. If States qualify and desire, they may add a fixed supplemental amount of money to all SSI checks instead of certifying eligible SSI recipients for food stamps. By law, the State must add at least $10 per month for single and two-person households out of its own funds; $10 is the minimum food stamp allotment for these households. By receiving aid in this way, elderly people are spared problems involved in certification and the embarrassment some feel in using food stamps. Currently, the only SSI cash-out States are California, Massachusetts, and Wisconsin.

A demonstration project, the SSI/elderly cash-out project, is now operating in seven States to test the feasibility and effectiveness of another method of cashing out food stamps for the elderly. Households consisting completely of persons 65 years of age or older, or persons receiving SSI benefits under title XVI of the Social Security Act, receive a check equal to the value of what their food stamp allotment would otherwise be. The check is issued by the State or local agency. The objective of this project is to try to increase the low participation of the elderly by removing perceived "participation barriers." These barriers are thought to include application procedures which are often difficult for the elderly or disabled, lack of transportation, and the "welfare stigma" associated with applying for and using food stamps. The effects on participation, nutrition, and administration will be evaluated to see if SSI/elderly cash-out should be implemented nationwide.

The demonstration project is operating in the following locations: Vermont (statewide), New York (one county), South Carolina (four counties), Ohio (one county), Minnesota (one county), Utah (statewide), Oregon (two regions; the area around Portland, and one other county), Virginia (one county).

FOOD DISTRIBUTION PROGRAM

USDA's substantial involvement in nutrition programs for the elderly funded under the Older Americans Act of 1965 and administered by DHHS, began in 1974. Since that time, the food distribution program (FDP) has played an important role in providing USDA-donated foods to the nutrition programs. Subsequent public laws amending the Older Americans Act have also altered USDA's role and responsibilities in providing food assistance. These amendments and their impact on the FDP are listed, in chronological order, as follows:

(1) Public Law 93–351, amending the Older Americans Act, was enacted July 12, 1974. This legislation set the minimum level of donated food assistance to the nutrition programs authorized under title VII of the act at 10 cents per meal, subject to annual adjustments for increased food service costs. It also required USDA to give special emphasis to purchasing high protein foods, meats, and meat alternates.

(2) Public Law 94–135, enacted November 27, 1975, amended the act to expand the food donation authority to maintain an annually programed level of food assistance to the title VII programs of not less than 15 cents per meal in the fiscal year ending on September 30, 1976, and not less than 25 cents per meal for the fiscal year ending on September 30, 1977. Applying the annual adjustment for increased food costs, this resulted in 16½ cents per meal for fiscal year 1976, and 27¼ cents per meal for fiscal year 1977. This legislation further provided, ". . . in any case in which a State has phased out its commodity distribution facilities before June 30, 1974, such State may, for purposes of the programs authorized by this act, elect to receive cash payments in lieu of donated foods . . ." Kansas was the only State eligible to qualify under this provision.

(3) Public Law 95–65, enacted July 11, 1977, extended the option for cash payments in lieu of donated foods to all States without regard to the termination of State food distribution facilities. The programed level of assistance was 29½ cents per meal in fiscal year 1978.

(4) With the enactment of Public Law 95–478, October 18, 1978, social service functions and the title VII congregate feeding program were integrated under an expanded title III program. In addition to the consolidation of services under this title, emphasis was included in the law to provide meal delivery services to the homebound elderly along with the continuation of congregate feeding. This law also called for the establishment under a new title VI, of nutrition services, comparable to those provided under title III, for older Indians that are represented by organizations of Indian tribes. The titles VI and III programs provide for both congregate and home-delivered nutrition services to persons aged 60 or older and their spouses. Both of these meal services are eligible for food donations or cash-in-lieu payments at the new legislated level of 30 cents a meal for fiscal years 1979, 1980, and 1981 as adjusted in the food-away-from-home series of the Bureau of Labor Statistics. Based on this adjustment, food donations or cash-in-lieu payments were provided on the basis of 38½ cents per meal in fiscal year 1979 and 43 cents per meal in fiscal year 1980. In fiscal year 1981, the programed level of assistance is 47.25 cents per meal.

FISCAL YEAR 1980 STATISTICS

In fiscal year 1980, 28 States elected to receive their entitlements in all cash payments. Five States elected donated foods only and 23 States chose to receive a combination of food and cash. This amounted to approximately $54.5 million in cash payments and $14.5 million in donated foods expended for fiscal year 1980.

USDA-donated foods or cash were provided to 1,178 nutrition programs with 12,475 sites serving an estimated 167.55 million meals. Of this number of meals, 163.23 million meals, or 97.4 percent, were eligible for USDA food assistance. The remaining 2.6 percent of the meals were served to program staff, visitors, and volunteers. The number of elderly and their spouses that were served through this program in 1980 was approximately 2.49 million persons.

In addition to the elderly nutrition programs administered by the Administration on Aging, USDA makes a limited variety of foods obtained through price-support activities available to public or private charitable institutions which may be serving senior citizens. Among the institutions which are eligible to receive food to the extent of the number of needy persons served are nursing homes, senior citizens centers, and meals-on-wheels programs not participating under the Older Americans Act. In 1980, charitable institutions received and served about $58.3 million of commodities to over 7,400 institutions which served an estimated 888,000 needy persons.

OFFICE OF EQUAL OPPORTUNITY (OEO)

Office of Equal Opportunity (OEO) provides leadership and direction to assure equal opportunity in USDA programs and activities. As part of this function, OEO monitors the civil rights compliance status of the various USDA agencies which administer federally assisted and direct assistance programs and activities. Specifically, OEO monitors agency compliance with the requirements of title VI of the Civil Rights Act of 1964 and other Federal nondiscrimination laws which prohibit discrimination on the basis of race, color, religion, handicap, or age. OEO monitors the requirements of these statutes in federally assisted programs, direct assistance programs, and employment programs of the Department.

The Age Discrimination Act (ADA) was enacted by Congress in 1975 as an amendment to the Older Americans Act. The Office of Equal Opportunity has responsibility for development of USDA implementing regulations. Although the ADA would appear to exclusively protect the elderly, its protections are extended to members of all age categories. Final USDA regulations implementing the ADA are expected early in 1981.

In May 1976, the provisions of the Age Discrimination in Employment Act (ADEA) of 1976 were extended to include Federal, State and local governments. The ADEA prohibits employment discrimination and protects persons between the ages of 40 and 75.

ITEM 2. DEPARTMENT OF COMMERCE

JANUARY 12, 1981.

DEAR MR. CHAIRMAN: Thank you for your letter requesting information for your annual report, "Developments in Aging." Enclosed are two copies of the report on activities relative to the aging which were conducted in fiscal year 1980 in the Department of Commerce.

In fiscal year 1980, this Department had a total identifiable expenditure of $7,104,000.

Sincerely,

PHILIP M. KLUTZNICK, *Secretary.*

Enclosure.

1980 REPORT ON AGING

The Department of Commerce currently has five bureaus that have programs that either directly or indirectly affect the elderly. Details of these programs are listed below by bureau:

BUREAU OF THE CENSUS

Statistical Reports

The following reports containing substantial amounts of data on older persons were issued by the Bureau of the Census in its "Current Population Reports" during 1980. The reports contain information about the demographic and socioeconomic characteristics of the population. Many of the "Current Population Reports" will be updated in 1981. Funding for these series is subsumed under general program expenditures and is not specifically identified.

Current Population Reports

Other Reports and Papers

Special reports and papers prepared by the Census Bureau include the following:

Preparation of a report on the "Demographic and Socioeconomic Aspects of Aging in the United States" based on the most recent available data, for publication in Current Population Reports, series P–23, continued.

A report on "Social and Economic Characteristics of Americans at Mid-Life" is being prepared for publication in Current Population Reports, series P–23.

A report on "Voting and Registration in the Election of November 1980" is being prepared for publication in Current Population Reports, series P–23.

J. S. Siegel's paper, "Recent and Prospective Demographic Trends for the Elderly Population and Some Implications for Health Care," was published in the Proceedings of the Second Conference on the Epidemiology of Aging, March 28–29, 1977 (sponsored jointly by the National Institute on Aging and the National Heart, Lung, and Blood Institute).

J. S. Siegel's paper, "Demographic Background for International Gerontological Studies," was accepted for publication in the Journal of Gerontology.

The Census Bureau is conducting research on ways of projecting mortality trends in the United States.

A paper on "The 1980 Census and the Elderly: New Data Available to Planners and Practitioners" was presented at the annual meeting of the Gerontological Society of America.

A paper on "Are the Elderly Residents of Sunbelt States Safer from Crime? A Tentative Answer from the National Crime Survey" was presented at the sixth annual National Victim Assistance Conference.

A paper on "Social Indicators of Aging" was presented at the annual meeting of the American Association for the Advancement of Science.

A paper on "Implications of Selected Structural Determinants on Use of Long-Term Care Facilities by the Aged" was presented at the Federal Statistical Users Conference.

A paper on "Structural Determinants of Institutional Use by the Aged: 1970" was presented at the annual meeting of the Gerontological Society of America.

A paper on "Direct Economic Costs of Criminal Victimization of the Elderly" was presented at the annual meeting of the Gerontological Society of America.

A paper on "Crime Against Elders: Factors Affecting Future Trends" was presented at the annual meeting of the Gerontological Society of America.

An address on the "Demography of Aging" was presented at the Federal Statistical Users Conference.

NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

The National Weather Service of the National Oceanic and Atmospheric Administration (NOAA) publishes daily weather forecasts which are very useful to all citizens. Specifically, this information is extremely important to the elderly. The forecasts of severe storms, extreme heat, pollution index, floods, tornadoes, and hurricanes provide advance information which helps less mobile older citizens plan and act on ways to avoid predicted weather which could cause a crisis. For long range planning, NOAA's Environment Data Service (EDS) makes information available concerning weather trends in various regions of the country.

At the National Oceanic and Atmospheric Administration both the National Marine Fisheries Service (NMFS) and the National Ocean Survey (NOS) provide information that can be of importance to those retired citizens who wish to take part in marine recreational activities such as fishing and boating. Such information is supplied through recreation guides, charts, and other publications. Another NMFS publication is a monthly guideline pertaining to the "best buys" on fish for each geographic region. This informs the elderly of less expensive ways to fill their diet with high protein food.

The National Oceanic and Atmospheric Administration continues to provide indirect assistance to the aged. During fiscal year 1980, the related programs and estimated expenditure levels were determined by using the latest available Bureau of Census percentage of elderly to total population of 11.2 percent. Therefore, the following estimates were derived (in thousands of dollars):

Programs:	*Fiscal year 1980 expenditures*
Regional weather trends—local weather dissemination, air pollution, weather services, climatic data services, environmental documentation and information services	$2,904
Recreational guides—nautical chart services, marine recreation fisheries	1,115
Fish food guidelines—economic and commercial fisheries statistics, increasing use of resources, fishery products quality and safety	1,326
Total	5,345

PATENT AND TRADEMARK OFFICE

The Patent and Trademark Office continued the procedure that permits patent applications submitted by applicants who are 65 years of age or older to be "made special." This procedure allows the patent application to be taken up for examination earlier than its effective filing date would normally permit (section 708.02, Manual of Patent Examining).

There are numerous patents relating to drugs, disease prosthetics and other devices that have a greater impact on the elderly than on the general population, but these patents are a byproduct of the total examining process.

NATIONAL BUREAU OF STANDARDS

Fire Research and Safety

A fire safety evaluation system for health care facilities has been developed to determine if a hospital or nursing home has the level of fire safety protection prescribed in the National Fire Protection Association Life Safety Code. The value of this system is that it permits the provider to have more flexibility in selecting the fire protection features to use in attaining the required fire protection as compared with meeting each specification in the code. Use of the fire safety evaluation system permits the achievement of required fire protection at less cost, especially in upgrading existing buildings. It also gives the architect more flexibility in designing a building that better serves the needs of the residents, especially in new buildings and major renovations. It is hoped that this will mean less institutional-appearing nursing homes in the future.

A fire safety evaluation system for community based group homes for the developmentally disabled has been designed. There are no fire safety regulations that were designed for group disabled. This system will fill a well recognized void. The target population is composed mainly of mentally retarded citizens, with or without physical disabilities. The system is currently being field tested and extended to cover other types of board and care facilities.

Dental Materials

The work the Bureau has carried out over the past 50 years on dental materials and methods impacts the elderly, particularly the more recent work on polymer composite restorative materials. Other dental research at NBS which will yield major benefits for the elderly are: the development of new alloy ceramics and their fusing to base metals, and research into the deterioration of dental amalgams. The overall goal of these programs is to provide materials of greater durability and wear resistance and improved base metal alloy alternatives to the costly gold prostheses.

Synthetic Implants

Work in this program has produced the first implant standard for acrylic bone cements, three standards for new implant metals, reference materials for tissue compatability, several ASTM recommended test procedures, as well as major conferences on implant retrieval and analyses.

Listed below are the expenditures during fiscal year 1980 for these programs (in thousands of dollars):

Programs:	*Fiscal year 1980 expenditures*
Fire research and safety:	
Health care facilities	$250
Group homes for developmentally disabled	250
Dental	865
Synthetic implants	294
Total, NBS	1,659

NATIONAL TECHNICAL INFORMATION SERVICE

The National Technical Information Service is not involved in any programs for the elderly at this time. They do publish three special bibliographies which

pertain to this subject. These publications primarily involve topics on social services, health, housing, and transportation problems. These documents are:

"Transportation for the Elderly of Physically Handicapped" (NTIS–PS–78/0828). This document contains abstracts of reports on transportation difficulties and designs as they relate to the aged and handicapped population. The source documents were submitted to NTIS by both Federal and non-Federal organizations.

"The Elderly (Social Health and Transportation Problems and Services)" (NTIS–PS–77/0672-volume I and NTIS–PS–78/0888-volume II).

These documents primarily treat topics on social services, health, housing, and transportation problems.

ADDENDUM

GENERAL ADMINISTRATION

In fiscal year 1980, the General Administration awarded a grant for $100,000 to the National Council on the Aging to help fund a Population Data Resource Center for Industry. The purpose of this center is to:

(a) Survey industry to determine the current corporate understanding of the impact of aging on their business.

(b) Encourage industry to assess its production patterns and marketing in light of the aging American population.

(c) Establish a systematic data collection, collation and analysis of pertinent aging information.

(d) Inform industry through quarterly newsletters, monographs, articles in trade publications and a national conference.

The center will study corporate attitudes towards gearing marketing strategies for aging Americans. It will also encourage industries to focus their production and marketing more towards aging markets through conferences and publications.

ITEM 3. DEPARTMENT OF DEFENSE

JANUARY 16, 1981.

DEAR MR. CHAIRMAN: This is in response to the letter from the chairman and ranking minority member, Senate Special Committee on Aging of October 30, 1980, which requested information on Department of Defense (DOD) actions and programs related to aging.

The DOD continues to operate a comprehensive retirement planning program for Defense Federal Service employees. Integrated into the overall personnel management process, our program is designed primarily to assist employees in their adjustment to retirement and to assist management in planning for replacement manpower needs. It encompasses extensive preretirement counseling for employees (and their spouses in many instances) on such subjects as financial planning, health needs, leisure time activities, living arrangements, and personal guidance; and includes trial retirement and gradual retirement options for employees where feasible. We believe our program helps alleviate many of the problems that employees have encountered in the past when approaching retirement age. We expect to continue the operation of this program in 1981.

The military departments and Defense agencies, in cooperation with community health officials, have continued to provide multiphasic occupational health programs and service to employees, and in some cases to former employees who have retired. Many of these programs and services are designed to address problems generally associated with increasing age. Included are health guidance and counseling, periodic testing for diseases and disorders, immunizations and treatments.

Within the Department active and continuing efforts are conducted to eliminate discrimination based upon age. These actions include the revision of internal regulations to assure that age is not used as a selection criterion or screening factor in any type of personnel action, and the continual examination of personnel policies, practices, and procedures for possible conflict with equal employment opportunity intent, including discriminatory use of age. These are continuing efforts.

In summary, the DOD has operated a comprehensive retirement planning program for civilian employees, provided extensive health care services to employees and carried out an ongoing, affirmative action program to preclude discrimination based on age. These program efforts will be continued in 1981.

Sincerely,

WILLIAM C. VALDES,
Deputy Assistant Secretary of Defense
(Civilian Personnel Policy).

ITEM 4. DEPARTMENT OF EDUCATION

JANUARY 14, 1981.

DEAR MR. CHAIRMAN: This is in further reference to your letter of October 30, 1980, requesting current information from the Department of Education to be included in part 2 of "Developments in Aging," the annual report of the Senate Special Committee on Aging.

In accordance with your letter, I am happy to enclose the updated material. An identical letter is being sent to Senator Domenici.

You will note that the Department no longer has the right to read program. The provisions of this program are now incorporated in the basic skills improvement program authorized under Public Law 95–561, the Education Amendments of 1978.

We have revised information for the following programs:

Vocational education
Community education
Adult education
Consumer education
Energy and education action center
Public library services to older Americans
Women's education equity
Indian education
Community services and continuing education
Captioned films and television

Moreover, three new programs have been added; they are basic vocation rehabilitation services, special projects serving the older blind population, and research and training centers.

If the Office of Legislation can be of further assistance, please let us know.

Sincererly yours,

ALBERT L. ALFORD,
Deputy Assistant Secretary for Congressional Services.

Enclosures.

INDIAN EDUCATION

The Indian adult education program is authorized by part C of the Indian Education Act, title IV of Public Law 92–318. Part C provides funds for special programs designed to improve educational opportunities for Indian adults. "Adult," as defined in the part C regulations, means any individual who has attained the age of 16. This includes the elderly.

The two programs operated under part C are:

(1) The planning, pilot, and demonstration program, for projects designed to test and demonstrate the effectiveness of programs for improving employment and educational opportunities for Indian adults.

(2) The educational services program, for the operation of projects that respond to local needs for improving educational opportunities for Indian adults.

Indian tribes, institutions, and organizations may apply for grants under both programs. State and local educational agencies may apply for grants only under the planning, pilot, and demonstration program, although priority in awarding grants under that program is given to Indian tribes and organizations.

In fiscal year 1980, $5,430,000 was available for grants under part C. Grants were awarded for 56 projects in 26 States to serve an estimated 10,000 Indians.

All grants went to Indian tribes and organizations. Grants ranged from $45,000 to $288,000 and were used to support a variety of activities, including:

—Basic educational skills training.

—Literacy programs.

—Programs to help Indian adults earn high school equivalency diplomas.

In fiscal year 1981, there will again be $5,430,000 available.

The Indian adult education program is administered by the Office of Indian Education in the Department of Education. The Office of Indian Education has recently funded a national survey of the educational needs of Indian adults. Results from that survey should be available early in 1981.

Technical assistance to improve the quality of adult education programs for Indians is available through five Indian education regional resource and evaluation centers.

Community Service and Continued Education Program

The community service and continuing education (CSCE) program under title I(A) of the Higher Education Act of 1965 (Public Law 89–329, as amended) provided funds to States and institutions of higher education for three purposes: to strengthen community service programs of colleges and universities; to support the expansion of continuing education in colleges and universities; and to support the expansion of resource materials sharing. The CSCE program was especially designed to meet the educational needs of adults who have been inadequately served by traditional education programs in their communities.

The State grant portion (90 percent of appropriated funds under this title) of the program was administered in each State by an agency designated by the Governor, under a State plan approved by the U.S. Commissioner of Education. The State agency established priorities and approved and funded institutional proposals. One-third of program costs were provided by non-Federal sources. The State grant program supported a number of projects designed to assist the older American. During 1979, more than 87,706 individual participants were involved in 82 projects in 29 States at a cost of $1,582,388 in Federal funds. Activities supported included programs to meet educational needs and interest of aging, legal aid and housing assistance, and programs providing training for professionals and paraprofessionals providing care and services to the elderly in multitopic areas.

Special projects, authorized by section 106, permitted the Commissioner to reserve 10 percent of the funds appropriated in order to support projects which were designed to seek solutions to regional and national problems brought about by a technological change. Such special projects were limited to demonstration or experimental efforts. Projects were based on a design for, and the implementation of, organized continuing education for adults.

In 1979, a renewal funding was awarded the Institute on Aging at Portland State University, in Portland, Oreg. This award of $67,000 continued work on a demonstration model to help solve work-related problems of middle-aged and older workers. The project identified alternative work roles and leisure options, developed a curriculum, tested and evaluated the processes, and synthesized and diffused the products nationwide. Total appropriations for the CSCE program fiscal year 1980 were $10 million. Of this sum $1 million was reserved by the Commissioner for special projects, with $9 million being distributed to the States. Ultimately, no special projects were funded because the funds reserved for them were rescinded by the Congress.

The Education Amendments of 1980, which reauthorized the Higher Education Act, amends title I to include most of the CSCE program as part of the new educational outreach program of part B. Through the education outreach program the Secretary of Education makes grants to the States to: conduct comprehensive postsecondary education planning, with particular emphasis on continuing education; develop and coordinate new and existing educational and occupational information and counseling programs; and support postsecondary continuing education programs for adults who have been inadequately served through traditional education opportunities. Institutions of higher education, public and private organizations, including business, industry and labor organizations, or any combinations of institutions and organizations are eligible to receive subgrants and contracts from States for information and counseling services and continuing education projects. One-third of the total program cost must be met from non-Federal funds.

COMMUNITY SERVICE AND CONTINUING EDUCATION PROGRAM FOR AGING AND OLDER ADULTS, FISCAL YEAR 1979

State and institution	Project title	Federal	Matching	Total
32 States, 79 institutions	82 projects	$1,582,388.09	$1,142,317.54	$2,724,705.63
Arizona:				
University of Arizona				
Arizona State University	Arizona elderhostel	9,260	4,630	13,890
Yavapai College				
Arkansas:				
University of Arkansas-Fayetteville.	Consumer problems of the elderly and related training.	10,650	11,100	21,750
University of Arkansas-Little Rock, School of Law.	Planning for resource sharing legal services to the elderly planning project.	2,118	23,312	25,430
California:				
Orange Coast College	When can I retire	2,300	1,150	3,450
Columbia College	Model adaptation for comprehensive program development for older adults.	23,000	20,346	43,346
University of California, San Francisco.	Intergenerational care-giving program.	50,000	25,000	75,000
Modesto Junior College	Telecommunications for older adults.	40,000	59,126	99,126
California State University, Chico.	Independent living skills for older adults.	60,000	32,425	92,425
University of California, San Diego.	Public access cabletelevision for elders.	30,000	15,000	45,000
Colorado:				
Arapahoe Community College.	The Emeritus College	7,020	5,460	12,480
University of Denver	Mobilizing educational programs for older adults at senior facilities.	4,431	4,431	8,862
Loretto Heights College	Statewide elderhostel project and establishment of elderhostel outreach.	25,125	12,589	37,714
Connecticut, University of Connecticut.	Improving medication use behavior of the elderly by utilizing pharmacists as educators.	19,429.66	9,713.33	29,142.99
Delaware:				
Wesley College	Lifespan planning	11,856	3,052	14,908
University of Delaware	Developing effective volunteer programs.	107,913	35,071	142,984
District of Columbia, University of the District of Columbia.	Closing the generation gap—an educational experience.	97,518	66,885	164,403
Florida:				
University of North Florida	Aging Studies Institute	20,059	13,090	33,149
Florida JC at Jacksonville	Center for the Continuing Education of Senior Adults.	20,760	17,516	38,276
Georgia:				
Berry College	Training program for workers who work with the elderly.	2,851	1,500	4,351
University of Georgia	Assisting service providers to meet the personal care and self-actualization needs of older adults: A holistic approach.	24,500	13,168	37,668
Illinois, DePaul University	Educational choices for older adults.	46,436	24,379	70,815
Indiana, Indiana University, South Bend.	Preparing for the 1980's	20,088.43	10,044.21	30,132.64
Iowa, Cornell College	An ongoing chautauqua program for the senior adult.	9,444	8,759	18,203
Kentucky:				
Georgetown College	Continuing education for the cultural enrichment of older persons in the Scott County area.	17,265	9,627	26,892
Southeast Community College.	Assistance to programs for senior citizens in Harlan County.	20,000	10,000	30,000
Western Kentucky University.	Multidisciplinary continuing education in applied gernontology for health personnel.	20,000	11,936	31,936
University of Louisville	Citizen participation training for older persons.	20,000	10,000	30,000
Morehead State University	Nutrition education for senior Kentuckians.	20,000	11,629	31,629
Kentucky State University	Preretirement planning program.	20,000	13,528	33,528
Thomas More College	Emeritus College	20,318	18,118	38,436
Murray State University	Functional education for the aging in the purchase area.	16,991	11,423	28,414

State and institution	Project title	Federal	Matching	Total
Maine, Westbrook College	Elder access to continuing education.	4,668	7,671	12,339
Maryland:				
Maryland Consortium for Gerontology in Higher Education, Inc.	Maryland Elderhostel, 1979-80	12,000	6,454	18,454
University of Maryland	Preretirement planning for disabled.	15,440	8,011	23,451
St. Mary's College	Institution for liberal learning in retirement.	12,378	15,345	27,723
Michigan: Oakland University	Career, personal and preretirement counseling for adults in university and community settings.	37,000	20,930	57,930
Mississippi:				
Mississippi University for Women.	A career development program for women in the golden triangle.	18,053	9,964	28,017
N.W. Mississippi Jr. College	Preretirement planning	23,554	13,000	36,554
University of Southern Mississippi.	Elders Institute of South Mississippi.	20,691	26,046	46,737
Missouri:				
East Central Junior College Union.	Senior citizen's service program.	5,244	2,622	7,866
University of Missouri, Rolla	University of the third age	13,918	6,959	20,877
Montana, University of Montana	Estate planning assistance for Montana's senior citizens.	4,300	2,550	6,850
Nebraska:				
Creighton University	Growing older—ways of coping	10,000	5,832	15,832
University of Nebraska, Omaha.	Workshops: Personal financial planning for retirement years.	19,030	10,008	29,038
New Hampshire:				
Keene State College	Education for those working with the elderly.	4,800	3,200	8,000
St. Anselm's College	Senior citizen representatives as resource advisors.	8,500	4,250	12,750
New Jersey:				
Montclair State	Older adult assistance	28,000	26,434	54,434
Rutgers University	Development of career ladders in gerontology.	32,000	60,823	92,823
New Mexico:				
University of New Mexico	Mental health skill development for nursing home operators.	15,000	8,041	23,041
New Mexico State University.	Training senior citizens to act as aides to handicapped.	17,000	7,558	24,558
New York:				
SUNY, Oswego	Program to intervene in the cycle of intergenerational Unemployment and underemployment by improvement of math and reading skills.	35,000	37,460	72,460
Brooklyn College, CUNY	Educational program for homemaker-home health aides.	35,000	27,884	62,884
New York City Community College, CUNY.	Extending continuing education to the elderly homebound.	50,000	51,616	101,616
North Carolina:				
University of North Carolina, Chapel Hill.	Horticultural therapy and continuing education for aged and disadvantaged.	16,500	10,519	27,019
University of North Carolina, Asheville.	Office for Aging	23,973	11,987	35,960
Mars Hill College	Health gerontology: Extension of education opportunities to the aging in Madison, Henderson, Buncombe, and Transylvania Counties.	19,548	9,774	29,322
University of North Carolina, Charlotte.	Crime prevention workshops for senior citizens.	4,208	2,123	6,331
North Carolina A&T State University.	Do-it-yourself weatherization techniques for low incomes and disadvantaged city dwellers.	8,927	5,000	13,927
North Dakota:				
Maryville State College	Physical education for the elderly.	14,009	7,004	21,013
Sinte Gleske	Continuing education for senior citizens.	13,270	6,635	19,005
Tennessee, University of Tennessee, Martin.	Guiding older adults in health care assistance.	7,000	2,310	9,310

COMMUNITY SERVICE AND CONTINUING EDUCATION PROGRAM FOR AGING AND OLDER ADULTS, FISCAL YEAR 1979—Continued

State and institution	Project title	Federal	Matching	Total
Texas:				
North Texas State University, Arlington.	Career service options for retired professionals.	14,500	11,600	26,100
Tarrant County Junior College District.	Senior citizen home health care training program.	13,000	6,500	19,500
University of Houston	Retirement planning	12,500	6,250	18,750
College of the Mainland	Focus on the future: Planning for retirement.	4,000	2,000	6,000
Hill Junior College	Enrichment program for senior citizens	4,000	2,000	6,000
Tarrant County Junior College.	Senior citizen home health care training program.	4,000	2,000	6,000
Texas Southern University	Internship assistance to State governmental agencies providing transportation for the elderly and handicapped.	4,000	2,000	6,000
Texas Tech University	Conference on current issues in gerontology—1980.	4,000	2,000	6,000
Utah, Dixie College	CSCE program for the aging and other neglected adults—phase VI.	5,500	2,750	8,250

Basic Skills Improvement Program

The basic skills improvement program is authorized under title II of Public Law 95–561. The basic skills program provides for instruction to children, youth and adults in reading, mathematics, and communication skills both written and oral.

In fiscal year 1980, the basic skills improvement program funded out-of-school projects designed to provide basic skills instruction to children, youth, and adults. Projects may serve older Americans as well as utilize the older Americans as tutors.

Consumers' Education

The consumers' education program, authorized by title III, part E, section 331–336, of the Education Amendments of 1978 (Public Law 95–561), provides funds to stimulate in both school environments and community settings, new approaches to consumers' education efforts through competitive contracts and grants. These awards are used for research, demonstration, pilot projects, training, and the development and dissemination of information or curricula. In addition, funds may be used to demonstrate, test, and evaluate these and other consumers' education activities.

Fiscal year 1980 was the fifth funding year for this program and the Department of Education continues its support for projects addressing the consumer needs of the elderly—59 grants in 22 States plus the District of Columbia and the Trust Territories, were awarded to bring consumers' education to many diverse groups. Twelve of those 59 programs dealt extensively with meeting the consumer needs of the elderly. Some of the activities were directed toward developing a consumer education module tailored specifically to meet the needs of deaf senior citizen leaders; training seniors to become more effective advocates; developing an educational program designed to enable the elderly to maximize the efficiency of their home energy usage; and to make seniors knowledgeable about legal medicinal (generic) drugs.

Energy and Education Action Center

The Energy and Education Action Center, established by the U.S. Office of Education (now the Department of Education) in collaboration with the Federal Interagency Committee on Education, serves as the point of focus for a Federal Government educational response to the challenges confronting schools and colleges created by emerging energy realities.

The general mission of the center is to promote all phases of energy education-related activities on an interagency basis by drawing upon all relevant, Federal, State, and local resources to assist educational clientele in implementing energy plans. This mission relates to the aging in three ways: encouragement, awareness, and assistance.

Because energy processes are so pervasive in our society, everyone benefits from energy education and awareness, whether it be preschoolers in a formal instruc-

tional setting, or young and old alike exploring energy concepts and demonstrations at community forums. Indeed, due to their fixed income status and higher vulnerability to certain types of illness, the elderly have an especially urgent need to learn energy conservation and cost avoidance techniques that are safe and effective, and to identify energy-saving products and practices which allow them to make lifestyle decisions that are desirable from a personal as well as societal standpoint.

Through workshops, telephone and mail inquiries, the Energy and Education Action Center provides technical and general information regarding energy conservation to contain costs through efficient use of facilities and through thermal efficiency. Questions, concerns, and suggestions are invited from any interested individuals or organizations.

Metric Education Program

The metric education program, authorized by title III, section 312, of Public Law 95–561, provides grants and contracts to institutions of higher education and State and local education agencies and other public and private nonprofit agencies in order to prepare students to use the metric system of measurement. The system of weights and measures is used in everyday consumer activities, as well as in international commerce. In order to make effective consumer decisions and sound economic judgments, it is essential that all practicing parties fully understand the units by which goods and commodities are exchanged or purchased. For the most part, the elderly must live within fixed incomes. An effort to meet their educational needs in this regard is critical. One strategy used under the metric education program is to strongly encourage all grantees and contractors to incorporate and delineate techniques by which they will actually teach parents and other adults, including the elderly, to use the metric system as a part of their regular educational and training program.

Public Library Services to Older Americans

Providing library service and information to aging persons is one of the priorities of the Library Services and Construction Act (LSCA); Department of Education (ED) program. This service, carried out by means of projects at the State and local level, is directed toward individuals as well as groups. ED provides assistance and functions in a coordinating capacity among governmental and nongovernmental agencies and groups at the national level to further the services of libraries to this age group.

Aging persons have used libraries and their information services just as any member of the public. In addition, the increasing number of persons in this age group and the growing awareness of their special needs have resulted in the development of particular programs and materials within the library, special information services, and outreach services to senior citizen centers, individual homes, and nursing homes. Libraries have been concerned with responding to the need for special services and the need to increase other agencies awareness of the value and breadth of the contribution which libraries are making and potential for greater involvement.

Federal money have been used to stimulate the purchase of talking books, large print materials, magnifiers, bookmobiles; and to pay for services such as home delivery, film programs, special seminars, outreach services to nursing homes and to other sites such as nutrition centers and senior day care centers. Though the 1973 amendments to the Older Americans Act included opportunities for strengthening library service to older adults through a new LSCA title IV, "Older Readers Services," this title was never funded. Services for the aging are provided from funds under title I, "Library Services."

Many successful programs in libraries are started with LSCA grants, frequently as demonstration projects, and then move to local funding as they prove their worth. North Carolina has used LSCA funds to start information and referral (I&R) services in local public libraries. As the local library takes over the funding, the next year's grant money goes to another location to start a similar project. One such endeavor, the Davidson Information Assistance Line (DIAL) has proved to be so important to the community that the sheriff's department answers the telephone service number after the library hours. Another I&R service in Pender County takes its program to the rural aging in its neighborhood information van.

Many aging persons find it difficult to get to the library, so the library finds ways to go to them. Outreach services such as bookmobiles for the aging, rotating and deposit collections for institutions and nursing homes, and personal delivery to the homebound bring needed materials and companionship to those unable to get out. Laurens and Lexington Counties in South Carolina have funded a 3-year demonstration project on outreach to the elderly that includes hiring two librarians to work full time with the programing for the aging. Other programs are coordinated by the library but are reliant on volunteers for the actual delivery of materials and conversation. The Snyder (Pa.) County Library program called VISITOR (volunteers insuring shut-ins the opportunity to read) and the James V. Brown Library's (Williamsport, Pa.) program called BRAVO (bringing reading to aging through volunteer organization) both rely on citizen helpers which include mobile senior citizens. In the BRAVO program, cooperation with other agencies that deliver services to the aging are stressed. The library coordinator for the program is experienced in Information and Referral work and has close ties to the rest of the social service community.

Using existing social, medical and nutritional support systems for the aging have frequently made LSCA funded projects more efficient. The Brooklyn (N.Y.) SAGE project (an already successful outreach program) found that it added 150–250 older readers when it "piggybacked" onto such programs as friendly visitor and meals-on-wheels. Another program that complements the LSCA funded efforts to serve the visually handicapped older readers is the Library of Congress system of loaning materials (such as braille and spoken tapes or records) through a network of 159 regional and subregional libraries for the blind and physically handicapped.

Other programs for those who cannot use conventional materials because of failing eyesight are frequently funded under LSCA. The Altoona (Pa.) Area Public Library records 60 minutes of features and news from the local newspaper each day and the cassettes are sent to those unable to read small newstype. Many libraries, like the Toledo-Lucas County Library, are increasing their large print collection and are bringing the awareness of the availability of the material to those in need of this service. Van delivery, bookmobile deliveries, and books-by-mail are used to get special materials to aging readers. Sites where those over 60 years of age gather also utilized by libraries for the delivery of materials and programs of special interest.

Programs on topics of interest to older citizens are given at the library as well as at nutritional sites, senior centers, nursing homes, churches, etc. The gray and growing programs by the Baltimore County Public Library are examples of programs that deal with improving the perceived value of life by the aging. Talks and audio-visual presentations are given on such accepted topics as health issues; art and crafts; reminiscences about the county fair, the 1920's, trains, and early Baltimore; and on controversial subjects such as sexuality and the aging. Many programs are jointly sponsored by the public library and other agencies interested in the problems of the aging. Seminars, such as the one on crime prevention sponsored by the New York Public Library, the Senior citizens crime prevention program, the New York City Foundation for Senior Citizens, Inc. and the department for aging of the city of New York, have been received good community support.

Programs vary by location and makeup of the community served. Local needs are assessed before programs are funded. One unique program for the aging is found in Hawaii. In this project most of the money for materials for the aging program are spent on foreign, especially oriental, language books since a large percentage of the over 60 population are bilingual or foreign speaking and/or reading.

As the local public libraries become more aware of the need for services tailored for the older reader, and as they work with other groups and agencies that are also concerned with service to the aging; a greater understanding of what libraries are doing and what more they can do will be gained by all parties. To further this kind of understanding, the Department of Education takes an active part in the Interdepartmental Task Force on Information and Referral, and outgrowth of the White House Conference on Aging in 1971, which provides for coordination among Federal agencies involved in projects on aging and aging populations.

These examples illustrate the commitment among those bringing library service to the aging, to offer relevant materials, programs and information to the

older library user; and in addition, to take library service to the elderly population that cannot come to the traditional library setting.

Women's Educational Equity Act

The women's educational equity act program, authorized by title IX, part C of the Elementary and Secondary Education Act of 1978 provides funds for demonstration, developmental and dissemination activities designed to promote educational equity for women. The reauthorized act includes a new purpose—to provide financial assistance to local educational institutions to assist them in meeting the requirements of title IX of the Educational Amendments of 1972. Among the act's six authorized activities are programs to provide educational opportunities for adult women, including unemployed and underemployed women. The program seeks to address the diverse needs of various racial, ethnic, age, and regional groups; women and girls of all age groups are potential program beneficiaries.

During fiscal year 1979 and 1980 a variety of program models and materials were developed to facilitate the reentry of adult women into the academic or employment ranks. Some project activity, for example, focused specifically on business management and leadership training. Other projects have been structured to provide continuing education and training, including a variety of counseling strategies for displaced homemakers. These project activities continue the program's early emphasis, in its 1976 to 1978 grant activities, on adult women's educational needs. Products of these grants are available, at cost, from the WEEA Publishing Center, EDC, 55 Chapel Street, Newton, Mass. 02160 (800–225–3088).

Adult Education

The Department of Education recognizes the rapid changes in the Nation's school age population and is moving toward the goal of ensuring equal educational opportunities for *all* citizens. While no Federal education program contains an explicit mandate relative to serving older persons, as the new Department moves in this direction and assists American education to adjust to socioeconomic demands, the elderly will become increasingly important.

Programs funded under the Adult Education Act, Public Law 91–230, as amended, are authorized to address the educational needs of all segments of the eligible adult population in a State. In these State-administered programs special emphasis is given to meeting the educational needs of older persons. In compliance with the basic purpose of the act, highest priority is given in each State's 3-year plan to those adults who are least educated and most in need of assistance. Formula grants are awarded to the 57 States and outlying areas to support basic education programs for out-of-school adults age 16 and over, and to assist them in continuing their education through completion of the secondary level. Individuals participating in the program are expected to acquire the basic skills and knowledges necessary to function in society, to secure training which will help them to become more employable, and to carry out their citizenship responsibilities in American society.

The grant formula is based on the number of adults in a State without high school diplomas who are not currently required to be enrolled in school. Federal funds support up to 90 percent of each State's program and up to 100 percent of the programs in outlying areas. At least 10 percent of each State's allotment must be used for special experimental demonstration projects and teacher training.

In addition to the State-administered program, the act authorizes educational programs for adult immigrants and adult Indochina refugees, planning grants to States, and a national development and dissemination program. Funds have not been appropriated to implement the last two provisions.

There are approximately 57 million adults in the United States 16 years of age and older who have not completed the secondary level of education, and are not required to be enrolled in school. It is not known how many adults who have completed the secondary level but are not functioning at that level. This group is also a major part of the target population.

The Adult Performance Level Study, funded by the Division of Adult Education, provided significant findings concerning the functional level of the adult population. The APL study reported that the largest percentage of persons who were functionally incompetent (35 percent) or were only marginally competent

(40 percent) were older persons 55 to 65 years of age. Persons older than 65 were not included in the study. (Adult Functional Competence: A Summary, Adult Performance Level Project. The University of Texas, Austin, Tex., March 1975, p. 7).

This age group also has a high turnover. Studies indicate that, "everyday only 5,000 Americans reach 55, and an estimated 3,600 persons die. The net increase is about 1,400 a day; or a half a million a year." Some of these adults are in mental and correctional institutions, boarding homes, hospitals, and many are homebound in high risk urban centers or in remote rural areas. All are isolated from their families and friends, and have limited access to education and other essential services.

Title XIII, part A of the Education Amendments of 1978, extends and revises the Adult Education Act and creates new program initiatives to improve and strengthen educational services to eligible adults, including older persons. The principal goal of the amendments is to expand a State's current delivery system of adult education, and to broaden outreach activities. States may award subgrants to public and private nonprofit agencies, in addition to funding local educational agencies. In implementing the structural and programmatic changes created by the 1978 amendments to the act, increased attention by the States is placed on serving older persons with limited English language skills. Opportunities for significant expansion of the delivery of adult education services are provided through cooperation with agencies, institutions, and organizations other than the public school systems such as, business, labor unions, libraries, institutions of higher education, public health authorities, antipoverty programs, and community organizations. States have instituted strategies to ensure the involvement in the development of the 3-year State plans for business and industry, labor unions, churches, public and private educational agencies and institutions, fraternal and voluntary organizations, community organizations. State and local manpower and training agencies, and representatives of special adult populations. States have developed special methods and techniques to increase their efforts in informing the adult populations who are least educated and most in need of assistance of the availability and benefits of the adult education program.

In order to ensure the participation of these adult populations, recipients of funds are required to provide reasonable and convenient access to the program. Programs must be more flexible in their course offerings, locations, and in terms of assuring the availability of support services such as day care and transportation.

Departmental activities in 1980 as well as in 1979 have continued to center around assisting the States in implementing the administrative changes required by these amendments to the act. Attention is focused on assisting the States in improving State participatory planning strategies, programs development, monitoring, coordination or integrated use of resources from multiple funding, sources, and evaluation.

Older persons were included in the participatory planning activities for the preparation of the 3-year State plans, and are continuing their involvement in State plan development and evaluations.

Some States have negotiated and implemented interagency agreements with State and area agencies on aging, and with other related agencies and institutions serving older adults. Other States are encouraged to consider this administrative strategy. Technical assistance services and resource materials are providing the States to help strengthen their capacity for program development in carrying out such process requirements as needs assessment, planning, monitoring, coordination and evaluation. Two major program initiatives were undertaken in the transportation and telecommunications fields. Some significant developments are described below.

The establishment of coordinated State systems of education and transportation services is encouraged. A national task force for this purpose was convened to give guidance and direction to this activity on the Federal level, and three regional meetings approved to be held in three cities—Jacksonville, Detroit, and Denver—for State directors and appropriate representatives of agencies and community-based organizations in Regions IV, V, and VIII. It is through this intergovernmental planning mechanism and process that States are assisted in establishing priorities, and to invert Adult Education Act resources in a coordinated or integrated agency services system reaching older persons and the handicapped.

The White House Conference on Aging in 1971 recognized that, "educational efforts on behalf of older persons are less effective without attention to *outreach* and the improvement of accessibility through the removal of *transportation* barriers." A strategy for technical assistance intervention was the development

of interagency agreements between the Administration on Aging and the Office of Education. In 1979 the revised agreements included the Department of Transportation, ACTION and the Community Services Administration. Guidelines for planning the establishment of transportation services for older persons through the use of cooperative strategies and processes resulted from five demonstration projects sponsored by DHEW, DOA, GSA, DOL, DOT, ACTION, and the Community Services Administration. Education agencies were not participants in these projects on any level. The extension of intergovernmental agency effort will be needed nationwide to help them in the planning of procedures to link education into future coordinated transportation services systems.

The first regional coordinated education/transportation services workshop was held on the site of one of the five projects, in Jacksonville, Fla., for State participants in Region IV (South Carolina, North Carolina, Kentucky, Georgia, Florida, Tennessee, Mississippi, and Alabama). These States have large older populations comprising 11 percent and over of the total population, with over one-fifth of the persons 65 years and over below the poverty level. Many of the aged poor in these States live in isolated rural areas and inadequate transportation is one of the major problems preventing access to educational and other services. The State of Florida has enacted chapter 427 of the Florida statutes establishing a coordinating council to foster coordination of transportation services provided to the "transportation disadvantaged." The definition of the "transportation disadvantaged" include "individuals who because of age are unable to transport themselves, to purchase transportation and are, therefore, dependent upon others to obtain access to education or other life sustaining activities."

This model State statute, requiring coordinated transportation services for the aged and other special populations is being widely distributed for other States to consider for legislative action. The North Carolina adult education program reproduced the technical assistance packet distributed at the regional meeting, and under section 310 of the act is funding two projects in a rural and urban area to demonstrate ways adult education agencies can provide coordinated transportation services to adult students. It was recognized early that educational agencies cannot provide this support service alone.

The adult education program in the State of Mississiopi is budgeting for the use of existing transportation services in the districts, including support of special buses and carpools.

Efforts are also underway to help the States to: (1) Increase the availability of resources for use in rural transportation services; (2) create a program that will provide technical assistance to (a) community based organizations and local governments administering adult education and transportation programs, (b) increase access to educational programs for adults statewide; (3) facilitate coordination of resources and overcome barriers to the implementation of transportation services for adults needing them.

In the area of research, the National Task Force is following the progress of two ongoing projects relating to transportation for the elderly, and supported by the Office of University Research, Department of Transportation, Shaw University in Raleigh, N.C., is investigating the use of schoolbuses for transporting the elderly and nonwheelchair handicapped persons during off-peak hours, including the legal and institution barriers to such use. In the second project, the Transportation Training and Research Center of Polytechnic Institute of New York is nearing completion of a study to develop a methodolgy for evaluating existing and new transportation services with respect to meeting the travel needs of the elderly and handicapped, and to develop suggested service standards for different types of handicaps. While the latter terms of the project are directed to the handicapped, the findings offer promise for applicability of the standards. According to studies by the Department of Transportation, more than one-third of the elderly are handicapped and will benefit from these activities.

Telecommunications technologies are also being examined to determine their potential applications as a means for outreach and as an alternative system for the delivery of educational programs and services to adults for whom this program is intended. Many older adults can be helped to overcome the disadvantages imposed by living in remote rural areas, and institutions, by being homebound or isolated from social supports essential to meet their daily needs. A collaborative relationship now exists between the program and the National Telecommunications and Information Administration of the Department of Commerce, the Corporation for Public Broadcasting, and commercial and public service broadcast agencies. This arrangement provides coordination and the free flow of informa-

tion, without committing the States, and lets them set their priorities, policies, and program directions. All-day workshops on "Educational Applications of Telecommunications Technologies" were held for all States east and west of the Mississippi River in New Orleans and San Diego, and cosponsored by NTIA. The workshops provided insights on the technologies, such as the electronic blackboard, ITFS, video-disc, cable and satellite. The steps taken by NTIA to "bring the benefits of the national investment in satellite technology to the public sector" were assessed to determine ways to strengthening working relationships between grant recipients and the State adult education programs.

Developments were presented by State directors from New York, Virginia, South Carolina, West Virginia, New Jersey, American Samoa California, Hawaii, Missouri, and Arkansas. These reports revealed a high level of interest, and differences in the development stages of both hardware and software in each State program. For example, the State director from Wisconsin reported that staff training seminars were being telecast via satellite by the Professor of Adult Education, University of Wisconsin, while on sabbatical leave in London, England. New York State is seeking equipment and funding support for interconnecting a tricounty televised system operating daily from an adult learning center in Albany. Colorado is seeking assistance in developing the adult education component of the Governor's 5-year plan for the use of telecommunications in the State. Under a Department of Education grant, the San Diego State University is developing televised programs for older adults, produced by older adults.

The potential of using instructional television fixed service (ITFS) for instruction and staff development was explored with the State director in Virginia and the program director for KPBS–TV, San Diego. State directors and their staffs will secure training in telecommunications for participating in a national teleconference via satellite sponsored by the National Training and Development Service. The use of mobile TV systems in rural areas of Mississippi has been targeted by the Appalachian Community Service Network and can be extended to other areas.

Policy and program implications were synthesized in workshop recommendations for future meetings, and technical assistance needs for tapping potential resources were identified. Two task forces were formed to give leadership and direction to this significant development. First priority in 1981 will be given to the development of a national catalog of instructional materials for adults to be used on public radio and TV.

It is too early to fully assess the effects of the above program initiatives and administrative actions on older adults and other segments of the adult population. A major beginning is underway to effectively implement the 1978 amendments to the Adult Education Act. Reports from the States indicate between 1978 and 1979 there has been a 19,748 (16 percent) increase in older adults 65 years of age and older in the program. In 1980 incoming enrollment data from the States provide a basis for the projected age distribution of participants below.

TABLE 1

Age group	Estimate	Percentage
16 to 44	1,488,905	79
45 to 64	261,961	14
65 and over	128,612	7
Total	1,879,478	100.0

The estimated increase in enrollments of participants by age groups in 1980:

TABLE 2

Age group	Estimated enrollment	Estimated increase	Percentage increase
16 to 44	1,488,905	26,326	2
45 to 64	261,961	22,727	10
65 and over	128,612	24,134	23
Total	1,879,478	73,187	4

The actual and projected increases in enrollment of older adults are compatible with national trends and are expected to continue in fiscal year 1981 and throughout the decade of the 1980's.

These projections are supported by the increasing number of special projects directed to older adults by the States. Under section 310 of the Adult Education Act, many States are giving priority to older adults as a population group meriting special attention. Grant awards have been made to determine new and innovative approaches for expanding outreach and improving the effectiveness of instructional methods in meeting the educational needs of older adults.

Eight selected State-agency-funded projects focus on diverse activities designed to benefit older adults:

LOUISIANA—OLDER ADULT IMPROVEMENT: PREPARATION OR PEACE OFFICER ACCREDITATION

A pilot teaching program for deputies over 50 years of age to reactivate academic abilities.

FLORIDA—LITERACY EDUCATION FOR ADULTS WITH READING NEEDS (PROJECT LEARN)

A tutorial project to utilize the older citizens in Wakulla County to reach and teach reading skills to nonreading adults in the public school program.

INTERAGENCY LINKAGES FOR EDUCATION AND AGING

The project will conduct a Statewide assessment of personnel providing services to older persons, and older workers, and develop an inventory of education and training resources.

ALABAMA—COMMUNITY ADULT EDUCATION PROGRAM

The program is designed to provide several support services to the elderly in Adult Basic Education classes, including transportation and recreational activities.

WEST VIRGINIA—TELEVISED INSTRUCTIONAL READING PROGRAM FOR OLDER ADULTS

This project will develop recruitment and individualized reading tapes to be transmitted by TV as a supplement to regular adult education program, and improve outreach to older adults.

CONNECTICUT—JOB SKILLS WORKSHOPS FOR THE ELDERLY

To conduct 12 workshops annually and establish a "job bank" for the elderly, and measure the number who find employment during and after the workshops.

TEXAS—RECRUITMENT AND RETENTION OF OLDER ADULTS

To develop models of increasing recruitment and improving retention rates among older learners in adult education programs statewide.

NEW HAMPSHIRE—DOVER NEIGHBORHOOD OUTREACH PROGRAMS

A neighborhood outreach program serving senior citizens residing in low income and Federal housing areas.

Vocational Education Program

The Vocational Education Act, as amended by title II of Public Law 94–482, provides programs and services to meet the needs of displaced homemakers and other special groups, such as single heads of households, homemakers and part-time workers who wish to secure a full-time job, and women and men in jobs traditional for their sex who wish to secure employment in a nontraditional area. Each State must conduct a needs assessment to determine the needs of these special groups. Although the act makes no age distinction in serving these groups, older adults are eligible to participate in the programs and services offered both for these special groups and in the regular vocational education program. All States are required to serve these special groups; however, funding levels for such programs is left to the discretion of each State. Total Federal and State expenditures in fiscal year 1980 for vocational education

programs serving displaced homemakers and other special groups were $2,432,778.

Community Education Program

The community education program authorized by the title VIII of Public Law 96-561, the Education Amendments of 1978, provides grants to State and local education agencies and to nonprofit, public and private agencies in order to stimulate the development of community school centers which provide educational, cultural, recreational, and other related services in accordance with local interests, needs, and concerns. Additional awards are made to institutions of higher education to train persons who will plan and operate community education programs.

Federal and/or State grants made to local education agencies are for the purposes of paying the administrative costs of planning, establishing, expanding, and maintaining these community-oriented programs. None of the costs of the actual services, educational programs, or other activities is supported under this legislation.

In order for a local education agency or a nonprofit agency to receive a grant the applicant must propose to meet eight minimum elements which are considered to compose any community school. One of those minimum elements is the potential of the community education program to serve all age groups in the community, including the elderly. In the local educational agency category, 48 projects were funded in fiscal year 1977, 45 were funded in 1978, 37 were funded in 1979, and 25 were funded in 1980 at an average of $40,000 per project. The first year of funding nonprofit agencies was 1980 when 9 projects were awarded an average of $55,000 per project.

Captioned Films and Television

Under the Education of the Handicapped Act, part F (Public Law 91-230, as amended), films and television are captioned for the deaf. The program provides a free loan of service of captioned theatrical and education movies to groups of deaf individuals across the Nation. A considerable number of the people served by this program are over age 65. Of great importance is the extension of the film program to include captioned television. Captioned television programs may reach as many as 5 million hearing impaired individuals over the age of 65.

Public television captioning has taken two forms: "Open captions," which are visible to all viewers, and "closed captions" which are visible only on sets and stations with decoding devices. The open captioned rebroadcast of the ABC evening news which was begun in December 1973 is widely known and still is the only captioned news program.

In 1973, the Bureau of Education for the Handicapped (now known as the Office of Special Education) contracted with PBS to develop a closed captioning system. This system became operational in March, 1980. ABC and NBC are each providing 5 hours of programing, not including specials that are captioned from time to time. PBS is providing approximately 20 hours of programing per week. Decoders are available from Sears, Roebuck and Co. in two formats: an adapter that can be attached to any television set and a 19-inch color set with built in decoder. This system makes it possible for hearing impaired persons to have a wide variety of captioned television programs without interfering with the normal viewing habits of the general public.

The deaf and hard-of-hearing population is estimated at 13.4 million. A large percentage of this population is made up of older Americans whose hearing has deteriorated with age. These individuals are a prime audience for captioned television.

Basic Vocational Rehabilitation Services

Under the Rehabilitation Act of 1973 as amended (title I, part B, section 110 basic vocational rehabilitation services are provided by State rehabilitation agencies to assist handicapped individuals to prepare for and engage in gainful occupations. Federal regulations provide that no upper or lower age limit is established as an eligibility requirement for the program. It is estimated that in fiscal year 1980 about 3 percent of those individuals rehabilitated through the program were 65 years of age and older. Services provided include medical diagnosis, vocational evaluation, counseling, medical care, vocational training and employment placement, and followup.

NUMBER OF PEOPLE REHABILITATED

Fiscal year	All rehabilitants	45 years of age and over	65 years of age and over
1979	294,396	63,309	7,076
1980	[1] 275,764	[1] 59,900	[1] 7,200

BUDGET DATA

Basic State grants	45 years of age and over	65 years of age and over
1979	$190,243,515	$21,263,000
1980	[1] 190,514,900	[1] 23,000,000

[1] Estimated.

A cooperative agreement, currently in the proceess of being revised, has been developed between the Rehabilitation Services Administration and the Administration on Aging. The agreement will improve coordination between resources available under the basic vocational rehabilitation program and those available under provisions of the Older Americans Act of 1965, as amended. Coordination of the Rehabilitation Services Administration with the Social Security Administration has also resulted in the referral of older and disabled persons who have applied for social security disability insurance and supplemental security income benefits to State vocational rehabilitation.

Special Projects Serving the Older Blind Population

Under the Rehabilitation Act of 1973 as amended (section 311 (a)(1)), special projects are funded to serve the older blind population. The consideration of age as a factor for receiving services is prohibited under these special projects.

During fiscal year 1980, the Rehabilitation Services Administration funded one new older blind project and continued five other special projects. These grant awards totaled $490,471. The projects address special problems of older blind people found in rural, urban, and inner-city areas; special problems of minority groups such as blacks and Hispanics; and special problems faced in employment settings such as home industries and second careers.

FISCAL YEAR 1980 SPECIAL PROJECTS SERVING THE OLDER BLIND

Grantee:	*Award*
Chicago Lighthouse for the Blind, 1850 West Roosevelt Road, Chicago, Ill. 60608	$101,800
New Hampshire Association for the Blind, 60 School Street, Concord, N.H. 0330i	86,150
Vocations and Community Services for the Blind, 117 West 70 Street, New York, N.Y. 10023	54,053
Pennsylvania Association for the Blind, 1930 Chestnut Street, Philadelphia, Pa. 19103	71,703
Massachusetts Commission for the Blind, 110 Tremont Street, Boston, Mass. 02108	44,646
Vera Institute of Justice, 30 East 39th Street, New York, N.Y.	132,119

Research and Training Centers

Rehabilitation research and training centers are authorized under title II sections 202 and 294 of the Rehabilitation Act of 1973 (as amended by Public Law 95-602). In fiscal year 1980, the National Institute of Handicapped Research funded for the first time two research and training centers in the area of aging—one at the University of Pennsylvania and one at Rancho Los Amigos Hospital in conjunction with the Ethel Percy Andrus Gerontological Center and the University of Southern California Medical Center. The centers will address problems of the Nation's 23.5 million elderly persons, many of whom are handicapped.

The two centers share the same goals: creating and conducting a research program related to rehabilitation of the handicapped elderly, providing training in rehabilitation of the handicapped elderly, disseminating information on the rehabilitation of this group and assisting others in using research findings, and developing educational materials. The focus of activities undertaken to accomplish the goals differ, however, for the two centers.

The University of Pennsylvania's research program currently focuses on the physiological and neurophysiological effects of stroke, the impact of bladder incontinence in the elderly, the effects of group therapy of disabled elderly, and the psychological status of families caring for the impaired aged. In its first year of operation, the center s training program is concentrating on disseminating existing information on aging and resources available to respond to the needs of the impaired elderly.

The center at Rancho Los Amigos Hospital is focusing on the effect of multidisciplinary treatment for depression among the elderly, the support provided to professionals working with the handicapped elderly, and health assessment and treatment needs of handicapped elderly Mexican Americans. The training program currently targets on providing continuing education to aging and rehabilitation professionals, students, the elderly handicapped and their families, providing internships to students from the health professions, and developing educational training materials.

Fiscal year 1980 funding for the centers totals $400,000.

ITEM 5. DEPARTMENT OF ENERGY

FEBRUARY 10, 1981.

DEAR MR. CHAIRMAN: In response to the letter from the Senate Special Committee on Aging requesting an update of the Department of Energy's (DOE) activities in 1980 affecting older Americans, we are pleased to submit the following report. The wide range of DOE activities affecting the lives of older Americans during 1980 are organized into five categories: Policy initiatives; service delivery programs; information collection and dissemination activities; public participation activities; and research on the biological and physiological aging process.

Before detailing the activities in each of the above categories, an overview of DOE's efforts should be considered. The immediate and long-term objectives are the assurance of adequate, available, and reasonably priced energy supplies for American consumers. DOE remains sensitive to the impact of energy cost and supply on older Americans and low-income households whose resources are strained to meet their basic energy needs.

During 1980, DOE has been aware of the need to address policy and price impact issues on the older consumer and has continued to make efforts to be involved with national organizations and other Federal agencies who have been concerned with energy needs of older Americans. Those activities will be addressed in more detail below. Energy conservation, the development of renewable domestic fuels, utility regulatory reform, energy development impact assistance, and conservation incentives through tax credit are some of DOE's activities that have had significant implications for older Americans. The following will be a description of activities and programs in each of the aforementioned categories:

POLICY INITIATIVES

DOE has continued as a very high priority the implementation of the National Energy Act. It has supported and contributed to other major legislation that will have an effect on the lives of older Americans, such as the low-income energy assistance program (title III of the Windfall Profits Tax Act). It has continued to make strenuous effort to assure that the energy-related needs of older Americans have been equitably met. The following are examples of policy initiatives that have been taken to respond to the issues concerning other Americans.

Utility regulatory reform activities: DOE completed an indepth review of 20 lifeline rate programs to determine their impact on elderly and low-income families, other customers, and the utility companies; and issued a three-volume report, "Lifeline Electric Rates and Alternative Approaches to the Problems of Low-Income Ratepayers." The report recommended that lifeline rate hear-

ings evaluate various promising nonrate policies along with lifeline proposals and thus, identify the most effective delivery mechanism for energy assistance to low-income households. (The report can be obtained from Economic Regulatory Administration, Washington, D.C.)

DOE provided funds under its innovative rates program to four States for 2-year projects to study: (a) The costs and benefits of lifeline-type rates to low-income consumers of electricity, (b) the kind of assistance programs currently available to this class of customers, and (c) whether a specific low-income rate is appropriate and justified. A fifth project, carried out by the Virginia State Corporation Commission was completed in September 1980. The completed report from Virginia, "An Evaluation of Lifeline Electric Rates," concludes that a "blanket" lifeline rate may not be an effective method of assisting low-income and/or elderly electric customers. Based on economic efficiency criteria, Virginia State Corporation Commission staff and their consultant agree that direct assistance is the preferred method of helping low-income customers. (Reasons for this conclusion and a brief summary of the project results are contained in the enclosed Virginia State Corporation Commission staff report.)

Energy assistance programs: DOE actively supported the administration's efforts to implement the energy crisis assistance program and the energy allowance program during the winter of 1979–80. These programs, administered by the Community Services Administration and the Department of Health and Human Services, respectively, provided $1.6 billion in assistance to low-income families. Much of this assistance went to the elderly; $400 million of the energy allowance program was specifically earmarked for recipients of supplemental security income program, who are predominantly elderly. During 1980, DOE was actively involved in securing passage of the Home Energy Assistance Act of 1980 (title III of the Windfall Profits Tax Act) and assisted Health and Human Services in implementing the provisions of this act during the winter of 1980–81. This program was the major followon to the energy crisis assistance program and is the formalization of a larger term program to assist low-income groups with a special emphasis on the elderly. Funding for the winter of 1980–81 is $1.8 billion.

Weatherization program: The elderly and the handicapped are given priority under this program, which provides grants for the installation of insulation, weather-stripping, storm windows, and other energy-saving measures. In response to some operational problems, key regulatory changes were made during 1980 which increased the number of eligible households and units weatherized.

Residential conservation service: During 1980, DOE approved State plans for the implementation of the residential conservation service program. This program, as originally authorized, required utilities to offer energy audits and to offer to arrange for the installation and financing of energy conservation measures on single-family dwellings. With the enactment of the Energy Security Act in 1980, two changes to this program have been made:

—Utilities are now permitted to directly finance energy conservation measures, therby allowing them to undertake lending programs for their customers.

—The benefits of the program have been extended to multifamily dwellings.

This program, while available to all customers of covered utilities, should be useful to the aged by providing objective information on energy conservation investments and the necessary financing for their installation.

New residential energy conservation initiatives: The Energy Security Act of 1980 authorized a Solar Energy and Conservation Bank. Under the provisions of the bank, subsidized financing (up to 50 percent) will be provided for energy conservation improvements. This program appears to benefit the elderly who have the highest rate of homeownership of any age group.

DOE is experimenting with a one-stop shop retrofit delivery system which would provide financing and quality control for conservation programs. This again could be helpful to the elderly by simplifying program delivery and assuring quality control.

Impact of energy prices and policies on socioeconomic groups: DOE continues to measure and analyze the impacts of energy policies and rising energy prices on various socioeconomic groups.

Service Delivery Programs

Weatherization assistance program: DOE, in cooperation with the Community Services Administration and the Department of Labor, initiated an action plan

to speed delivery services. The low-income elderly and handicapped receive priority under this program, which provides grants for the installation of insulation, weatherstripping, storm windows, and other energy-saving measures.

In the 1980, the weatherization assistance program awarded over $163,544,231 in grants to States and 24 Native American tribal organizations for the weatherization of homes of low-income persons. Reports from the inception of the program through October 1980, indicate that 487,541 low-income homes were weatherized and that the majority of those dwellings were occupied by the elderly. In fiscal year 1980 alone, 265,182 homes have been weatherized.

Residual conservation service: Scheduled for implementation by the States in early 1981, this program requires major utilities to offer energy audits, to offer to arrange for the financing of the purchase and installation of energy conservation measures and to permit repayment of the loans through monthly utility billings. The program also requires development of State-approved lists of suppliers and contractors and should be useful to the elderly as well as other members of the population.

Residential tax credits: The residential tax credits provide tax incentives to individuals for the installation of energy-conserving equipment and devices. Available through the 1985 tax year, the program provides for tax credits of 15 percent of the cost of equipment purchase and for installation up to a maximum of $300. While the program is available to all taxpayers, it appears to be useful to the elderly, many of whom occupy older homes with less efficient heating equipment and insulation.

Institutional conservation program: Title III of the National Energy Conservation Policy Act provided for a matching grant program to support professional analyses of the energy conservation potential in public care facilities. The effect of this program is to identify for building operators ways to conserve energy and thus cut their operating costs. The program also hopes to influence the capital investment decisions of the institution's management.

During fiscal year 1980, the program made awards to 75 nursing homes. As of this writing, no reports have been received on the results of those awards.

Appliance efficiency program: During 1980, DOE continued its effort to develop minimum energy efficiency standards for 8 of the 13 products initially covered by this program. The eight products are furnaces, clothes dryers, refrigerators and refrigerators-freezers, freezers, central air-conditioners, room air-conditioners, water heaters, and kitchen ranges and ovens. The proposed standards are slated for initial promulgation in January and February 1981. While this program is of benefit to all purchasers of these appliances, it appears to be useful to the elderly whose limited incomes require purchase of the most cost-efficient products.

Information Collection and Dissemination Activities

The Energy Information Administration conducts analyses of the expenditure impact of changing energy prices and other energy policy issues of various population groups, including the elderly. These analyses are conducted using the "Microanalysis Transfers to Household/Comprehensive Human Resources Data System, MATH/CHRDS" computer model.

During 1980, the Energy Information Administration prepared a report containing information concerning expenditures for energy by the elderly. This report, prepared by the Office of Applied Analysis, contains estimates of expenditures for energy by fuel type for 1975 and 1985 for elderly and nonelderly households. The report, entitled "A Comparison of Energy Expenditures by Elderly and Nonelderly Households—1975 and 1985" (GPO No. 061-003-00117-3), provides both regional and national level estimates.

In addition, the Energy Information Administration, through its Consumption Data System (CDS), collects and publishes comprehensive data on energy consumption, storage, cost by fuel type, and related housing unit characteristics (such as size, insulation, and major energy-consuming appliances) for the residential sector.

In 1980, Consumption Data System published the following information concerning the elderly:

Results about the elderly from Energy Information Administration's first nationwide survey of residential energy consumption were published in 1980. The 1978 national interim energy consumption survey collected data from individual households and actual billing data from the households' fuel suppliers for 1 year's period. The report, "Residential Energy Consumption Survey: Consump-

tion and Expenditures, April 1978 through March 1979" (GPO No. 061–003–00131–9), provides national estimates of the cost and amount of electricity, natural gas, fuel oil and kerosene, and liquefied petroleum gas used by all households including those headed by the elderly.

Another national interim energy consumption survey report, "Residential Energy Consumption Survey: Conservation" (GPO No. 061–003–00087–8), presents national estimates on insulation characteristics of housing units for which the household head is elderly (large apartment buildings are not included). The report also indicates the type of insulation and equipment covered by the energy tax credits that have been added by the elderly in 1977 and 1978.

These three reports can be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

PUBLIC PARTICIPATION ACTIVITIES

In its continuing efforts to actively involve older Americans in policy formulation and decisionmaking process of the Department, the Consumer Affairs Advisory Committee has included representation for a major national organization of older persons. The National Retired Teachers Association/American Association of Retired Persons, is now represented on this advisory committee.

DOE was actively involved during 1980 in formation of, and has been represented on the "Ad Hoc Energy and Elderly Consortium." This organization is composed of over 60 organizations from the public sector, private nonprofit sector, and from the energy industry. This organization is the only one of its kind that brings together Federal agencies such as DOE, Community Services Administration, and Administration on Aging together with national aging organizations, and the private industry sector such as the American Gas Association, American Petroleum Institute, Edison Electric Institute, and others, to review and discuss solutions for the energy-related needs of the elderly.

Through participation in this group, DOE has exercised leadership in forming partnerships with a variety of organizations that have worked to meet the energy needs of the elderly.

DOE helped underwrite and actively participated in the 1980 Mini-White House Conference on Energy and the Elderly, entitled, "Energy Equity and Elderly for 1980's." This miniconference was jointly funded by several Federal agencies and conducted by National Retired Teachers Association and American Association of Retired Persons. DOE actively collaborated in conceptualizing and conducting this conference. The conference report which is expected to be issued in early 1981 will present a series of recommendations and policy options for energy and the elderly.

DOE is represented on the Intergovernmental Task Force for the 1981 White House Conference on Aging. This activity brought together several activities in DOE to address the policy issues formulated during 1980 miniconference on "Energy Equity and the Elderly."

DOE developed and published a comprehensive analysis and report on State utility commission termination of service policies. This report identified specific policies that were sensitive to vulnerable population groups like the elderly.

DOE prepared a thorough assessment and a series of options to redistribute oil company overcharge funds to low-income consumers and the elderly who would be in need of additional resources for fuel and utility costs during the winter. These funds were obtained by DOE in legal settlements.

During 1980, DOE began a major report on the impact of increasing energy costs on the moderate- and low-income households that will give attention to needs of the elderly.

RESEARCH ACTIVITIES

Although DOE does not sponsor an organized program of research on the aging process, two categories of studies related to biological aging were continued during 1980: (a) Studies not directly concerned with biological aging but that produce data on physiologic and pathologic changes occurring in aging human and animal populations, and (b) studies directly concerned with elucidating the biological basis of aging.

A complete description of these research activities is enclosed.

We are pleased to contribute to your annual review of Federal actions and programs related to aging.

Sincerely,

JAMES B. EDWARDS.

Enclosures.

Enclosure 1

Summary of An Evaluation of Lifeline Electric Rates by Virginia State Corporation Commission

In order to assess the findings and recommendations resulting from any study, a careful evaluation of the methodology and scope of the project must be made. Through careful planning of this project, every effort was made to insure the applicability of the results; however, time and financial constraints prevent any study from being universally applicable. Thus, in order to properly evaluate the recommendations and findings contained in the consultant's report, it is appropriate to note the limitations of the project. Section I discusses the scope of the demographic survey and section II presents staff comments on the analysis of alternative assistance plans.

I. THE DEMOGRAPHIC SURVEY

As documented in volume I of the consultant's report, a telephone survey was conducted. Because of time and financial constraints, the consultant and the SCC concluded that a telephone survey was the preferred method. This approach excludes from consideration those individuals without telephones or with unlisted numbers. According to telephone company statistics it was expected that approximately 5 percent of households are without telephones while 12 percent have unpublished numbers. However, in actually obtaining the telephone numbers for the randomly selected master sample, the consultant found that in the VEPCO service territory 22 percent had no number listed and 10 percent had unpublished numbers. For the APCO master sample, 23 percent had no number listed while 5 percent had unpublished numbers. Although these percentages are noted in the consultant's report, it should be pointed out that checks performed on the sample data revealed that there was *no measurable bias* of the sample as a result of unlisted and unpublished telephone numbers. A comparison of the sample data to secondary data and to master sample data revealed that there was no perceived effect on the critical variables; average household size, income, and electricity consumption.

The method chosen for the selection of the master sample by the utilities (see volume I) eliminated from consideration master metered households as well as households with less than 12 months of billing history at that address. Further, the survey did not cover the entire State, only the APCO and VEPCO service territories were included. It should be noted, however, that APCO's and VEPCO's residential electric customer accounts comprise approximately 80 percent of all such accounts in the State of Virginia.

II. THE ANALYSIS OF LIFELINE ELECTRIC RATES

The consultant developed an algorithm used to quantify the impact of hypothetical lifeline rates on various customer groups. This algorithm is presently being installed at the SCC and will be used by the staff to evaluate specific rate schedules proposed by the legislature and the utilities. The algorithm coupled with the data base obtained from the survey represent the major contribution of the project in that it allows the staff to quantify the impact of specific lifeline rate proposals.

As part of their analysis, the consultants estimated the tax burden per income level necessary to raise $100 of additional revenue. These estimates are intended to be illustrative of the general level of the tax burden for comparison to lifeline rate burdens. The tax burden estimates were based in part on a study of tax levels in Richmond, Va., and should not be interpreted to precisely measure the burden for the entire State.

The hypothetical lifeline rates examined in the study (see volume II) provide general information on the impact of changes in the size of the lifeline block, the lifeline rate, and target population. This analysis shows that a "blanket" lifeline rate may not be an effective method of assisting low income and/or elderly electric customers. Based on economic efficiency criteria, the staff agrees with the consultants' conclusion that:

"The comparison of lifeline rates to alternative assistance programs shows that direct assistance is the preferred method of helping low-income customers for several reasons. With a direct assistance program:

—Benefits can be directed specifically toward persons in need of assistance.
—Greater amounts of individual assistance can be provided than through lifeline rates.
—A significantly smaller dollar transfer is needed to yield an equal level of benefits. Conversely, greater per capita benefits could be realized for the same gross level of transfers.
—The taxes necessary to support a direct assistance program are more progressive or directly related to income.
—Cost-based electricity prices increase economic efficiency and social welfare by giving the proper signals to customers concerning the costs to society of additional electricity consumption."

The SCC staff is in agreement with the general methodology employed by the consultant to analyze the assistance programs. The consultant's analysis presented in volume II provides background information which is used in the design and selection of assistance programs. However, before recommending or rejecting a particular method of assistance, the costs and benefits of the *specific* program should be analyzed. In addition, other issues must be welfare questions, and administrative considerations. Once specific lifeline proposals are presented to the Commission, either with respect to a lifeline hearing or in some other context, then the methodology will be used to conduct an economic analysis of such proposals.

Enclosure 2

REGIONAL ACTIVITIES RELATED TO THE AGED DURING 1980

REGION I

Senior citizens are among the groups contacted to give testimony at public hearings on the Department of Energy (DOE) policy and regulations. Such an effort last year involved the gasoline rationing hearing, as well as the proposed changes to the weatherization regulations which now provide greater flexibility, with the end result being that more homes are being weatherized. During 1980, in the six New England States, approximately 12,910 senior citizens were assisted through the weatherization program.

REGION II

Consumer affairs officer moderated the energy panel at a conference of the hispanic elderly held at Fordham University in March 1980. An overview of energy programs benefiting the elderly was provided; Spanish language literature on energy matters was distributed; and a list of persons to contact for various energy related matters was developed specifically for this conference.

Consumer affairs officer continued to represent DOE on the Federal Regional Council's Subcommittee on Aging. Membership on this subcommittee has enabled us to inform, on a timely basis, the Administration on Aging and other relevant Federal and State agencies of energy programs and other developments significant to the elderly population.

Nine subgrantees of the urban and communities program of New Jersey's Energy Extension Service are delivering services to the elderly. Among the services provided are energy audits, one-on-one technical assistance on low cost/no cost energy conservation measures, and workshops that tell senior citizens how to avoid and what to do in the event of hypothermia, shutoffs, and difficulties with fuel merchants. Many of the workshops are held at senior citizen centers and other places where the elderly normally gather.

From January 1 through November 30, 1,728 elderly persons in New Jersey were assisted by the weatherization assistance program. During the same period of time, 4,765 elderly persons in New York were assisted under the weatherization assistance program.

REGION III

During the fiscal year 1980, there were 20,395 elderly occupants in the 35,201 homes weatherized under a program funded at $22,072,620.

In addition, the State energy offices are encouraging public care institutions to take advantage of the grants program for schools, hospitals, local government, and public care institutions which provides 50–50 matching funds to conduct energy audits, technical assistance reviews, and to implement specific energy conservation measures in these facilities.

REGION IV

Region IV developed two publications which were found to have significant impact in terms of their meeting information needs in the area of conservation for senior citizens. The first publication was written by the consumer affairs officer who geared the publication toward meeting the needs of the elderly on low and/or fixed incomes. The brochure is entitled, "How to Keep Warm and Cut Your Fuel Bill," and has proved to be an excellent booklet which is both easy to understand and whose energy-saving ideas are simple to implement. 150,000 copies of the booklet have been distributed across the region to public and private organizations serving the needs of the elderly population. Requests for this publication have been received from across the Nation. The same energy- and money-saving ideas offered in the booklet "Tips for Energy Savers" was made available through region IV efforts on a 33 rpm flexible disk in both English and Spanish. The disk was specifically developed as an aid to the elderly, blind, and handicapped. The material was endorsed by the President's Committee on the Employment of the Handicapped.

Hot weather energy conservation and safety is a major concern to region IV due to its geographic location. The need for increased response to this topic was dramatized this summer as temperatures rose to record heights. The number of people who died from heat-related causes increased greatly and many people, especially the elderly, suffered from the heat simply because they were unaware of alternate methods of cooling. To assist in remedying this problem, region IV is currently working to develop a publication focusing on energy conservation during hot weather months. This project will be funded through DOE, Office of Consumer Affairs.

During 1980, $22,410,200 was awarded to States for weatherization assistance in region IV. As of the third quarter of 1980, a total of 31,316 homes were weatherized and 28,900 of these homes were occupied by elderly residents. The appropriate technology program received 2,111 applications in 1980 and approximately 18 percent of those proposals were from the elderly.

The Georgia energy assistance program in conjunction with the Department of Human Resources and State Government Economic Opportunity Office asked for our assistance in providing conservation information to recipients of program funds. 150,000 publications, including seven different energy conservation pamphlets were distributed to local agencies. Sixty-one percent of the total households served by the program consisted of elderly residents.

REGION V

The weatherization program in region V is the largest in the country. For example, of approximately 30,000 homes weatherized across the country in the month of September 1980, more than 26 percent (over 8,100) were done in the six States in region V. In 1980, 27.7 percent of those receiving assistance under this program in our region were the elderly—50,770 out of 183,518. By regulation, this program is designed to help low-income people, particularly the elderly and handicapped. It is this sector of the population which benefits the most from weatherization of their homes, as 30 to 40 percent of their income goes to pay for energy.

Two funding cycles have now been completed under the DOE program granting energy conservation funds for schools, hospitals, local government buildings, and public care facilities: 20 percent of the region V grants under this program were to facilities which aid the elderly; 400 out of 2,000 grants were to hospitals and public care facilities. The benefit to the elderly should be both direct and indirect, as the energy audits, technical audits, and installation of energy conservation measures funded by the program lead to improved comfort in living environments and reduced operating expenses for these facilities.

A program of the Wisconsin Energy Extension Service, run by the University of Wisconsin Extension, Milwaukee, is housed in the inner city of Milwaukee. It targets moderate-income residents, providing information on conservation and solar energy, workshops, and energy audits. A significant number of the clients served are elderly.

The appropriate technology program encourages individuals and small businesses, who may have ideas for energy-saving devices or systems, to apply for grants to assist them in developing those ideas which may end up in the open marketplace. In 1980, two retirees received one of these grants (46 were given in all), and in 1979 3 out of 62 were grants to retirees.

In addition, DOE region V cosponsors (with the Use Energy Wisely Committee of Chicago) an annual Energy and Home Improvement Fair, with exhibits, workshops, and 300 to 350 booths. Among the 100,000 attending in each of the 2 years it has been held, are elderly residents of the greater Chicago area.

REGION VI

The weatherization program directly responds to the needs of senior citizens within region VI. During the first 9 months of 1980, homes with 14,186 elderly or handicapped persons in residence were weatherized against winter temperatures. During the heat wave of the summer of 1980, funds were made available for attic fans. An example of the need for hot weather measures is indicated by the installation of 771 attic fans and the repair of 22 cooling units in about 793 homes in Oklahoma for about $165,400.

Dialog has begun with the Southwest Society on Aging to determine possible means to alert the public and particularly the elderly concerning the hazards of extreme ambient temperatures which may result in hypothermia or hyperthermia.

A total of $1,146,948 was provided to the five States in region VI during 1980 to conduct preliminary energy audits and energy audits as part of the institutional buildings grant program. Through June 30, 1980, a total of 1,548 hospitals and nursing homes had received assistance to conduct preliminary energy audits. In addition, region VI awarded technical assistance and energy conservation measures grants totaling $3,788,562 in fiscal year 1980 to hospitals and public care institutions. These funds indirectly assist senior citizens, as well as all citizens, by curbing the rising energy costs of health care operations.

During 1980, region VI awarded two grants under the appropriate technology small grants program (a total of $28,100) which assisted the elderly.

Senior citizens have been given exemptions under the DOE emergency building temperature restrictions program. Senior citizen nutrition and recreation centers are permitted to raise the dry bulb temperature to 70°F (rather than 65°F) during the period of time senior activities are conducted.

Three States in region VI under the energy extension service (EES) program have programs which are aimed at providing assistance to the elderly. The State of Arkansas has implemented a senior Arkansas value energy program to assist elderly Arkansans cope with the high cost of energy. To date this program has been responsible for performing 320 home energy audits of elderly persons' homes. In New Mexico, EES funds are being used for a public information program which includes a toll-free hotline. It is estimated that about 690 senior citizens have been assisted to date in 1980. The State of Oklahoma has also established an energy information center where elderly persons can obtain advice and information on energy conservation.

The regional energy information center (REIC) provides information and referral services on DOE programs and activities as well as other energy-related subjects. Up to 500 information requests are handled per month by the REIC. Senior citizens who need assistance with energy conservation information or in finding sources of financial assistance are among those calling the REIC. Bulk supplies of pamphlets are provided to groups such as the Southwest Society on Aging. The REIC maintains mailing lists for the use of the regional representative and other program areas containing selected categories such as individuals representing the American Association of Retired Persons and the National Retired Teachers Association.

The regional bimonthly Consumer News Brief newsletter is sent to many seniors and their representatives as part of the developing networking system which includes other Federal agencies, State, and local groups.

REGION VII

Region VII recently sponsored an energy extension service conference in Clinton, Mo., where attendees heard from some enthusiastic solar consumers. This sounds routine except that these solar advocates were in their seventies and eighties. They were recipients of solar systems in the nine-county area served by the West Central Missouri Rural Development Corporation, directed by Charles Braithwait. Starting 3 years ago with an office of aging grant and continuing through the solar utilization/economic development and employment (SUEDE) project, this agency has installed 135 systems on houses of aged and low-income families. The houses had previously been weatherized under the DOE weatherization assistance program.

These solar consumers give a new perspective on what was described at the conference as the "reality" of low-cost solar. One woman in her eighties, when asked how she knew the solar system had saved her fuel, pointed to her yard and said, "If it wasn't for solar, that wood that I cut myself would now be gone." Benefits were often described in terms of warmth rather than just energy savings suggesting that high fuel costs had previously prevented the people from maintaining adequate temperatures in their homes. The fuel saved can also be used for other purposes as illustrated by the woman who used surplus propane left after a solar-assisted winter to can food for her whole family. It is clear that the benefits need to be measured in terms other than just utility bill reduction or simple payback.

REGION IX

The most direct response to senior citizens has been the weatherization program which provides insulation and other improvements to low-income homes to protect them from winter cold or the searing heat of the Arizona and Nevada desert.

A total of 17,552 homes were weatherized in region IX in 1980. The total includes Arizona, 2,467; California, 12,900; Navajo Nation, 530; and Nevada, 1,655. The program gives preference to senior citizens.

REGION X

The most direct assistance program to the elderly has been the weatherization program. In fiscal year 1980, region X provided approximately $9 million through this program to region X States (Alaska, Idaho, Oregon, and Washington) with production doubling over the previous fiscal year. In addition to the four State grants and four Indian tribe grants, this region has 70 local delivery subgrantees. The program gives preference to low income and the elderly.

Region X boasts one of the most successful regional appropriate technology programs. Of the 272 project grant awards, approximately 20 were awarded to senior citizens.

The energy extension service has expanded from the Washington State pilot EES program to now include all four States in the region. The extension service, oriented to local community needs, offers workshops and classes which draw many elderly citizens interested in home energy efficiency. In the States of Washington and Oregon, a master conservation program provides participants with 50 hours of indepth training in energy conservation and renewable fuels use in exchange for 80 hours of volunteer public service to the community. This program has drawn particular interest from the retired community.

The institutional building grants program provided approximately $5 million during cycle II for technical assistance grants and energy conservation measure grants. Grants to nursing homes and hospitals indirectly assist senior citizen users of these public institutions by curbing rising energy costs.

Senior citizens turned out during public hearings on the standby gasoline rationing plan and the standby Federal emergency energy conservation plan which both had a direct effect on recreational vehicles. Region X participation on the latter hearing was instrumental in deletion of the personal rulemaking measure on recreational watercraft restrictions.

Senior citizens continue to be a large portion of the many visitors and callers to the public affairs office seeking general and specific energy information. The office assists them by answering questions directly, mailing out energy conservation pamphlets, or by referring citizens, in the area of crisis intervention, to other appropriate Federal and State agencies.

Speech requests continue to come from senior citizens groups such as the Civilian Conservation Corps Alumni.

Enclosure 3

Research Related to Biological Aging

As in previous years, the Office of Health and Environmental Research (OHER) has administered a major program of research aimed at identifying and characterizing health impacts of the energy-producing technologies. In assessing energy-related health impacts, it is particularly important to determine long-term and late-appearing health effects induced by chronic exposures to low levels

of hazardous chemical or physical agents. Since health effects induced by chronic low-level exposures to toxic agents typically develop progressively over the entire lifespan or a significant fraction thereof, it is essential that such effects be clearly differentiated from functional decrements, morbidity patterns, and mortality that occur as a result of the aging process. To make a statistically valid differentiation between induced health effects and spontaneously occurring aging effects, detailed information on pathophysiologic changes occurring throughout the lifespan must be collected for both exposed and unexposed (control) populations of adequate size. Pathophysiologic data are collected from human populations whenever possible but primarily from controlled studies of animal populations. Studies conducted in this manner inevitably generate data describing age-related changes that occur in unexposed populations and in populations exposed to specific toxicants. Such data not only help to characterize the aging process but also define how sensitivity to hazardous agents may change with age. Given the importance of the biological aging in the study of late-appearing health effects, additional studies are conducted in order to obtain a better understanding of the aging process itself. Thus, although the Department of Energy does not sponsor an organized program of research on the aging process, two categories of studies related to biological aging were continued during 1980: (a) Studies not directly concerned with biological aging but that produce data on physiologic and pathologic changes occurring in aging human and animal populations, and (b) studies directly concerned with elucidating the biological basis of aging.

As in the past, lifetime studies of human and animal populations constitute the major effort in the ongoing program of research related to biological aging. Because of an extensive and long-term involvement in lifetime animal studies, several Department of Energy laboratories are contributing information to the laboratory animal bank that is being developed by the Battelle Columbus Laboratories under support from the National Library of Medicine and other Federal health agencies. The Department of Energy laboratories are providing data on life histories, pathology, hematology, and clinical chemistry obtained from control (unexposed) animals, both long-lived and short-lived, used in long-term studies. Five research scientists actively involved in lifetime animal studies sponsored by the Department continue to participate in the work of the National Academy of Sciences' Committee on Animal Models for Research on Aging. This committee was established in September 1977, to evaluate small vertebrates as animal models for research on aging.

As in previous years, research directly concerned with the aging process was conducted on a limited scale at several of the Department's contractor facilities. Work at the Argonne facility focuses principally on the evolutionary-comparative paradigm of aging and longevity in which genetic considerations play a prominent role. George A. Sacher of the Argonne staff has recently served 1 year as president of the Gerontological Society. The Oak Ridge program is oriented toward molecular and cellular studies including research on the error theory of aging. This program is conducted jointly with the University of Tennessee Graduate School of Biomedical Sciences and is partly supported by a training grant from the National Institute on Aging.

Summarized below is research on or related to aging that the Department sponsored in 1980.

LONG-TERM STUDIES OF HUMAN POPULATIONS

These studies provide valuable data on health effects and life-shortening in human populations exposed to hazardous chemical and physical agents associated with the energy technologies. Additional information on lifespan and aging in human populations is also collected. Since long-term studies of human populations are costly, time-consuming, the complex, they are initiated on a highly selective basis.

The Radiation Effects Research Foundation (RERF), which is sponsored jointly by the Governments of the United States and Japan, continued work on a large-scale lifetime followup of survivors of atomic bombings that occurred in Hiroshima and Nagasaki in 1945. Over 100,000 persons are under observation in this study. Detailed clinical and laboratory studies as well as the collection of mortality and autopsy data are performed on both irradiated and control populations in order to identify diseases that have contributed to elevated morbidity and life-shortening among survivors. An important feature of the RERF

program is the acquisition of valuable quantitative data on dose-response relationships. Useful data on genetic effects are also being collected. From time to time studies specifically concerned with age-related changes are conducted. Based on extensive data, it was recently reported that the "effects of ionizing radiation on mortality are specific and focal, and principally carcinogenic."

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. The clinical followup has continued on a semiannual basis. Thyroid pathology, which has generally responded well to therapy or surgery, has been prevalent in individuals heavily exposed to radioiodine. Near completion is a study to determine the feasibility of providing birth to grave medical care for segments of possibly the entire population (±20,000) of the Marshall Islands.

There is a study going on at Wadsworth VAH, Los Angeles, which is producing information about immunologic changes as related to aging and the effects of radiation on immunologic reactions.

Nearly 2,000 persons exposed to radium occupationally or for medical reasons have been studied at the Center for Human Radiobiology, Argonne National Laboratory. Many individuals in the study receive medical and radiologic (dosimetric) examinations at the Center. Autopsy data are obtained when possible. Current work emphasizes the study of persons with relatively low body burdens of radium. Valuable data on tumor induction by bone-seeking, alpha-emitting radionuclides such as radium-226 are being generated in this study. Of particular importance are quantitative dose-responsive data for tumorigenesis. The Center recently initiated an epidemiologic study of a large worker population occupationally exposed to thorium (an alpha-emitting radioelement) by inhalation during the period from about 1935 to 1974. This study utilizes vital statistics, employment histories, and records from the Social Security Administration to evaluate health effects of internally deposited thorium. Medical and radiologic examinations are being conducted on 100 randomly selected workers. Data on both morbidity and mortality are being collected. The Center is also conducting a followup study in a small group of exposed humans to evaluate late-appearing health effects of plutonium.

At the Los Alamos Scientific Laboratory, an epidemiologic study of plutonium workers, past and present, at six Department of Energy facilities is in progress. This study involves a lifetime surveillance of worker health and causes of death. An estimated 15,000 to 20,000 workers will be followed in the study of mortality data and at least one-third of these will also be studied further by collecting detailed morbidity and personal-history data periodically via questionnaires. Data on internal dosimetry are routinely collected in order to study dose-response relationships. Autopsy data are obtained through the U.S. Transuranium Registry (see below). Valid conclusions are not yet possible but so far there is no excess mortality due to any cause in 224 males with the highest plutonium exposures; the possibly higher than normal incidence of cancer of the lymphatic and blood systems is no longer occurring; the higher than normal incidence of digestive tract cancers in both males and females is more likely due to cultural and socioeconomic factors; and, 26 males exposed to plutonium mostly by inhalation under extraordinarily crude conditions during World War II yield no evidence yet that adverse health effects exist 32 years after exposure.

A population of some 170,000 past and present contractor employees at Department of Energy production and laboratory facilities is being analyzed in an epidemiologic study designed to assess health effects produced by long-term exposure to low levels of ionizing radiation. Worker populations at the Hanford (Washington) and the Oak Ridge (Tennessee) plants plus a smaller group of contractor employees at the Mound Laboratory (Miamisburg, Ohio) are the subjects of the study, which is directed by the staff at the Oak Ridge Associated Universities (ORAU) with assistance in data collection and processing from teams at each of the facilities that house the workers' records. The study involves the statistical analysis of work records, medical records, and vital statistics (including mortality data and causes of death). Radiation dosimetry as well as exposures to other toxic agents in the work environment are carefully evaluated.

The U.S. Transuranium Registry, which is operated by the Hanford Environmental Health Foundation, collects occupational data (work, medical, and radiation exposure histories) as well as information on mortality and causes of death

in worker populations occupationally exposed to plutonium or other transuranium radioelements. Detailed autopsy data are obtained on workers registered with the Foundation at the time of death. Every effort is made to obtain good dosimetric data on all registrants. At the present time, some 14,500 workers from 10 facilities are registered with the Foundation, and 73 autopsies have been performed. The autopsy data are made available for use in ongoing epidemiologic studies such as the ORAU study of radiation workers and the Los Alamos study of plutonium workers. A similar registry of uranium workers was started last year.

A lifetime study of human populations occupationally exposed to hazardous agents associated with nonnuclear energy technologies has been initiated. It is an epidemiologic study of workers at the Paraho oil-shale retorting plant located at Anvil Points, Colo. In this case, a small population of about 100 workers exposed to oil-shale dust and fugitive emissions from the retorting process is being studied to identify possible work-related health effects. The study involves an occupational survey (medical records), industrial hygiene survey (inplant monitoring of fugitive emissions), and periodic physical examination of workers.

LIFETIME STUDIES IN SHORT-LIVED MAMMALS

Although data from exposed human populations are indispensable in the assessment of health impacts associated with any hazardous agent, limitations inherent in human studies make it mandatory to acquire a substantial body of quantitative data from carefully controlled lifetime studies of animal populations. Reliable data from animal surrogates significantly enhance predictive capabilities. For purposes of comparison and a better understanding of variables affecting response patterns, data from both short-lived and long-lived mammals are needed.

Small rodents with lifespans of 2 to 3 years (rats, mice, hamsters) provide lifetime data in a minimum of time and at low cost. Because of these advantages, rodent populations have been extensively used in large-scale studies of late somatic and genetic effects induced by low doses of ionizing radiation. For example, at the Argonne National Laboratory and the Oak Ridge National Laboratory combined, more than 50,000 mice have been exposed to various doses of externally applied ionizing radiation delivered in different daily increments in order to characterize radiation-induced diseases and abnormalities that reduce the lifespan under various exposure regimes. These studies, in which both gamma and neutron radiations have been employed, continue to yield valuable information on the importance of dose rate and radiation quality as variables affecting mammalian responses to radiation stress. In addition, the careful study of control (unexposed) populations is providing valuable data on lifespan, morbidity patterns, and causes of death in unstressed animals. Additional lifetime studies of tumorigenesis and other late-appearing somatic effects of ionizing radiation in rodent populations have been carried out at the Brookhaven National Laboratory, the Lawrence Berkeley Laboratory, the Los Alamos Scientific Laboratory, the Battelle-Pacific Northwest Laboratories, the University of Utah, and the Lovelace Inhalation Toxicology Research Institute. These studies have included work with various types of ionizing radiation delivered to the animal body from external radiation sources and from internally deposited radionuclides. Approximately 30,000 rodents are currently under observation in lifetime studies at the above-mentioned laboratories. Included in the ongoing effort are studies involving external sources (neutrons, gamma radiation, and heavy ionizing particles), actinide isotopes that are present in nuclear fuels (plutonium-239, uranium-232, uranium-233, and others), radium isotopes, and products of nuclear fission (including tritium and krypton-85).

Rodent populations are also utilized in lifetime studies of health effects associated with exposures to energy-related chemical agents. In view of the large number of potentially hazardous materials requiring toxicological evaluation, such studies are conducted as part of a systematic multitiered screening and testing program. The number of ongoing lifetime studies has been increasing as short-term toxicological studies have continued to identify additional requirements for long-term testing. These studies are now producing data related to chronic disorders including cancer.

The bulk of the ongoing lifetime studies of chemical agents addresses potential health impacts of present-day and advanced fossil-fuel technologies. Two studies with a genetic focus are defining variables that influence tumor induction by polynuclear aromatic hydrocarbons that are present in emissions and effluents

from many fossil-fuel operations. One is a study at the Brookhaven National Laboratory in which the induction of mammary tumors in the rat is under investigation. In the other generic study, a better understanding of processes involved in the multistage induction of rodent skin tumors is being gained. A recently concluded lifetime study was performed by investigators at the Pacific Northwest Laboratories to evaluate chronic diseases of the respiratory tract that might be caused by the inhalation of coal dust, diesel-engine exhaust, or combinations of the two. The latter study helped to define the carcinogenic and other health risks that exist in coal mines located deep underground.

Four ongoing studies are assessing health risks of coal-combustion technologies. Research at the University of California, Davis, is defining health effects of powerplant fly ash, alone and in combination with sulfur-containing emissions (sulfur dioxide or sulfates), using rats subjected to long-term exposures by inhalation. The major objective of this study is to determine functional and morphologic consequences of damage to the respiratory tract. At the Lovelace Inhalation Toxicology Research Institute, lifetime studies of rodents chronically exposed to emissions from conventional and fluidized-bed combustion facilities are in progress. Initial studies are concerned with particulate emissions (fly ash). Biological end points being assessed are lifespan shortening, functional disorders, and structural changes, including carcinogenesis. Two projects at the Pacific Northwest Laboratories are devoted to the study of the chronic toxicity of metals and metal oxides present in emissions and effluents from coal-combustion facilities. In these studies, rodents are exposed by ingestion and by inhalation. Special emphasis is placed on evaluating iron-deficient and newborn animals as subpopulations particularly sensitive to toxic metals. Ongoing work is evaluating aspects of cadmium toxicity.

A number of lifetime health-effects studies are conducted in connection with technologies concerned with the conversion of coal to secondary fuels and the extraction of oil from oil shale. Studies are underway to assess the cancer incidence and lifespan reduction caused by exposure to polynuclear aromatic hydrocarbons produced or released as a consequence of coal gasification and coal liquefaction. Argonne National Laboratory conducts a program which emphasizes research on the role of cancer-promoting agents in the enhancement of tumor yield and reduction of the latent period for malignant tumor production in skin, lung, and liver. At the Oak Ridge National Laboratory, lifetime animal studies are evaluating on a comparative basis skin, lung, and nonspecific cancer caused by various classes of compounds found in coal liquefaction products. A related project has begun to assess the chronic toxicity of various classes of chemical agents found in effluents and waste products from coal liquefaction operations. Lifetime studies in rats and hamsters now in progress at the University of Connecticut, Farmington, are defining chronic toxicity and carcinogenic risks associated with the ingestion and inhalation of nickel-containing materials present in waste streams of coal gasification facilities. Health risks associated with the solvent refining of coal to a solid fuel (SRC I product) and to a liquid fuel (SRC II product) are being defined at the Pacific Northwest Laboratories, where long-term studies of rodents chronically exposed by inhalation or dermal application to components of process streams and fugitive emissions are in progress. Also in progress at the Los Alamos National Laboratory is a project designed to assess chronic pulmonary toxicity of raw and spent oil shale and to define the pulmonary carcinogenitcity of crude shale-oil fractions.

Additional lifetime studies involving short-lived animals are providing increased knowledge regarding the inhalation toxicity of asbestos-containing insulating materials and of aerosols containing strong mineral acids of the type present in effluents and emissions from some energy-producing operations. These studies are conducted at the Pacific Northwest Laboratories and the New England Deaconess Hospital, respectively. In both cases, emphasis is directed toward the study of tumor induction. In the asbestos study, tumorigenesis after oral intake or intraperitoneal administration of the toxic agent is also under evaluation.

LIFETIME STUDIES WITH LONG-LIVED MAMMALS

From the point of view of lifespan and certain of the organ systems of particular interest, long-lived mammalian species represent better human surrogates than do their short-lived counterparts. This being the case, it is desirable to obtain quantitative data on responses of long-lived species to hazardous agents

of concern. The beagle dog, with a life expectancy about one-fifth that of man, has served for more than 20 years as the long-lived mammal used in lifetime radiation-effects studies sponsored by the Department of Energy. Data from studies with beagles significantly facilitate attempts to interrelate data on animal responses with human response patterns. At the Argonne National Laboratory, the University of Utah, the University of California, Davis, the Lovelace Inhalation Toxicology Research Institute, and the Pacific Northwest Laboratories, more than 5,000 beagles have lived out their lives under careful experimental observations. In lifetime studies at these research centers, periodic clinical examinations and laboratory analyses are performed on all populations, exposed and control, and complete data on gross pathology and histopathology are collected at autopsy. Accumulated data contain a wealth of information on lifespan, age-related changes, morbidity, mortality, and causes of death in normal animals, as well as alterations in these characteristics that are induced by superimposed radiation stress. Approximately 3,000 beagles are currently under scrutiny in lifetime studies of late-appearing radiation effects. Included are studies of external radiation (gamma radiation) and internally deposited radionuclides of various types administered by inhalation, ingestion, or injection. All ongoing studies involve careful dosimetric measurements and the acquisition of dose-response data.

Because of their cost and the time required for completion, lifetime studies of beagle populations are initiated on a highly selective basis. No energy-related agent other than ionizing radiation has yet been evaluated in the beagle. It is anticipated that limited studies of other agents will be undertaken in the future as needs for such efforts are identified by shorter term testing in other systems.

RESEARCH MORE DIRECTLY CONCERNED WITH AGING

Several foci of interest within the Department of Energy laboratory system sustain a low level of research directly related to the aging process.

Ongoing studies at the Argonne National Laboratory are primarily concerned with developing an evolutionary-comparative paradigm of aging and longevity. This effort seeks to explain differences in lifespan of animal species on the basis of the natural selection of genetically determined traits. The Argonne investigators favor the view that longevity in mammalian species has evolved from a selection of traits conferring on individuals a lifespan and vigor that results in something approaching an optimum of growth, development, and reproduction for a particular ecological niche.

Over the years, extensive work on molecular, cellular, and physiologic aspects of biological aging have been conducted at several national laboratories. For example, Oak Ridge investigators have completed a substantial number of studies that have helped define age-related changes in the immune system of irradiated and unexposed rodent populations. The chief focus, however, of ongoing research at Oak Ridge is directed toward molecular and cellular aspects of aging.

Recent studies show that certain transfer RNA molecules, essential components of the cell's protein synthesizing machinery, change with age. This may explain earlier findings with hemoglobin that the fidelity of the synthesis of hemoglobin declined with age. Work continues on the multispecies comparative study of correlations that may exist between longevity of organisms and cellular capacity for the repair of damage in DNA molecules that encode genetic information. Studies of guinea pigs at the University of California exposed to radioiodine shows that the radiosensitivity of the thyroid gland of the animals changes with age. This study points out the need to be flexible in assigning risks for exposure to radioiodine and in applying radioiodine therapeutically.

TRENDS AND PROSPECTS

Given the need to assess long-term and late-appearing effects of hazardous agents associated with energy-producing technologies, lifetime studies of animal and human populations will continue. It is evident, in fact, that additional lifetime studies of chemical agents will be needed in the future. Accordingly, more data describing age-related changes should be forthcoming, and a modest program of research on the aging process itself is expected to continue.

SUMMARY OF RESEARCH SUPPORT

Table I provides a summary of Department of Energy support of research related to aging for fiscal year 1980.

TABLE I.—RESEARCH RELATED TO AGING SPONSORED IN FISCAL YEAR 1980 BY THE DEPARTMENT OF ENERGY

Research category	Number of projects	Fiscal year 1980 funding (in thousands) [1]
Research directly related to aging: Cellular and organ systems	4	$552
Research indirectly related to aging:		
(a) Lifetime studies of short-lived animals (nuclear)	12	4,095
(b) Lifetime studies of short-lived animals (nonnuclear)	15	3,493
(c) Lifetime studies of long-lived animals	13	6,561
(d) Lifetime studies of human populations (nuclear)	11	7,604
(e) Lifetime studies of human populations (nonnuclear)	2	390
Total	57	22,695

[1] Total operating dollars.

ITEM 6. DEPARTMENT OF HEALTH AND HUMAN SERVICES

JANUARY 22, 1981.

DEAR SENATOR CHILES: I am responding to the letters of October 30 and November 26 from you and Senator Domenici to former Secretary Patricia Roberts Harris requesting information for part 2 of the committee's annual report, "Developments in Aging: 1980." Mrs. Harris asked the Administration on Aging to compile the Department's response. We are pleased to assist in this effort.

The material you requested is enclosed. It includes information regarding the programs and activities of all HHS agencies listed in the October 30 letter. We did not submit information for the Rehabilitation Services Administration, as that agency was transferred to the Department of Education. I understand that the committee has requested information from the Department of Education directly.

I am sending similar letters to Senators Heinz and Domenici.

Sincerely yours.

M. GENE HANDELSMAN,
Acting Commissioner on Aging.

Enclosure.

OFFICE OF HUMAN DEVELOPMENT SERVICES

ADMINISTRATION ON AGING

REPORT FOR FISCAL YEAR 1980

INTRODUCTION

This report is submitted by the Administration on Aging (AoA) in response to the request by the Special Committee on Aging, U.S. Senate, for information on the programs and activities of components of the Department of Health and Human Services relating to the "needs of the elderly" during fiscal year 1980. This information will aid the committee "in tracking the Federal response" to the problems which confront older Americans and is scheduled for publication in part 2 of the committee's annual report, "Developments in Aging."

The Administration on Aging is a component of the Office of Human Development Services (OHDS) which is one of the principal operating components of the Department of Health and Human Services. AoA was established in 1965 in accordance with the provisions of the Older Americans Act of 1965, as amended. The Older Americans Act charges AoA with responsibility for leadership within the Federal Government for building a strong intergovernmental partnership to address the concerns and problems of older Americans.

AoA undertakes a variety of activities in seeking to foster the growth of this "partnership in aging." Title III of the Older Americans Act gives AoA responsibility for aiding States and communities in developing "comprehensive and coordinated service systems to serve older individuals." Funds to support the establishment, maintenance and expansion of these "service systems" are provided through formula grants for social and nutrition services, as authorized in title III. These funds are awarded to State agencies on aging which then make grants on a substate basis to area agencies on aging for the planning and management of services. The area agencies award title III funds to local providers for the actual delivery of services to older persons. Like AoA, State and area agencies are also charged under title III with advocacy responsibilities on behalf of the elderly. The whole range of title III activities is discussed in section I of this report.

In addition to the requirements for the development of service and advocacy systems under title III, the Older Americans Act also contains a number of other provisions which are designed to help AoA improve the life situations of older persons. Title IV, a program of discretionary grants, authorizes funds for training, research, and demonstration activities which specifically focus on the improvement of the services and benefits to older citizens. Similarly, title II, among many other provisions, authorizes evaluation efforts which aid in the improvement of services, as well as a "National Clearinghouse on Aging" which acquires and distributes information on the needs of the elderly and the programs designed to meet those needs. Title VI, which was funded for the first time in fiscal year 1980, provides a system of direct grants to qualified Indian tribal organizations for the provision of services to older Indians. AoA's activities in each of these areas during fiscal year 1980 are discussed in section II of this report. Section II is followed by a series of appendices which include additional information on the subjects covered in sections I and II.

Section I: Title III Social and Nutrition Services

The purpose of this section is to provide comprehensive information on the services which are available to the elderly through title III of the Older Americans Act. This discussion will focus on title III services and activities in fiscal year 1980.

Section I is divided into three major components. The first of these subsections summarizes the key provisions of title III with respect to services for older Americans. The second describes the elements of the national network of Federal, State, and community organizations by which these services are planned and delivered. The third subsection presents key quantitative and descriptive information on title III services in fiscal year 1980.

A. TITLE III—OVERVIEW

The Older Americans Act of 1965 established a system of State agencies on aging. These agencies awarded grants to start local programs to provide social services to older persons. Since 1965, the act has been amended eight times. The nutrition program was established in 1972. The 1973 amendments required each State agency on aging to divide the State into planning and services areas and to designate an area agency on aging in each area for which an area plan would be developed. Also in 1973, the multipurpose senior centers program was authorized (although funds were not appropriated until 1976). The 1978 amendments consolidated under one title, title III, three programs (social services, nutrition services and multipurpose senior centers) which had been authorized under separate titles. Final regulations to implement the 1978 amendments to title III were published in the Federal Register on March 31, 1980. Regulations for this program are found at 45 CFR Part 1321.

Title III is a formula grant program to provide social and nutrition services to older persons. In fiscal year 1980, $589 million was appropriated for title III.[1] This is about 90 percent of the AoA budget. The amounts of the grants to States are based on the number of persons in each State aged 60 and older. This program is administered through a network of 57 State agencies on aging (including the territories). At the community level, the network includes 602 area agencies on aging and about 25,000 service providers.

[1] AoA's total budget for fiscal year 1980 may be found in appendix I.

The act requires each State to submit to AoA a 3-year State plan based on area plans developed by the area agencies. State agencies distribute funds on a formula basis to area agencies which purchase nutrition services and a wide range of social services depending upon the needs in the local community. In fiscal year 1980, 54 percent of title III funds were used to provide meals for the elderly.

Title III services are supported with allotments which each State receives in accordance with the formula in section 304 of the Older Americans Act. These allotments are from funds appropriated under title III, part B (social services), title III, part C, subpart 1 (congregate meals) and title III, part C, subpart 2 (home-delivered meals). See appendix II for each State's allotment under these three appropriations.

The most recent amendments to the Older Americans Act were passed in 1978. These amendments provided for a 2-year transition period during which States were allowed to request "waivers" of certain requirements imposed by the 1978 legislation.

During fiscal year 1980, the States and communities completed administrative and program changes necessary to insure full implementation of the 1978 amendments. Considerable progress was made in fiscal year 1979 toward achieving full implementation of the new requirements. For example, the States were given the option of requesting a number of waivers in their 1979 State plans. The number of States requesting all available waivers for the 1979 plan period was 13. However, only one State made a similar request for 1980. Similarly, 36 States requested a waiver of the long-term care ombudsman requirement for 1979, but this number dropped to 22 in 1980.

Thus fiscal year 1980 witnessed continued progress toward full implementation of the new requirements. The State plans submitted for the 1981–83 period (the 1978 amendments made 3-year plans mandatory beginning in fiscal year 1981) commit the States to full compliance beginning October 1, 1980.

Fiscal year 1981 will, therefore, be the first program year in which the requirements of the 1978 legislation will be fully in force. The report which AoA submits to Congress for fiscal year 1981 will provide information on the experience of the States and communities in executing all the provisions of the amended statute.

B. IMPLEMENTING TITLE III—THE NETWORK ON AGING

Many different organizations participate in the effort to implement title III. In addition to AoA, with its central headquarters in Washington and its 10 regional offices, there are the State agencies on aging, the area agencies on aging, and a variety of community-level organizations which, in most instances, are responsible for delivering title III services to the elderly. These network components are discussed in greater detail below.

1. AoA Central Office

Located in Washington, D.C., with a permanent staff ceiling of 140 persons, the AoA central office [2] serves as the focal point within the Federal Government for the concerns, problems, and opportunities which older Americans confront. In this capacity, the central office discharges key coordination and policy development and review responsibilities vis-a-vis other Federal programs. In addition, the central office provides overall guidance and direction for the establishment and maintenance of the community based service systems administered by the States discussed in section I of this report. The central office also plays a major leadership role in planning and administering the discretionary programs discussed in section II.

AoA's central office is organized as follows:

The Commissioner's office is responsible for providing policy, program and administrative direction.

The Office of Management and Policy Control is responsible for preparing the program budget, managing the salary and expense budget, and preparing guidelines for management plans and performance requirements. It also has responsibility for policy guidelines and the preparation of legislative testimony.

The Office of Education and Training manages the discretionary grant programs for all career preparation, continuing education and technical assistance activities.

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[2] An organizational chart for the AoA central office is found in appendix III.

The Office of Research, Demonstrations and Evaluation manages the discretionary grant program for activities related to knowledge building, testing of new programs, evaluating existing programs and disseminating the results. Long-term care activities including policy analysis and research and demonstration projects are conducted by a staff unit located in this office.

The Office of Program Development manages title VI programs, the development of program guidance relating to titles III and VI programs and the development of programs with other Federal or State sector agencies.

The National Clearinghouse is responsible for information and referral systems, reports on population trends and oversight of the SCAN system.

The Office of Public Information produces publications such as Aging magazine, speeches, and displays. It also handles major promotions such as Older Americans Month.

The Office of Program Operations is responsible for providing overall program and management support functions to the 10 regional offices. This office provides program guidance; policy clarification/interpretation; statistical analysis of national program performance reports; and management oversight functions. The 10 regional Program Directors report directly to the Associate Commissioner for Program Operations.

2. Regional Offices

AoA has 10 regional offices [3] located in Boston, New York, Philadelphia, Atlanta, Chicago, Kansas City, Dallas, Denver, San Francisco, and Seattle. The regional offices are responsible for providing technical assistance to, and for monitoring the performance of, State agencies on aging. The regional offices are responsible for providing direction and guidance to States in the planning and development of a statewide system of comprehensive services for the elderly.

The regional offices represent and act for the Commissioner in the implementation of national policies and priorities in the development of programs for the elderly. They provide assistance and advise States in development of State legislation to assist the elderly. The regional offices assist States in the achievement of efficient and economical social and nutritional services for elderly persons, especially those with greatest economic or social need. They assist States in the development of 3-year State plans on aging, negotiate resolution of Federal/State issues when those plans are submitted by the Governor, and approve acceptable State plans. Regional offices also assist States in the coordination of public and private resources which serve the elderly, and provide information and policy recommendations to other agencies and organizations which concern themselves with needs of elderly. The regional offices work collaboratively with the staff of the 1981 White House Conference on Aging to support State and regional activities related to the conference.

The regional offices are also responsible for the collection of the performance data which is used in analyzing the effectiveness of the program. They conduct on-site assessments, audit reviews, and generally monitor State compliance with program requirements.

In addition to their responsibilities for title III activities, regional offices administer selected discretionary grants including some model projects and training grants authorized under title IV. They provide information and technical assistance to existing and potential grantees and contractors. The regional offices facilitate coordinated efforts between States and educational institutions. and conduct best practice utilization and demonstration meetings to disseminate information and experience from ongoing research and demonstration programs.

Regional Office Profile

The average regional office has 14 staff, 11 of which are professional personnel. The largest regional office, located in Atlanta, serves eight States and has a staff of 18. There are four regions which have only 13 staff members. These four regions have fewer States, less elderly population or less geographic area to cover.

Regional Offices: Assistance to States and Communities in Service Delivery

The regional aging offices are called upon to provide a variety of expertise and knowledge in the conduct of Older Americans Act activities. For instance, in one region the staff has developed national expertise in providing disaster assistance

[3] A listing of the 10 regional offices may be found in appendix IV.

services during Presidentially declared emergencies. They have prepared a technical assistance manual which provides guidance to States and area agencies relative to the procedures to follow in coping with national declared emergencies. Regional office efforts to help deal with the adverse consequences of rapid community growth (the "boom town" syndrome) provide another example of how these offices can assist in expanding the services available to older persons. One regional office identified 360 communities in its area of responsibility which have a high proportion of retired, low income elderly persons. These communities are experiencing rapid growth due to development of energy resources. In these communities the influx of additional residents, most of whom are highly transient, has driven up living costs, and created housing shortages. At the same time, these new residents have placed additional demands on the local service systems. Such demands have the effect of reducing the attention and the resources the affected communities can allocate to the elderly. The regional office has undertaken an in-depth review of the impact these developments have on the lives of older persons in the affected communities and have prepared publications about the problem which have received nationwide circulation and attention.

3. State Agencies on Aging

Every State (and territory) has a designated State agency on aging [4] to help administer Older Americans Act programs. State agencies on aging are a primary organizational entity for carrying out the purposes of the act. State agencies develop, organize, support and provide technical assistance to area agencies on aging. States administer 3-year plans, and approve and monitor the area agencies' conduct of 3-year comprehensive plans for developing and providing services through grants and contracts awarded to public and private service providers. State agencies, in cooperation with State advisory committees, initiate collaborative agreements with other State agencies, initiate legislative and regulatory proposals to improve service to older people, initiate statewide demonstrations with public and private organizations and agencies, and seek to generate non-AoA, State, and local public and private resources to carry out the purposes of the Older Americans Act in their State. State agencies conduct public hearings, review programs administered by other agencies and represent the interests of older people in the State before boards, commissions and other public and private organizations and agencies.

In 1980, State agencies have been concentrating attention on carrying out the 1978 amendments of the act.

As noted above, a review of 1981–83 3-year State plans indicates that all States are rapidly moving toward compliance with the 1978 amendments. The consolidation of nutrition, social services, and senior center functions is well underway at both the State and area level.

The State agencies faced a significant challenge in the implementation of the 1978 amendments. This challenge included adjustments in planning and service area boundaries, designation of new area agencies, facilitating adjustments in grants and contract agreements between area agencies and service providers, and implementing the new program requirements contained in the 1978 amendments.

Long-term care ombudsman programs are developing in each State and many States are extending the service through designated local representatives. State plans also indicate general compliance with the requirement that 50 percent of the title III social services allotments be spent in three priority service areas: access, in-home, and legal services. Similarly, the plans indicate compliance with the requirement that States spend, in title III funds, an amount equal to 105 percent of what was spent for social services, nutrition services and multipurpose senior centers in rural areas in fiscal year 1978.

Of particular interest are a number of trends toward greater State-level concern for the problems of the elderly. State government continues to supplement Older Americans Act resources with non-Older Americans Act funds. Increasing numbers of States are facilitating the development of organizations of older people by supporting Silver-Haired Legislatures. Some States are assigning new responsibilities, or transferring functions and programs to State units on aging. State agencies are increasingly involved in the development of long-term care services as reflected in section II of this report. State agencies are also extending

[4] A listing of State agencies may be found in appendix V.

support and staff resources to State White House Conference on Aging efforts. In general, in spite of inflationary pressures and moderate funding, service levels are being maintained, and in some instances enhanced.

State Agencies: Profile Data

All 57 States and other jurisdictions have approved State plans on aging. State agencies are organizationally located in State governments either as independent agencies reporting directly to the Governor, or as parts of larger human services agencies. Twenty-nine of the State agencies are independent agencies, and 28 are organizations within larger State agencies. The average State agency employs a total of 31 persons, approximately 10 percent of whom are older persons themselves. There are an average of 15 planning and service areas (PSA's) in each State with designated PSA's. Thus there is an average of 15 subgrants to area agencies which State agencies administer, monitor, and for which technical assistance and related support is provided. In fiscal year 1980, States reported spending approximately $34 million for State agency activities, of which only $22 million (65 percent) was from title III resources. State agency staffs range in size from three in Wyoming to 87 in California, and with a range of fiscal year 1980 outlays (title III funds and State funds) for State plan administration of $145,307 in Wyoming to $3,148,529 in California.[5]

The following includes selected examples of State agency activities intended to enhance and improve services and advocacy for older people.

Virginia.—The Virginia Office on Aging operates as a single purpose, independent agency and currently has 25 employees. The State has been divided into 25 planning and service areas to meet the needs of its elderly population. An AAA has been established in each PSA. In its effort to identify policies and priorities for organizing services to the elderly, it has initiated a legislative task force to study and recommend ways to improve care of the impaired elderly; and has undertaken policy development initiatives with the Council of Higher Education to project long-range labor force requirements for employment and training opportunities for personnel serving the elderly.

In fiscal year 1980, the State agency augmented aging program operations by pooling $4.5 million, and provided employment opportunities for 153 elderly persons at the State and area agency level. Also during this time the following person-units of service were provided in the service categories indicated. Transportation: 90,951; home services, 13,015; legal and related counseling, 5,709; residential repair and renovation, 1,473; information and referral, 5,223; escort, 1,129; outreach, 132,016; all other, 69,564.

The State agency developed an advocacy plan to produce and disseminate budget reports and pertinent materials to lawmakers, State agencies and the general public; conducted public hearings; and coordinated with other State agencies to fully implement a statewide long-term care ombudsman program.

Ohio.—The State agency developed a policy on the housing needs of older people based on an assessment of the adequacy and condition of existing housing resources. This policy will help to initiate statewide action to improve current housing and to develop housing to meet future needs.

Nevada.—The State agency has undertaken a long-term effort to establish a senior center in every community in the State. Over the past several years, the State has garnered a great deal of community support for providing social services to older persons. This effort has resulted in considerable volunteerism in the local communities through provision of materials and/or labor to build or refurbish buildings for this purpose. Now every community throughout the State has such a facility.

Utah.—State agency on aging has initiated a new program entitled the "alternatives program." This is a joint initiative with the State medicaid program, whereby each area agency has appointed a coordinator who is responsible for working with the medical community in evaluating the social service needs of older persons who are about to be placed in a nursing home. Where possible, the older person has been linked with title III services such as transportation, nome delivered meals, etc. In a number of cases, this has avoided or considerably delayed nursing home placement.

Washington State.—The State agency on aging has undertaken a unique information and assistance program implementing a case mangement system for

[5] Exclusive of the island jurisdictions, but including Puerto Rico and D.C. A table of title III allotments for State plan administration may be found in appendix VI.

older persons. This program is administered through the area agencies on aging and is designed to maintain the option presently available to older persons relative to living arrangements, life style, etc. The system provides for an individual needs assessment, development of a service plan, arrangements for obtaining the needed services and followup to assure appropriateness of the service.

Pennsylvania.—The State agency on aging in cooperation with the Department of Public Welfare administers a domiciliary care demonstration program through area agencies in 28 counties. Supported by State funds, title XX funds, SSI and medicaid, the program included 720 older people placed and supervised in 672 foster and group homes in 1980. The State agency became a cabinet-level department in 1978. In 1980 transportation services supported by State lottery funds were extended to rural areas under legislation supported by the department. The State has also initiated a new statewide consumer discount program for older people. The department also joined with the State Health, and Public Welfare Departments to initiate a long-term care development plan.

Missouri.—In the State of Missouri, the title XX program and responsibilities for licensure and regulations of nursing homes were transferred to the State agency on aging.

Florida.—A home care program for the elderly, initiated in 1978, was designed to encourage the provision of care in family-type living arrangements in private homes for three or fewer elderly relatives or nonrelatives. The program is targeted for low-income persons, aged 65 or older, who are most at risk of institutionalization. Services provided include basic support and maintenance, housing, food, clothing, incidentals, and personal care. Available through an adult services counselor are counseling and health support, family preservation and assistance counseling to relatives providing services, respite care, and adult day treatment center services. During the past year, 1,402 elderly benefited from the home care program; a waiting list included an additional 675 potential recipients for the services.

Washington, D.C.—The State agency has been instrumental in establishing a long-term care service program which joins inpatient and outpatient care and services, individual diagnosis, assessment and case planning.

4. Area Agencies on Aging (AAA's)

Under title III subgrant awarded to them by the State agency, area agencies have similar leadership and service development responsibilities within their planning and service areas as the State agencies do within the States. Through planning, coordination, service development and advocacy activities, they try to increase and improve the secrets and benefits which local agencies provide the elderly in the PSA. Area agencies play a leading role in coordinating the development of comprehensive local service delivery through interaction with existing public and private service providers, and through financial support via subgrants and contracts to service providers in order to expand the services of those providers to meet older persons' needs. In addition, area agencies vigorously seek to redirect the use of nontitle III resources (e.g., title XX funds, local nonprofit funds, etc.) to assure that older persons receive maximum benefit from those resources. In carrying out these responsibilities, area agencies have major administrative duties to perform in managing subgrants and contracts awarded under their area plan to local service providers, and assuring that title III funds are used for appropriate and allowable purposes. Similarly, they provide technical assistance and related support to service providers in the community to improve the management and quality of services available to older persons.

Area Agencies on Aging: Profile Data

There are currently 602 area agencies on aging operating in 44 of the 57 States and other jurisdictions. The remaining 13 jurisdictions operate as "single PSA" States which means that the entire State is considered a planning and service area for the purpose of planning, delivering and monitoring services to the elderly under title III.

The average area agency employs a total of 13 persons. This includes both those supported with title III resources and those paid with other funds. Of these 13 staff members, approximately three are older persons themselves.

In fiscal year 1980, each area agency (and the social and nutrition service providers which it funded) were supported, on the average, by over 400 volunteers. Thus, more than 264,000 volunteers work locally in AoA-supported programs under the Older Americans Act.

About 60 percent of the all area agencies are organizationally located in local government agencies, with the remainder being located in private agencies. A typical planning and service area served by an area agency included five and one-half counties, with approximately 51,000 older persons living in the PSA. In the average PSA in fiscal year 1980, approximately 14,000 older persons were provided social services, and 4,400 persons received congregate and/or home delivered meals.

Like State agencies, area agencies engage in a wide variety of efforts to improve and extend services, in many instances using non-AoA public and private resources. Area agencies were involved in the conduct of thousands of community forums preparatory to the 1981 White House Conference on Aging. Area agencies have also been instrumental in efforts to colocate services to make them more accessible to the elderly. For example, over 1,600 nutrition sites are now located in housing facilities serving the elderly. Numerous area agencies have provided staff and resources to support local ombudsman programs to extend the service to older people in their areas. Area agencies are directly involved in implementing the department's long-term care demonstration program. There is an extraordinary diversity of local experience and a growing degree of cooperation between area agencies, public and private agencies, local public officials and particularly older people which is at work in thousands of communities across the Nation. The following provides a profile of an AAA at work in a large city. Examples of AAA activities in other communities will follow the discussion of the Buffalo, N.Y., program.

Erie County, N.Y.—The Erie County (Buffalo) Area Agency on Aging operated with a budget in 1980 of $6.6 million. Of the total, 58 percent ($3.8 million), came from Older Americans Act funds. The Erie County AAA serves a planning and service area covering 1,029 square miles with an elderly population of 169,800. Twenty-five percent of the elderly population is estimated to be low income. The area agency operates with a paid staff of 75 full- and part-time persons.

Some of the services provided under the auspices of the Erie County Area Agency in 1980 included:

—22,425 hours of homemaker services to 160 people—with an average of 140 hours of service per person.

—2,377 units of home health services for 317 clients—these services include environmental modifications for impaired persons to make their homes safer and accessible.

—Other support services in the home to 2,560 high risk elderly. These include 166,000 units of telephone reassurance and 44,430 units of services such as friendly visitors, errands, shopping assistance and letter writing.

—55 workshops on retirement planning attended by 2,350 persons.

—Legal services to 2,100 persons.

—160 persons placed in jobs subsidized with funds authorized under the "community service employment for older Americans" program administered by the Department of Labor. In addition, title III funds were used to place 390 older persons in full- and part-time unsubsidized jobs in the private sector.

—Provision of 714,310 congregate meals to 9,800 persons and 326,000 home delivered meals to 1,250 persons.

—121,075 trips to congregate meal sites, stores, medical facilities and other community services (46 percent of trips were for medical care).

In response to congressional mandates and local needs, area agencies on aging seek to coordinate and enlist community support to improve and expand services and benefits for older residents. Some of the Erie County AAA's 1980 activities for this purpose were:

—Development of new funding sources which increased resources by 14 percent.

—Initiation of a new needs assessment for a 5-year period to promote more effective long range planning.

—Establishment of seven clusters of community service focal points to facilitate coordination and colocation of service.

—Provision of technical assistance to 17 senior centers to assist in programing.

—Monitoring/administration of 90 contracts, 50 of which were major service contracts.

—Began implementation of case management plan to serve at least 400 high risk, impaired older individuals.

The Erie County Area Agency budget comes from a variety of sources in addition to title III. The county provides approximately 20 percent of the funds. ACTION provided $100,000. Title XX funds amounted to $589,643. Department of Labor funds came to $900,000. State and county mental health agencies provided $150,000. New York State appropriated $80,000 for recreation services and $413,000 for community services.

In summary, the activities of Erie County AAA have contributed significantly to improving and expanding community support for the well being of older persons in that locality.

Area Agency Activities and Priorities: Other Examples

In addition to the many creative programs and initiatives undertaken by the Erie County AAA, examples can be cited of similarly successful efforts by AAA's in other communities. The following illustrate how area agencies are working with both the public and private sectors to expand services to the elderly in Central Texas; Jacksonville, Fla.; Baltimore County; New York, and Spokane.

Central Texas.—The Central Texas Area Agency on Aging entered into a contract with four other community agencies to provide emergency in-home care for needy elderly. The organizations participating with the Central Texas Area Agency include the Texas Department of Human Resources, Home Care Health Services, Inc., Senior Citizens Activities, Inc., and Hill Country Community Action Association, Inc. Services include personal and household tasks, and escort service for medical care.

Twenty-nine senior centers located within the planning and service area are the intake points. Center directors report tentative clients. The Department of Human Resources assesses each individual case and issues a service order to Home Care Health Services to provide paid assistance to the client. Senior centers then arrange for volunteers to supplement the paid assistance. This arrangement was initiated by the area agency on aging to pool resources in order to help the community to provide needed home care services and prevent premature institutionalization.

Jacksonville.—The City of Jacksonville, Fla., has completed construction of a new citywide multipurpose senior center through which public and private agencies provide a wide range of health, social, educational, and recreational services to the older people of the city.

Baltimore County.—Baltimore County, in cooperation with county officials and older residents, has developed a countrywide plan to renovate up to 28 senior center facilities. This ambitious and unique effort joins the AAA, county officials and architects with neighborhood citizens planning groups from the beginning in site selection, use of space design, and services development.

New York.—On Staten Island, the New York City AAA has developed a fixed route portal-to-portal transportation service joining a wide variety of transportation providers. The program is highly successful and has dramatically extended transportation for shopping, medical care and/or health and social services.

Spokane.—In Spokane, Wash., the AAA and the community mental health center (CMHC) have jointly developed a case management and service program to reach and serve the mentally and physically impaired. In 1980, over 25 percent of the clients served by the CMHC have been older people.

For the most part, social and nutrition services supported under title III are delivered by some 25,000 community-level providers, including both public and private organizations. Within the private sector, voluntary and "for-profit" agencies are used. In some instances, the provider is a special purpose organization dealing exclusively with the concerns and needs of older persons. In other situations the provider may service a number of constitutent groups, including older persons. In all instances, however, the providers are selected because of their expertise, their capacity to deliver the services older persons need, and because of their commitment to helping the elderly.

C. TITLE III OF THE OLDER AMERICANS ACT—SUPPORT FOR COMPREHENSIVE AND COORDINATED SERVICE SYSTEMS

The different types of services made possible by title III are discussed in this part of section I. A brief survey of advocacy activities at the State and community levels will be presented first, followed by a discussion of services in four specific categories (access, community/neighborhood, in-home, and those provided in institutions) which title III supports.

1. Advocacy Activities

Title III charges both State and area agencies with a broad range of advocacy responsibilities. Three major areas of advocacy involvement, the "pooling" of non-Older Americans Act resources in support of title III goals, the efforts to secure improvements in State and local legislation and government programs for the benefit of the elderly, and the work of "silver haired legislatures" will be discussed below.

Pooling.—As indicated above, non-Older Americans Act resources are a key part of the State funding base for programs supported with title III monies. The following table indicates the overall degree of success which State and area agencies have experienced in fiscal year 1980 in securing non-OAA funds for title III activities. In interpreting these data on pooling, it should be noted that, in fiscal year 1980, title III appropriations for social and nutrition services totaled $567 million.

(In millions)

	1979	1980
Local resources	$123	$157
State resources	66	115
Federal resources	248	389
Total resources pooled	437	661

Advocacy to Influence Legislative Change

The Older Americans Act requires State and area agencies on aging to assume an active advocacy role on issues including those associated with State and local legislation which affect older persons. The legislative advocacy activities of the Washington State agency illustrate how State agencies across the country can serve as effective and visible advocates to influence legislative change on the State and local level. The Washington Bureau on Aging employs an attorney who identifies and monitors proposed legislation and legal issues which affect older persons. The State agency attorney provides technical assistance to the aging network to encourage legislative changes important to the well-being of older persons in the State of Washington. This attorney compiles information which is used by members of the State legislature and other legislative bodies when considering aging issues. The attorney attends legislative hearings and committee meetings and serves on task forces such as one which deals with the legal rights of older persons in the context of mental health issues.

Other examples of such 1980 State legislative achievements in the field of aging include:

—A Maryland law which provides relief for persons 65-plus on the State tax of pensions.

—A Massachusetts law which provides for $1 million program to purchase condominiums for needy elderly residents of converted apartment buildings.

—A Massachusetts law which indexes eligibility for State funded home-care services to social security increases.

—Pennsylvania legislation to license boarding homes for the elderly.

—Nursing home ombudsman access legislation passed in New York and Kansas.

—A Colorado law requiring the reporting of suspected abuse, neglect or exploitation of older persons in the community and in institutions to be followed up with protective services. The law provides penalties for failure to report elder abuse.

—A Kansas elder abuse law which also requires reporting.

—A Delaware law which provides State funds to help low income older persons to pay prescription medicine costs.

—Florida legislation which expands patients' rights in nursing homes, establishes a nursing home rating system, provides increased optional State supplementation for nursing home residents, and mandates certification of adult congregate residence.

Silver Haired Legislatures

A number of States have undertaken a variety of efforts to establish ongoing "Silver Haired Legislatures." Simulated legislative sessions are held to identify

and recommend State legislative innovations or changes. In some States, the elderly have developed State agendas for legislative action on the part of the official State legislature. They obtain legislative sponsors for introduction of legislation, assist in the drafting of bills and advocate through elected officials for passage.

In Florida, in 1979, 10 bills which were passed by the Silver Haired Legislature were introduced into the State legislature, favorably reviewed and subsequently enacted. The issues addressed included waiving tuition for the elderly, regulations for adult congregate living facilities, labeling of prescriptions with the expiration date, State retirement for those over 60, condominium conversion, cost-of-living increases for State retirees (the first such increase ever received), electric utility rate relief, health insurance, and training of gerontological professionals in State colleges and universities in Florida. In 1980, the Silver Haired Legislature passed 12 bills, 10 of which will be introduced into the forthcoming session of the State legislature. During 1979–80, the State Office on Aging provided $60,000 from title III funds for support of the Silver Haired Legislature.

2. Serving Those In Need

Under title III, a variety of social services (including such services as transportation, home health, legal, residential repair and renovation, information and referral, and escort and outreach) and nutrition services, were provided to older persons particularly those disadvantaged by economic or social need, in 1980. The range of services offered can be grouped into four categories: access, community, in-home, and institutional. Each of these will be discussed below.

Access services include such services as transportation, outreach, information and referral, escort, individual needs assessment and service management. In 1980, there was a particular demand for access services, as indicated by the estimated 3.5 million person units of service provided in the area of information and referral and the more than 2 million estimated units in the transportation area. In other access services, 1,472,000 (estimated) person units of service were provided in outreach and 210,000 (estimated) in escort services during the past year. The success and creativity of programs in facilitating access to services for older persons are illustrated in the following examples.

A unique radio network, termed "New Aging Radio," and tailored to the needs of the elderly, was established in Ohio with the assistance of the Ohio Commission on Aging. The network offers an entertaining way of providing specific information about aging-related services offered in Ohio. Programs discuss a broad range of topics including finances, health, leisure, legal matters, housing, and new lifestyles. Listeners are invited to write in with questions, concerns, and suggestions. The network is designed for two-way communication as many in the audience lead solitary lives. The conversational tone also encourages audience participation. Listeners are given a telephone number which they can call for further information.

An emergency alarm system called "Lifeline" is now being used by vulnerable elderly and handicapped people living independently at home in Fulton County, N.Y., with assistance from funds provided by the county office on aging. "Lifeline" provides 24-hour access to help at the push of a button. The system is based on a small box that plugs into the phone and automatically dials the number of a 24-hour emergency station. An emergency operator is automatically contacted and calls to find out what the problem is. If the person does not answer, a predetermined list of nearby helpers is called for an immediate response. This cooperative community effort has also encouraged service providers and other groups such as churches, service organizations, and public agencies to identify the most vulnerable residents of the community and increase their access to both community and emergency services.

In Florida, a "companion service" provides a personal in-home emergency service which senses when a person needs assistance and automatically summons help via trained personnel. It is based on the installation of a private phone line and strategically placed sensors in the home. An assist button, which can be carried, allows a person to contact the communications center. Some 800 individuals, 85 percent of whom are elderly, are being served in Pinellas County, Fla., an area encompassing St. Petersburg. Beginning in January 1981, a new project, with support from title III–B funds, is being initiated in Tampa in Hillsborough County for 150 elderly persons.

Community services include such services as residential repair and renovation, congregate meals, legal services, continuing education, day care, recreation, and the acquisition, alteration, and renovation of facilities to be used as multipurpose senior centers. In 1980, estimates indicate that 315,000 person units of service were provided for legal services and 80,000 for residential repair and renovation. Congregate meals were offered through 1,178 nutrition projects which operated 12,475 sites located throughout the country. Nearly 3 million elderly participated in the nutrition program in 1980, two-thirds of whom were low-income, and one-fifth from minority groups. Over 123 million meals were served to those older persons who came to congregate settings, located in senior centers, churches, schools, apartment houses, and other sites.

Following are some examples of programs which highlight the development and coordination of community services in several areas during the past year.

Supported by title III–B Older Americans Act service funds and county revenue sharing money, a mobile counseling team called PACE (psychological alternative counseling for elders) started a year ago in Orange County, Calif. The project now meets with approximately 1,600 elderly at 21 centers throughout the county. One of the project goals is to involve the elderly in helping each other. PACE and the county department of mental health have begun intensive programs to train older persons to become peer counselors at nutrition sites and senior centers. This training demands considerable commitment and skill development on the part of participants. Through the use of trained volunteers, community mental health resources are expanded to help troubled older persons live independent, dignified lives.

Harbor Springs, Mich., is integrating older persons in the local high school program. Joining the combined middle-high school student body of 916 boys and girls in grades 6 through 12 are an estimated 70 men and women aged 65 and over. The older people mingle with the younger, joining classes either as students or instructors and taking part in extra-curricular activities as well. School buildings have found new life as senior citizen centers around the Nation, but Harbor Springs is providing total classroom integration of the older and younger generations. The local senior center is moving from a church basement to renovated quarters in the Harbor Springs High School. The Northwest Michigan Area Agency on Aging helped finance the move and renovations with a $16,000 grant.

The category of *in-home* services includes such services as home health, homemaker, preinstitutional evaluation, casework, counseling, chore maintenance, visiting, shopping, letter writing, readers, telephone reassurance, and home-delivered meals. In 1980, an estimated 630,000 units of services were provided to elderly persons in their homes. In addition, more than 40 million meals were delivered to the homebound elderly, an increase of nearly 30 percent over the number delivered in the home in fiscal year 1979.

Some of the ways in which vulnerable older persons and their families were assisted by services provided in their homes are illustrated in the following examples:

—An innovative and successful program which provides respite care for older persons was established by an area agency on aging in Massachusetts. "Respite care" is directed at families which are involved in the 24-hour-a-day care of older persons. The program is filling a real need in providing support for the efforts of families involved in the constant care of an elderly person, most of whom are between the ages of 75 and 80. Under this program, CETA workers are utilized to provide services to the family, allowing up to eight hours each week of time away from the home on a regular basis. In addition, the elderly person benefits from outside companionship and conversation. Because of the CETA grant there is no charge for those determined to be in need of the services. The program is viewed as a creative and cost-containing means of helping families care for the sick and/or disabled elderly on a part-time or emergency basis.

—The East Central Florida Area Agency on Aging finalized plans for contracting with Hospice of Orlando to provide home care for terminally ill elderly. The District VII Area Agency on Aging was the first in the State to offer a range of all services available through hospice programs and estimates suggest that more than 100 clients will receive inter-disciplinary services which will provide for psychosocial, therapeutic and health care. Florida is the first State to have enacted a unique law regulating and recognizing Hospice as a total care program for the terminally ill.

The fourth category of services, *institutional*, are those services provided to residents of long-term care facilities, emergency shelters, and other congregate living arrangements. Institutional care services are discussed both in terms of the ombudsman program below and in section II under discretionary programs.

The Administration on Aging's nationwide long-term care ombudsman program is now in its fifth year of existence. Information provided to AoA by State ombudsman programs shows marked development of the program. This development is indicated by:

(1) Considerable expansion of the program to the local and area levels, with a total of over 250 local ombudsman programs by the end of 1980;

(2) An increase in the number of States which have passed ombudsman enabling legislation from 3 in 1975 to 11 in 1980; and

(3) The fact that almost half the States (23) have secured access for ombudsman program representatives to long-term care facilities and residents of those facilities.

The 1978 amendments to the Older Americans Act required every State to have a long-term care ombudsman program and specifically defined ombudsman functions and responsibilities. There are three primary sources of funding for the ombudsman program at the State level: social services money under the Older Americans Act (title III–B), State money, and the State advocacy assistance grant. Long-term care ombudsmen throughout the country are involved on a daily basis in resolving a range of problems affecting residents of long-term care facilities. Such problems or complaints often serve as the basis for the development of major new legislation or regulatory changes. Sometimes resolution requires only bringing the situation to the attention of someone who can affect the needed change. Whether a complaint is simple or complex, the critical factor in its resolution is often the individual involvement and sustained focus that the ombudsman can provide. The following examples of actual cases handled by ombudsmen in a variety of States demonstrate this fact:

—A resident of Arizona wrote to a Federal official complaining about deplorable conditions in an Arizona boarding home where her mentally retarded uncle resided. The niece's letter was forwarded to the Arizona ombudsman along with a request that he investigate conditions at the facility and determine whether Federal funds were involved. The ombudsman made an unannounced visit to the boarding home and confirmed that the barracks-type structure was filthy (goats and pigs were actually living inside the structure), the plumbing was non-functioning, residents were locked out in the morning to sit outside all day, perishable food was not refrigerated, and several fire hazards were evident. All 28 of the former State mental hospital patients who reside there received Federal supplemental security income. As a result of the ombudsman's intervention, the operator's business license was revoked and all residents were transferred to another facility. More importantly, the ombudsman convinced State officials of the need for boarding home regulations, and subsequently, the State adopted standards (which the ombudsman helped to develop) for all such facilities in the State.

—A nursing home resident in Idaho registered a complaint with the State ombudsman concerning a notification she received in June that, as of July 1, she would be ineligible for medicaid because of a 14.4 percent raise in social security benefits. A check with the sub-State ombudsman revealed that approximately 112 nursing home residents would also lose their eligibility for medicaid reimbursement for nursing home care. Investigation revealed that the State medicaid program had issued a policy announcement stating that ceilings for medicaid eligibility would not be raised to reflect the July social security increase. After negotiation between the ombudsman and the medicaid agency, the policy announcement was rescinded and eligibility ceilings were raised to reflect the 14.4 percent increase in social security benefits.

—In response to a complaint letter, the State ombudsman in Wisconsin visited a resident confined to bed. The resident was an alert man who had been placed in a room with another resident who didn't talk. Eight months earlier this resident had been up and using a wheelchair. With an explanation of, "The wheelchair is needed by someone who needs it more than you do," a staff member had taken the wheelchair away. The resident was put to bed where he remained for 8 months. During this period, the resident was repeatedly told by staff that complete bed rest had been ordered by the physician and was essential. When questioned by the ombudsman, the director

of nursing admitted that there was no physician order for bed rest and that she didn't know why the resident was not allowed to be out of bed. Another wheelchair was then issued to the resident.

The Administration on Aging is charged with a number of responsibilities regarding the planning and delivery of services to the elderly, as discussed in section I. Technical assistance to the network components which actually coordinate and manage the service delivery efforts is one such responsibility. Monitoring the quantity and quality of title III services is another.

In addition to these activities, AoA is also responsible for assisting State and area agencies to carry out new service development initiatives through the use of its discretionary programs. These include the research, demonstration, and training programs authorized under title IV of the Older Americans Act. In addition, the evaluation activities authorized under title II are also part of this effort, as is the program of the National Clearinghouse on Aging (another title II activity). Finally, the direct grants to Indian tribes which are authorized by title VI and funded for the first time in fiscal year 1980 are also in the service development category. These activities are discussed in section II of this report.

Section II: Building the Knowledge and Practice Base for More Effective Services—AoA Discretionary Programs

The ongoing transformation of the population of the United States is the result of extraordinary social progress in the century. Since 1900, we have extended life expectancy from birth by more than 60 percent. The next half century will bring a continued shift in the population structure due to declining birth rates and extended longevity. We are thus in the midst of significant social changes, one of which is the addition of new generations of older people.

These dramatic population changes present us with significant challenges and opportunities. As a Nation we need far more information than is currently available concerning the needs of the elderly, the services and benefits required to address those needs, and the resources the elderly can themselves provide to help in resolving both the issues associated with old age and also the significant questions concerning other population groups.

AoA's discretionary programs, authorized under titles II, IV, and VI of the Older Americans Act, offer unique opportunities to target resources in effectively addressing these questions. The evaluation program authorized under title II can contribute significantly to this effort, as can the activities of the National Clearinghouse on Aging. Through the research, training and demonstration activities which are supported with title IV resources, AoA can continue to shape and support the agenda of inquiry which this country must sustain if we are to secure the answers we need regarding the basic issues associated with our changing demographic patterns. Finally, the insights gained through the implementation of the new title VI program for services to older Indians can add to our understanding of how services are planned, managed and delivered.

The basic roles and functions of AoA are established in title II of the Older Americans Act. The provisions in title II and the subsequent authorities and mandates establish a formidable agenda which can be aggregated into four primary areas of responsibility. These areas are: (1) The societal integration of older people through policy development and advocacy; (2) serving those in need; (3) long-term care; and (4) improving capacity through application of knowledge. The following material about AoA's discretionary programs is also organized in terms of these same four areas. Two additional programmatic and research efforts are also included below. One is the implementation of title VI, in which, for the first time in 1980, awards were made to Indian tribal organizations for the provision of social and nutrition services to elderly Indians. The last activities described are ongoing evaluation studies to assess the effectiveness of programs designed to meet the needs of older Americans.

A. SOCIAL INTEGRATION OF OLDER PEOPLE THROUGH POLICY DEVELOPMENT AND ADVOCACY

1. National Policy Development

AoA assists in shaping national policies on critical issues by providing forums for consensus building. This occurs through the conduct of national policy conferences in selected areas. In addition AoA impacts on national policy through

knowledge gained from examination of basic social issues and the effects of social, political, or economic intervention. This examination occurs through AoA sponsored social policy research and social policy demonstrations.

AoA also aggregates knowledge and practice in areas through support for special emphasis policy study centers.

Policy Conferences

The 1981 White House Conference on Aging (WHCOA) wil provide an opportunity—for, older Americans together with public and private interest groups—to formulate a national perspective on policies affecting older persons. The Conference will produce a final report which must express "comprehensive coherent national policy on aging together with recommendations for implementation of the policy." The goals of the White House Conference converge with the functions of AoA. Therefore, AoA in 1980 supported seven mini-WHCOA preconferences in special areas, 51 State conferences, and four regional WHCOA hearings.

AoA also conducts national policy review and development conferences in areas of national policy significance. The objectives are: (1) To review and integrate research findings; (2) to review current practice; (3) to disseminate knowledge; (4) to stimulate best practice replication in the public and private sector; and (5) to provide new policy and program options. Each conference involves: (1) Identification of policy questions and problems; (2) preparation of policy background papers; (3) review and critique by invited experts (governmental officials, academicians, public and private agency administrators); and (4) submission of reports and recommendations to AoA. These conferences provide a flexible vehicle through which the government can assemble the most knowledgeable individuals in and out of government to examine major social policy problems of immediate and long-range importance. In 1980, AoA funded 13 conferences focusing on such issues as abuse or neglect of older persons, age discrimination, long-term care, and older women.

Policy Research and Demonstrations

Social scientists in every discipline have identified extensive and far reaching changes in the social structure with profound effects on the elderly. It is vital to identify and analyze the impact of these changes on existing public and private structures to allow planned development and redesign of policy and services for the elderly of the future. In 1980, AoA funded 14 projects designed to further policy analysis to promote the integration of the elderly into society.

An example of social policy demonstration activity in AoA is its small business initiative. During fiscal year 1980, AoA took the first steps in developing a multiagency, public and private sector initiative that is designed to address the needs of older people for increased economic opportunities and the continuation of active and productive roles in society.

Policy Centers

The AoA has funded national aging policy study centers, mostly based in academic institutions, for the purpose of providing interdisciplinary study of six major policy areas. The centers and their areas of emphasis are listed below:

Income maintenance—Brandeis University.

Housing and living arrangements—University of Michigan.

Employment and retirement—University of Southern California.

Education, leisure and continuing opportunities for older persons—the National Council on Aging.

Older women—the University of Maryland.

Health care for the aging—University of California of San Francisco.

The national aging policy centers will aggregate and synthesize AoA and non-AoA research, and demonstration findings for: (1) Introduction into teaching curricula; (2) defining future research agendas; and (3) examining government program and policy implications.

Policy Development: Synthesis

AoA's research, conference and policy development activities are interrelated and coordinated. Research is directed at knowledge development. The policy conferences utilize research findings as one source of information for policy and program formulation and for knowledge dissemination. In 1979, for example, AoA funded research projects on abuse and neglect. During fiscal year 1980, the results have been analyzed and a report is to be released. Legal Research and

Service for the Elderly (Boston) will hold a conference to review abuse and neglect of older people by families and in institutions. This conference on abuse and neglect will utilize research results, examine demonstration projects on abuse and join academicians and State policymakers in a review of literature and State protective service laws and programs to protect abused adults. Findings will be made available to the WHCOA and the policy centers.

Another example is in the housing and living arrangements. As indicated above, AoA supports a National Aging Policy Study Center on Housing and Living Arrangements at the University of Michigan Institute of Gerontology. This center, the basic experimental and developmental center for AoA in housing, will study such special problems as the housing needs of frail and chronically impaired older persons and rural older persons and energy factors.[6]

2. Discretionary Support for Advocacy—Individual Rights and Responsibilities

The goal of enhancing the freedom and well-being of individual citizens is supported by the use of law to establish and protect rights and through the establishment of programs to enhance well being. As noted by the U.S. Civil Rights Commission (in its report to the Congress, Age Discrimination Study December 1977), the use of chronological age carries the burden of imposing value and worth to classes of individuals on the basis of age. It has fostered and sanctioned private and public actions which deny individuals the right of choice in such crucial matters as work and retirement. Individuals are denied access to services and assistance through the application of cost/benefit determinations according to age.

State Advocacy Assistance Grants

The Congress began a process of eliminating discrimination against the elderly with the enactment of the Age Discrimination in Employment Act, the enactment of the Age Discrimination Act, and the 1978 amendments to the Older Americans Act expanding publicly supported legal services for older people.

Older persons confront pressing needs for legal advice and representation to protect their rights and to obtain benefits and entitlements. These include rights to public benefits, pensions and other retirement income, rights to employment without age discrimination, rights to federally funded services without age discrimination, rights to housing and health care, rights of institutionalized older persons, and rights to alternatives to institutionalization. Each of these problems has a legal component and may require a legal remedy. In some cases class actions are an appropriate means for addressing the problems faced by our older population. Therefore, the Administration on Aging has consistently sought to encourage the development and expansion of legal service activities on behalf of the elderly.

As noted in section I, the long-term care ombudsman program is now a mandated State-administered program. The ombudsman program must: (1) investigate and resolve complaints made by or on behalf of older individuals who are residents of long-term care facilities; (2) monitor the development and implementation of laws, regulations, and policies with respect to long-term care facilities in that State; (3) provide information as appropriate to public agencies regarding the problems of older individuals residing in long-term care facilities; and (4) train volunteers and promote the participation of citizen organizations to participate in the ombudsman program.

Systems to implement the legal services and ombudsman services mandates are now firmly in place. The Administration on Aging has promulgated regulations for legal services and the ombudsman program. As indicated previously, AoA is using discretionary resources to implement these activities which are described below.

Beginning in 1978, grants ranging from $50,000 to $137,000 per year have been made to the State agencies on aging to assist them in developing systems to provide advocacy for individual older persons and advocacy on issues which affect large numbers of older persons. Grants totaled $2,762,558 for fiscal year

[6] AoA devoted the following discretionary resources for national policy development in the ways described above: Policy conferences, $2,787,000; policy research and demonstrations, $1,745,000; policy centers, $959,000.

A detailed listing of projects under this category is contained in appendix VIII.

Note: Of the $2,787,000 for conferences, $678,000 was for national policy conferences and $2,109,000 for activities related to the 1981 White House Conference on Aging.

1979, and $2,816,769 for fiscal year 1980.[7] The States have used these funds to support development of their legal services and long-term care ombudsman programs and to promote a variety of other special advocacy initiatives. Guidelines for 1980–81 focus on objectives which will help the States implement the specific provisions of the Older Americans Act related to development of the legal services and ombudsman programs.

For the ombudsman program these include activities to secure access for ombudsmen to facilities, residents and residents' records; working with area agencies on aging to develop sub-State ombudsmen programs; involving community groups and volunteers in the ombudsman program; and establishing statewide uniform complaint documentation systems.

For legal services, activities focus on developing policies and procedures for implementation of legal services requirements of the Older Americans Act; coordinating area agencies on aging and title III funded legal services programs; and coordinating area agencies on aging and title III funded legal services programs with private bar and law school resources and with nonlegal services advocacy, such as ombudsman programs.

Biregional Support Centers for Advocacy Assistance

Five advocacy assistance support centers help the States to execute their mandate to advocate for older people, expand legal services, and implement the long-term care ombudsman program. The centers provide materials, research, and lawyer backup to the network. The centers are staffed by experienced professionals in the field of aging, lawyers, and paralegals who can design and deliver materials, training, and support to all States in their regions.

The work of the centers includes:

—Holding training conferences for State legal services and ombudsman personnel to provide them knowledge and capacity in substantive areas (e.g. medicare, food stamps, age discrimination).

—Helping States design statewide training systems for advocates, providing packaged training materials for States, and training trainers in each State.

—Providing counseling and materials on setting up services delivery systems, including model designs, model contracts, evaluation instruments, and funding proposals.

—Assisting States in establishing linkages to Legal Services Corporation projects, bar association, law schools, and other components of an advocacy system.

—Conducting workshops in every State on legislative issues, techniques for legislative advocacy (e.g. silver-haired legislatures), and model legislation; and

—Providing analysis of law reform issues and assistance in pursuing law reform litigation and other remedies for elderly clients in the courts.

National Task Force and Support Program

Discrimination against older people is reflected in policy and practices of public and private institutions which are beyond the reach of State and area agencies. State and area agencies have advocacy responsibilities that go beyond legal services and ombudsman programs. State agency plans recommend objectives to assist older people in the protection of their rights under the Age Discrimination Act of 1975, and under the Age Discrimination in Employment Act of 1967, as amended; to implement section 504 of the Rehabilitation Act of 1973, as amended; and to increase access of older persons to benefits programs under specific Federal and State entitlement programs.

During 1980, the White House established a Standing National Task Force on Older Americans Civil Rights and Age Discrimination. Members of the Task Force are the ranking officials of the signatory agencies: the Office for Civil Rights (DHHS); the Equal Employment Opportunity Commission; the Legal Services Corporation; the American Bar Association; the Administration on Aging; and the U.S. Commission on Civil Rights. The parties signed an agreement to promote full implementation of the two antidiscrimination statutes, to promote the expansion of legal representation and the development and implementation of the ombudsman program, and to enhance public knowledge and understanding of needs and rights of older people.

No AoA discretionary funds were committed to this effort in fiscal year 1980.

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[7] The State advocacy assistance grants represent combined fiscal year 1978 and fiscal year 1979 funds, and fiscal year 1979 and fiscal year 1980 funds, for program years 1979 and 1980 respectively.

Additional Legal Service Support

In addition, AoA has entered into a cooperative agreement with the Legal Services Corporation to provide:

—Leadership, backup, clearinghouse, and coordinating functions for biregional centers and the AoA advocacy system (to be performed by the National Senior Citizens Law Center).

—Access for AoA advocates to LSC's national clearinghouse.

—Two major national conferences on medicare litigation strategies and long-term care advocacy.

—Special projects carried out by LSC national support centers for direct substantive issue support; and

—Access to the sophisticated skills, expertise, and materials of LSC's 17 national support centers.

During fiscal year 1980, AoA also funded:

—The *American Bar Association* to stimulate the involvement of its membership in the provision of legal services for the elderly.

—The *National Citizens Coalition for Nursing Home Reform* to promote and organize citizen involvement to improve the quality of life for nursing home residents.

—The *Colorado Congress of Senior Organizations* to establish a task force for the purpose of studying the effectiveness of and need for outreach and services to the elderly in Spanish-speaking communities in Southern Colorado and Northern New Mexico.

The Administration on Aging and ACTION agreed to promote the direct involvement of older people and organizations of older people as lay advocates. ACTION and AoA will jointly issue guidance and provide technical assistance promoting the direct involvement of organizations of older people and volunteers in developing and implementing initiatives under the agreement.

There are now approximately 350 local title III supported legal services programs, compared with approximately 100 programs in July 1976. The numbers of older persons receiving title III funded legal services increased from 200,000 in fiscal year 1977 to 400,000 persons in fiscal year 1980.

During fiscal year 1980 the three biregional support centers then in existence conducted planning events in 32 States, convened two training conferences for about 60 legal services developers and ombudsmen, and held approximately 90 training events for both trainers and advocates. In addition, staff members from the centers made visits to the States to participate in planning sessions, conferences, and workshops.

Training packages are now available from the centers on basic advocacy skills, systems building, public benefits representation, nursing home advocacy, legislative advocacy, and long-term care issues. Substantive materials exist on social security, SSI, food stamps, medicaid, housing, consumer, mental health, guardianship, commitment, and other subjects.[8]

B. SERVING THOSE IN NEED

1. Improving Systems and Services

In this area, AoA supports projects designated to foster the continued development of systems and services, to improve community based services, to strengthen family support activities, to reach out to minorities, to address the unique needs of special target populations, and to provide relief to older persons who are victims of natural disasters.

A description of activities carried out with discretionary resources intended to provide knowledge supporting the continued development of improved systems and services follows. Included are discussions of efforts to strengthen information systems and reporting, and to solve special system problems.

Information Systems and Reporting

State and area agencies represent a unique social experiment in service delivery built on the principles of local responsibility, coordination of multiple

[8] Total $5 million appropriated under section 451 reserved for legal services or to facilitate the provision of legal service through: Advocacy assistance grants. $1,893,000; biregional advocacy support centers for advocacy assistance, $2,427,000; additional legal service support, $707,000.

A detailed listing of projects under this category is contained in appendix VIII. The $5 million resource commitment represents only fiscal year 1980 amounts.

public and private resources, and public-private partnership in the management and provision of services. Developing accurate information about State and area agency systems and services is necessary to provide policymakers with the capacity to evaluate the effectiveness of public funding commitments and to permit national judgments about ways to improve and enhance services to older people. Unique problems exist in developing such information in view of the degree of flexibility given to State and area agencies and the mix of public-private management of resources. The AoA objective is to develop information usable by local and State policymakers while also providing data necessary for national policymaking and for accountability to the Congress and, at the same time, limiting paperwork requirements.

A joint advisory body of State and area agency personnel under the auspices of AoA, National Association of State Units on Aging (NASUA) and National Association of Area Agencies on Aging (N4A) has been: (1) Advising AoA on modifying formal reporting requirements; (2) developing a taxonomy for service definitions; (3) advising NASUA on an AoA-funded project to codify and disseminate model information systems to State and area agencies; (4) advising AoA on the implementation of ongoing joint Federal-State area agency assessment activities; and (5) advising the GAO on the conduct of a national survey of State and area agencies.

Previously, AoA provided funds to NASUA and N4A to develop and disseminate model information system designs to State and area agencies. Subsequently in 1980, AoA competitively awarded one year information system development grants to five agencies (four State, one area) in Texas, New York, Connecticut, Ohio, and Alabama. Each agency will utilize the NASUA models to develop operational systems. AoA also has awarded funds to the University of Illinois and to the Assistance Group in Silver Spring, Md., to further develop data base information and to assist AoA in the development of State and area plan formats and self-assessment instruments.

Solving Special System Problems

AoA has funded four research projects designed to provide data on special system problems facing State and area agencies. The first, at Portland State University, examines techniques for intervening with community and neighborhood systems to improve services for older people. The second examines models for targeting resources in specific service areas. The third, conducted by the University of California, examines the impact of the decentralized structure of State and area agencies on funding patterns, service priorities, and performance standards or criteria employed by State agencies. The fourth project studies the effectiveness of neighborhood and community organizations in developing effective self-help programs.

2. Improving Community Based Services

The community based services authorized in title III of the Older Americans Act are classified in four categories: Activities which improve access to services; community and neighborhood services; in-home services, and services to residents of care providing facilities. Discretionary activities to strengthen and improve services in each category are discussed below.

Improving Access to Services

Access involves the development of services and community systems of varying degrees of complexity to provide information to clients, to assess their individual needs, and to counsel, refer, and directly assist individuals in obtaining services including escort and transportation. AoA uses discretionary resources to develop models and knowledge which can be evaluated and made available to State and Area agencies to improve the operation of access services nationwide.

AoA is supporting three research projects to study case management. One of particular interest, in Louisville, Ky., will develop a model to increase the client's ability to exercise choice in selecting services and service providers. A second, conducted by the University of Pennsylvania, seeks to develop information on assisting older people in emergency and crisis situations. A third at the University of Southern California is conducting an inventory of case management and coordination programs for the aging.

AoA-sponsored model projects include the use of a community voluntary board to monitor services. Another at the Miami Jewish Home and Hospital is utilizing a multidisciplinary team to assure access to a full continuum of services.

Three research projects are examining ways to improve the effectiveness of transportation services.

Community and Neighborhood Services

Older people are dependent on the neighborhood and the community for meeting basic needs. Studies are being conducted to estimate the number and characteristics of special retirement communities. A study by the National Center for Black Aged is examining problems of older people in neighborhoods undergoing revitalization.

The National Council on Aging is developing models for senior centers. The Waxter Center in Baltimore is developing a model for providing services for the disabled at senior centers. Similar projects are being supported by AoA at the Jamaica Service Center in New York. The Northern Kentucky Mental Health Mental Retardation Board is operating an experimental day care center program for older people who are "at risk" of institutionalization.

Older people consistently report problems in securing adequate health care services. Area agencies report that needing assistance with health care services is one of the most frequent requests of older people who use information and referral services. In addition to the nationwide annual promotion of community health fairs initiated by AoA in 1978, and the national-impact primary health care demonstrations conducted by AoA and the Health Services Administration, (described elsewhere), research and model projects related to these services are being implemented in six locations around the country. Among these is a very promising project encouraging health promotion conducted by the University of Washington at the Wallingford Senior Center in Seattle for persons over 75. In another project the American Dietetic Association is studying food service technologies for AoA. In still another project Temple University is studying and reviewing the national policy implications of a series of AoA-supported community service demonstrations and will prepare the results for disseminaton to State and area agencies.

In-Home Services

Two research studies to examine and improve in-home care are being supported in conjunction with the departmentwide long-term care program. Brandeis University is examining several issues in home care, including how well care planning is done, whom providers select, and the cost of services provided. The Benjamin Rose Institute is studying the effects on families of providing care for older people in residence.

Services to Residents of Care Providing Facilities

AoA is supporting a number of efforts to expand the supply and improve the services available to older people residing in such facilities. Among them is the rural congregate housing initiative.

Under an agreement between the Administration on Aging and the Farmers Home Administration (FmHA), both agencies have been collaborating to enhance the quality of housing and care for older persons living in rural areas. The primary focus of their effort is the design, development, and implementation of a national cooperative demonstration effort in ten sites across the country. During 1980 the sites were developing model congregate housing projects for older persons, with FmHA funds being used to construct the facilities, and AoA funds being used to assist area agencies on aging to support the service components of those facilities. Over the 3-year demonstration period (fiscal years 1980–82), FmHA has targeted $10 million to the project and AoA $2.55 million.

The demonstration sites include Clairborne County, Miss.; Lake County, Mich.; Charles Mix County, S. Dak.; the Eastern Oregon Development Council; Accomack County, Va.; Rio Grande Council of Governments in New Mexico; the Southern Iowa Council of Governments; Riverside County, Calif.; Carroll County, N.H.; and Chatauqua County, N.Y.

This national demonstration program serves as a catalyst to stimulate awareness and cooperation between the State and local networks of each agency. The long-range goal is for projects similar to the demonstrations to be initiated, developed, and supported by the regular programs administered by FmHA and AoA (e.g., section 515 rural rental housing program and title III of the Older Americans Act) at the local level. The section 515 rural rental housing program supported elderly congregate housing for the first time through the 10 site demonstration program.

FmHA has subsequently revised its regulations for the 515 program to: (1) Include elderly congregate housing projects as a category to be funded as a part of the regular funding patterns of the program; (2) require that all applications for elderly congregate housing reflect the involvement of area agencies on aging in the planning for that project; and (3) require that applications for elderly congregate housing include a package of services similar to the package required for the demonstration grants.

3. Strengthening Services To Support Family Care

Families provide more care at home for the elderly than all publicly and privately supported home care combined. AoA regards the family as *the* primary care and support system. Public and private supports are necessary when needs extend beyond the capacity of the family. Large numbers of older people have no living children. Many older people have living parents.

AoA funded five research and eight model projects on the problems associated with assisting the family as a primary care giver. Research is being conducted on older people as self-help care givers, the use of high school students as care givers, measuring intrafamily transfers, and the impact of formal organizations on family networks. A study is being conducted to synthesize and analyze current literature and data for AoA.

The eight model projects include a project to develop and disseminate a training module directed at assisting adult children to be better care givers. Others design and test peer support systems and the use of multidisciplinary teams to strengthen efforts of families and friends in both urban and rural areas.

4. Reaching Out to Minorities

AoA has initiated a major effort to improve services to minorities. The minority elderly population groups are expanding faster than the general population of older people. They experience problems which are different in kind and in degree from the general population.

Lack of familiarity with minority groups' languages and customs can lead to the provision of inappropriate services patterned after a cultural mode which is both alien and unacceptable to minority group members. Recognition of cultural patterns and sensitivities, as well as hiring of minority staff, are needed to develop more acceptance of area agency services in areas with large concentrations of minority group members. Barriers between providers and clients need to be broken down in communities where services may be viewed with suspicion.

During fiscal year 1980, AoA conducted a national competition to permit a limited number of area agencies to implement special affirmative action programs in an effort to improve services to minorities. Four area agencies competed succesfully. Successful models will then be used by AoA to improve nationwide performance of agencies providing services to older people. In addition AoA is conducting six projects specifically targeted to Hispanics as part of an eight-State Office of Human Development Services initiative.

AoA has also entered into cooperative agreements with four national minority organizations. These organizations work directly with minority communities to provide information about available services under Federal and State benefit programs. They work directly with AoA regional offices to assist States and area agencies to improve services to minority communities. In addition, AoA has awarded six research grants to improve information and knowledge about minority needs and services.

5. Special Populations and Special Problems

AoA has also used its research and model project authorities to develop knowledge and practice models to address a number of special problems and special population groups. Five State or area agencies were awarded model projects to demonstrate improved methods for service delivery in rural areas. A research grant was made to the American Foundation for the Blind to study adaptive techniques to compensate for sensory impairment. A handbook will be produced. Three State and area agencies were awarded funds to develop models for meeting needs of abused older persons. Two awards were made to extend services to migrants and refugees. The Columbus Colony is conducting a demonstration at the Ohio State School for the Deaf. Several community hospice projects for the terminally ill are being supported.

6. Extending Cooperation in the Public and Private Sectors

The Older Americans Act authorizes AoA to utilize the resources and capacities of public and private organizations to carry out the purposes of the act. The act also authorizes AoA to extend technical assistance to such agencies seeking to enhance their ability to serve older people. In 1980, AoA extended support to a variety of these organizations. The National Council on the Aging through its affiliate, National Voluntary Organizations for Independent Living for the Aged, is working with more than 200 national private organizations to increase their commitment to older people. NASUA and N4A provide extensive technical assistance to State, area agencies, and their providers. The Western Gerontological Society is working with State and area agencies to improve methods to reach underserved populations. The National Association of Counties and the National Conference of Mayors are providing assistance and support to local public officials. The Urban Elderly Coalition and the United Neighborhood Centers of America are extending assistance and support to urban public and private organizations.

7. Disaster Relief

The Disaster Relief Act of 1974 provides an orderly and continuing means of assistance by the Federal Government to State and local governments in carrying out their responsibilities to alleviate the suffering and damage resulting from major disasters—hurricane, tornado, snowstorm, fire—or any other catastrophe. The Older Americans Act authorizes AoA, from its discretionary funds, to reimburse a State for funds that it makes available to area agencies for delivery of social services during a major disaster.

The following States received disaster relief funds during fiscal year 1980: Ohio, Washington, Nebraska, Wisconsin, and Alabama. These funds helped provide needed services to older persons for food, clothing, and shelter during disasters.[9]

C. LONG-TERM CARE—MOVING TOWARD A CONTINUUM OF CARE FOR THE FUNCTIONARY DISABLED

The 1978 amendments to the Older Americans Act gave significant impetus to AoA's role with respect to the vulnerable, chronically incapacitated elderly. In particular, Section 422 empowers the Commissioner to make special grants to support the development of comprehensive coordinated systems of community long-term care for older individuals.

Population characteristics of the elderly make clear why the need for long-term care programs is urgent. It is estimated that between 13 and 18 percent of the noninstitutionalized elderly, or over 4 million persons, are to some degree functionally disabled. In 50 years, over 7 million of the population will be functionally disabled.

AoA defines long-term care as health care, social services or personal care including supervision, treatment, or any sort of simple help with everyday tasks, provided formally or informally on a recurring or continuous basis as needed to functionally impaired individuals. The care is provided in homes or other homelike settings in the community, if possible, or in an institutional setting if that is either the client-preferred or the medically necessary option.

Current public policies and programs do not provide a reasonably comprehensive and coordinated range of community based long-term care services. Instead, we have a mix of laws, policies, programs and agencies which result in serious gaps and overlaps in available services and in client eligibility. We have very high government expenditures for medically-oriented institutional care and very little for large numbers of persons who need less costly social-maintenance care in their own home and community. Last year, Federal expenditures for skilled and intermediate care were double the combined costs for SSI, title XX services, in-home care under titles XVIII and XIX of the Social Security Act, community mental health, special housing constructed by DHUD and Older Americans Act funding.

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[9] AoA devoted the following discretionary resources for the purposes described above: Improving systems and joining public and private sectors, $1,871,000; improving community based services, $4,898,000; strengthening family support, $1,360,000; reaching out to minorities, $8,751,000; special populations and special problems, $2,879,000; disaster relief, $162,000.

A detailed listing of projects under this category can be found in appendix IX.

The multidisciplinary centers and the geriatric fellowship programs are intended to intensify staff resources development, intensify and spread technology development, and intensify basic and applied research in long-term care.

1. The Long-Term Care Gerontology Center Program

The concerns which the long-term care gerontology center concept addresses are: Health and medical training and research basically oriented to acute problems in an era in which the incidence of chronic illness and functional impairment are rapidly increasing; fragmented orientation to a problem which required a multidisciplinary and interdisciplinary approach; rapid expansion in services; and long range population projections. AoA perceived a need for a Federal effort to establish a basis for intensifying multidisciplinary staff development and basic and applied research, as well as speeding innovation in the treatment of chronic impairment and functional disabilities. Meeting that need meant establishing an organized, integrated capacity in institutions of higher education, in partnership with Federal agencies, geographically dispersed to serve national developmental needs in long-term care. Discussions with the Health Care Financing Administration, Veterans' Administration, National Institute of Mental Health, Health Services Administration, and Health Resources Administration, as well as with academicians indicated agreement with the concept.

Focusing on a combined health/social services approach, these centers have a defined relationship both with a medical school and with community based long-term care services provider agencies. The four-fold purpose of this major program is:

—To enhance the education and training of medical and social service professionals and paraprofessionals regarding the long-term care needs of the elderly and the cost expert and appropriate modes of care, treatment, and services, thereby enlarging the capacity of educational institutions to meet our society's present and future long-term care staff resource needs.

—To increase the amount and quality of practice-oriented and policy-relevant research dealing with long-term care problems.

—To facilitate innovation and experimentation in long-term care service delivery in an experimental environment; and

—To disseminate best practice and knowledge through consultation, technical assistance, continuing education and training, and public information.

AoA is funding the program as a 5-year developmental effort to establish up to 12 multidisciplinary LTC academic centers of excellence. AoA and the institutions provide basic core support for establishing the centers. Each center formally joins medical schools, health science schools, social welfare schools and other units in the phased development of a multidisciplinary program under the direction of the center.

Year one (1978) involved program planning and concept development jointly with Federal agencies and the academic community. Year two (1979) executed first-year planning awards to 22 institutions (out of nearly 50 proposals). During year three (1980), five centers were established as operational, four institutions received second year planning awards, and seven institutions received new planning grants. Thirteen institutions funded in 1979 were competitively dropped. Years four and five will develop up to 12 fully operational centers, geographically dispersed.

2. Geriatric Fellowship Program

With rare exception, undergraduate and postgraduate training of today's primary care physicians does not include exposure to and competence in the growing body of knowledge concerning clinical and case management problems that occur frequently with older patients.

In an effort to improve the quality of medical care and to encourage new professionals to enter the field or geriatric medicine, the Administration on Aging is supporting a number of geriatric fellowships which will offer future medical professionals exposure to the special body of knowledge related to geriatric medicine, to the special ethical issues related to the care of older persons, to the social, economic and psychological problems which interact with health problems, and to new approaches to long-term care in the community and/or institutions. These geriatric physicians will then become members of medical school facilities for the purpose of training other geriatric physicians, exposing medical students to geri-

atric issues, and supervising and encouraging research and practical experiences related to geriatric care.

During fiscal year 1979, the Administration on Aging awarded six grants (which were continued in fiscal year 1980) to support the development of multi-year programs to train 18 future faculty members.

3. National Channeling Demonstration Program

The national channeling demonstration program is a major Departmental initiative aimed at testing the extent to which State and local governments and agencies can develop, coordinate, and manage long-term care services that: (a) Are available and accessible to those persons who need them; (b) are provided in the least restrictive environment, preferably at home or in other community settings; and (c) can be delivered without any substantial amounts of new dollars, by de-emphasizing the use of acute care and nursing home facilities. At the core of the channeling concept are the functions of client assessment and case management including monitoring and reassessment as methods for organizing care to meet individual needs and controlling long-term care expenditures. It is a departure from current general practice because it includes both client-focused services and an altered set of relationships among health, mental health, and social services agencies which help clients gain access to a wider array of services than is usually available.

Twelve States received 2-year contract awards in fiscal year 1980 to develop and carry out the channeling demonstrations. Accompanying the channeling demonstrations is an evaluation contract to measure the effects, benefits, and costs of the channeling projects, and a technical assistance contract to inform, advise, train, and otherwise help the channeling projects in their work. Eight projects were competitively awarded to State agencies on aging. Twenty-two of the 28 sites are either area agencies or were jointly selected by State and area agencies. AoA and the Health Care Financing Administration (HCFA) jointly share in funding this Departmental initiative, which is being coordinated by the Office of the Assistant Secretary for Planning and Evaluation (ASPE).

4. State System Development

Another component in the channeling demonstration program is State system development. In 1980, State system development grants were given to 15 States. Under these grants the States will identify the long-term care needs of the population with emphasis on the elderly, survey the available services, and analyze barriers which restrict the establishment of an effective statewide long-term care system. The States will plan such a system and submit the plan to HHS with recommendations for legislative and administrative changes needed at all levels of government for implementation.

5. State and Community Model Building

Another objective of AoA's long-term care activities is to conduct model projects to promote and develop community based planning and service capacities to meet the needs of chronically ill and functionally impaired older people. The AoA/Health Services Administration demonstration projects utilize primary health care facilities as model service delivery points for vulnerable older persons. The long-term care model projects demonstrate the effectiveness of special services ranging from a continuum of care.

AoA/Health Services Administration Demonstration Projects

The AoA/HSA demonstration projects represent a joint effort aimed at the effective use of primary health care facilities and services by vulnerable older persons. A corollary objective is to coordinate existing social and health services delivery systems through the AoA and HSA networks. In order to implement this program AoA and HSA developed a memorandum of understanding to improve the health and social services systems for older persons through each agency's respective network.

Activities under the memorandum of understanding commenced with funding in fiscal year 1979 by AoA of five awards to community health care clinics and three awards to Indian tribal organizations supported and served by HSA through two of its bureau, the Bureau of Community Health Services and the Indian Health Service. Three new awards to Public Health Service hospitals were made in fiscal year 1980.

Long-Term Care Model Projects

The objective of these projects is to demonstrate how appropriate services can be made available to chronically ill or impaired older persons along a continuum of care. Past experience documents that persons with varying degrees of functional impairment may be found in each of a wide range of settings including their own homes, public housing projects, mental hospitals, acute care hospitals, and nursing homes. In most cases, placement is determined by eligibility and reimbursement provisions of categorical programs. Though many of the impaired elderly need only help with everyday living functions, medicare and medicaid do not pay for such services unless they are provided in conjunction with medical treatment.

Grants support demonstrations testing: Technological advances such as electronically controlled surveillances and reaction systems; innovative methods in developing and providing shelter and supportive personal services at the community level; emergency and respite services to informal support systems; and the ability to monitor the suitability of placement for the older person. Several have subsequently received waivers of medicaid funding restrictions and will measure the impact of decategorized funding on utilization, quality, and cost of services.

Ten model projects were funded in 1980. The grants were awarded to community organizations and area agencies on aging.

6. Long-Term Care Policy Formulation and Information Exchange

This AoA effort involves two projects. The first was a national policy conference grant to the University of Chicago School of Social Service Administration as lead agency in an informal consortium of academic institutions to conduct an analysis of policy options for improving the provisions of long-term care to the elderly. Papers on six selected topics along with an integrating overview paper were prepared and thoroughly reviewed by panels of specialized experts. These papers were distributed in May, 1980, to about 50 invitees to a 2-day symposium held in June, for which the papers provided a common basis and framework for discussion. The papers have been made available to the Department and are being prepared for publication.

The second project is based upon a cooperative agreement with the National Conference on Social Welfare and its subcontractor, the University of Chicago Center for the Study of Welfare Policy. The major purpose of this effort is to develop and disseminate existing and emerging knowledge about long-term care and related policy issues to designated target audiences including State legislators, program administrators, and other policymakers. The project will disseminate the Chicago Symposium papers and other recent reports through presentation at regional conferences.

7. Long-Term Care Data Base

AoA is an active participant in a Departmental effort to develop a comprehensive data base for future long-term care policy decisionmaking. Two key projects were begun in fiscal year 1980 as part of a Departmental statistical plan for nationally representative long-term care data. One contract award was for the analysis and assessment of existing data on various important aspects of long-term care. The second contract award was for the development of methodology to conduct two future national surveys: a survey of impaired individuals in households and a survey of individuals in institutions. These projects are funded by HCFA.[10]

D. IMPROVING CAPACITY THROUGH APPLICATION OF KNOWLEDGE

The development of health and social services for older people parallels the increase in the older population. The ability of families, community agencies, and State and area agencies to care for older persons is affected by the degree of skill

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[10] AoA devoted the following discretionary resources to the purposes related to long-term care described above: Long-term care gerontology centers, $4,023,000; geriatric fellowships, $585,000; channeling demonstrations, $8,550,000; State system development, $1,769,000; State and community model building, $2,572,000; policy formulation and information exchange, $338,000.

A detailed listing of the projects under this category can be found in appendix X.

and competence of personnel. It is also affected by the use of new technologies and practice techniques. A primary objective of AoA is to improve the knowledge and skills of policymakers, administrators, and service providers and to provide them with improved techniques for developing and managing services.

Utilization involves the development of knowledge through research, aggregating and organizing information for systematic distribution and dissemination, preparing users through training, technical assistance and applied demonstrations to use knowledge, and ultimately incorporating knowledge in policy articulation, program implementation, and practice.

1. Career Preparation

The title IV–A gerontology career preparation program is designed to support the training of persons who are employed or preparing for employment in the field of aging. AoA is committed to building the capacity of institutions of higher education to prepare persons for careers in aging and to retrain other persons already working with older people.

Priorities in 1980 were: (1) Policy formulation, planning, and management; (2) case management or services management; (3) administration of services including health, mental health, legal services, employment guidance and counseling, services delivered in congregate housing and community focal points, home care, day care, protective services, or transportation; and (4) administration of services to special populations such as minority groups, the rural elderly, the inner cities elderly, or the developmentally disabled.

AoA funds universitywide projects, graduate and professional school projects, 2- and 4-year undergraduate projects, and consortia projects. In 1980, 80 institutions received support under the career preparation program. A study conducted for AoA by Ketron, Inc., indicated that courses are being offered in over 200 degree programs across a wide variety of disciplines. Over 14,000 students were enrolled in courses on aging. Over 3,100 students received degrees with a concentration in aging and another 1,100 completed full degree programs in aging. Only 1,400 students received financial assistance. Almost 95 percent of those specializing in or receiving degrees in aging were employed within 1 year of graduation. Sixty percent of those concentrating in aging and 82 percent of the degree holders were working in aging-related jobs. More than 20 minority institutions received support in 1980.

2. Enhancing Careers in Aging for Minorities

The minority research associate program was initiated in response to the 1978 amendments to the Older Americans Act. In addition to increasing support for minority institutions under the career preparation program, AoA implemented this program to strengthen the participation of minority scholars in the field of aging research.

Five projects were funded with institutions or organizations with sufficient program resources to effectively recruit qualified minority social scientists and to foster research activity focused on expansion of knowledge concerning the needs of racial and ethnic minority elderly—Asian/Pacific Americans, blacks, Hispanics, and Native Americans—and the improvement of services to meet such needs.

3. Development of Continuing Education Material and Technical Assistance

The national continuing education and training program strategically focuses limited resources on continuing education systems in an effort to assist in the redesign of curricula and approaches to delivery of education and training for personnel working with older people. Continuing education and technical assistance programs have two interrelated objectives. Simultaneously, projects develop specific curricula for introduction into the continuing education programs of higher educational institutions and provide direct training of personnel working in the aging network. Contracts or grants are awarded competitively for the development and field testing of training and technical assistance materials.

Once developed, tested, and adopted for use by AoA, packages are distributed to educational institutions, regional offices and State agencies. Depending on the scope and scale of the dissemination task, AoA awards a supplemental grant to the originating grantee to train regional office and State agency personnel in the

use of the package or it is turned over to the regional education and training program (described below) to conduct multiple State and area agency training workshops.

The primary targets of continuing education and technical assistance efforts are individuals employed in programs administered under the act. The dual approach also institutionalizes the use of educational curricula in ongoing continuing education programs, thereby reaching other professionals and practitioners.

In 1980, AoA supported 22 continuing education and technical assistance grants and contracts. Projects span the services systems of State and Area agencies. NASUA has designed model information system development guides and is now extending technical assistance to State and area agency personnel. Miami-Dade Community College is developing curricula on serving minorities. A technical assistance contract has been awarded to improve fiscal management activities for State and area agencies. Assistance is being provided to 85 Indian tribes receiving support under title VI. Other projects are in the areas of long-term care systems, in-home services, senior centers, housing, health promotion, and counseling.

4. Marshaling Resources To Support Operational Programs—The Regional Education and Training Program

The primary goal of the regional education and training program is to foster, on a regional basis, a more holistic, coordinated approach to education and training by promoting greater understanding and linkages among higher education institutions, State and area agencies on aging, and service providers. Pursuing such an approach will result, over time, in more strategic uses of limited education and training resources, both those available under the Older Americans Act and those from other sources. Under this program regional offices:

—Convene regular regional conferences to bring together representatives from higher education institutions, State and area agencies and service providers to discuss common education and training problems and opportunities.

—Convene regional research utilization and dissemination conferences around subject matter areas of common interest to academics and practitioners using results of ongoing research and demonstration projects.

—Promote and assist with the pooling of education and training resources to meet common interstate needs.

—Prepare, in cooperation with the State agencies on aging, regional education and training needs assessments of current personnel in the field, starting with State and area agency staff and local service providers.

—Prepare inventories of all education and training resources available in the region and develop strategies for better utilizing these resources.

—Examine the need for and, as appropriate, develop employment or placement services programs for gerontology students and graduates and practitioner personnel seeking jobs in the region.

—Act as a regional clearinghouse for gathering and disseminating educational, training, and technical assistance materials; and

—Assist in the planning for national, biregional, and regional training, technical assistance, and continuing education efforts.

To help implement this new program, contractual assistance has been made available to each regional office. The purpose of these 10 procurements is to assist in institutionalizing the regional education and training program over a multiyear developmental period.

5. Improving Skills of State, Area and Service Personnel

State agencies were awarded support in 1980 for the following training activities:

—In-service training to upgrade the job knowledge and skills of State and area agency on aging staffs and service provider personnel.

—Staff development programs to improve performance and career opportunities; and

—Planning, resource development, and administrative undertakings designed to promote consortia building.

6. Dissemination and Utilization

The need for a highly visible and effective information system in the field of aging has been intensifying for some time. Over 5,000 new publications on gerontology are issued each year. The rapidly rising demand for information from those working within and outside the national network on aging has created a need for systematic dissemination and utilization of information. A mechanism for bibliographic literature control and timely access to the information contained in the literature is essential if the field of aging is to continue to mature. For example, AoA has developed a dissemination and utilization strategy aimed at both the broad base of gerontological literature and those products and reports funded by AoA's discretionary programs.

7. National Clearinghouse and Service Center for Aging Information (SCAN)

SCAN is a national bibliographic information system which is designed to be an active rather than a passive system. To make its clientele aware of what is available for use and encourage use, several current mechanisms and an aggressive marketing strategy are part of the system. Current awareness will be highlighted by a monthly abstract journal and newsletter. Marketing will include user workshops at professional conferences and a system of approximately 240 repository libraries to provide access and assistance to the community level.

Two resource centers are planned for implementation of the SCAN system and each will be organized along disciplinary lines covering the broad topic areas of social gerontology (funded in 1980), and biomedical sciences (to be funded in 1981). The functions of each resource center will be to process (acquire/select, index, and abstract) literature in its assigned subject area, to provide user services, and to prepare special publications. Each resource center will identify a wide spectrum of literature pertaining to its topic area. Each center will collect English language journal and document literature. The literature to be collected will include not only the fundamental research literature, but dissertations, books, monographs, conference papers, and special reports.

The social gerontology resources center will also collect information about projects which can be determined to be innovative or suitable as a model for replication elsewhere. This function is known as the program experience exchange. The resource center will use an advisory board to review projects for selection into the file. The resource center also provides access to a file of institutional and training materials organized by subject. The advisory board will consider such factors as innovativeness of programs, best practice, and representation of all program areas during the selection process.

As of fiscal year 1980, the social gerontology resource center has acquired and abstracted approximately 4,000 new documents and journal articles, completed 100 special bibliographies, and six technical publications. The bibliographies, when organized under major topic areas, and the reports will be disseminated to the network of State and area agencies on aging for their use. Requests from individuals for bibliographic and information services are received at rate of 200 per month. The SCAN information system has been exhibited, and/or symposia held, at five major conferences during the past 18 months.

During fiscal year 1980, staff of the clearinghouse also responded to over 3,500 inquiries which required individual written replies, distributed over 700,000 publications based on requests of single and multiple copies, responded to 18,000 telephone requests for information, and provided services to 2,000 visitors.

National Data Archive

AoA and the National Institute on Aging are supporting a national data archive at the University of Michigan through the Institute of Gerontology and the Institute for Social Research. The archive collects, codifies and stores original data base information in a diverse array of areas. The archive project provides ready access, training and technical assistance in using the data for secondary analysis to over 270 academic institutions as well as aging network personnel.

Gerontological Research Institute

AoA has funded the Gerontological Research Institute to develop an agency utilization strategy. The GRI has studied past utilization of AoA projects to provide insights for future strategy building. At the request of AoA, the GRI will

prepare for general dissemination research synthesis reports aggregating findings of several research products in defined areas.[11]

E. "GRANTS FOR INDIAN TRIBES"—TITLE VI OF THE OLDER AMERICANS ACT

At the end of fiscal year 1980. AoA awarded title VI grants totaling $6 million to 85 Indian tribal organizations. These awards were the first to be issued under the authority of title VI. (There was no funding for title VI in fiscal year 1979.) The grants were made in accordance with the title VI regulations issued July 18, 1980.[12]

The purpose of the new program for tribal organizations is to promote the delivery of needed social and nutrition services to Indians aged 60 and over. While funds for services for older Indians have always been available through State and area agencies under the Older Americans Act, the new title allows Indian organizations to apply for direct Federal funding. This method of funding is consistent with the policy of self-determination for Indian tribes. Tribal organizations may receive funds through State and area agencies under title III directly from AoA under title VI, as long as each funding source is used to serve different individuals. In addition to social services, such as legal services, nutrition and information and referral, title VI funds may be used for acquiring, altering or renovating multipurpose senior centers for Indians.

Although the minimum age for Indians participating in title VI programs is set at 60 years, spouses of any age may participate in nutrition services.

Applications for grant awards were accepted from those tribal organizations that established their eligibility through a preapplication process.

F. EVALUATION

During fiscal year 1980, AoA had no evaluation studies scheduled for completion. However, the following is a brief report on the progress of current evaluation activities:

—*Longitudinal evaluation of the national nutrition program for the elderly:* Work on a new sample design for the collection of wave II data for this study has been completed. The package containing the new sample design and revised data collection instruments is ready for submission to the Office of Management and Budget.

—*Analyses of food service delivery systems used in providing nutrition services to the elderly:* The contractor responsible for this study has recently completed a telephone survey of 1,155 nutrition projects and has exhaustively analyzed the data through an interim report. Data collection for the full-time length study is expected to be completed by the end of March 1981 which will be followed by a final report containing data analysis around July 1981.

—*Evaluation of differences in needs and service programs between the rural and urban elderly:* AoA is in the process of preparing an interim report based on secondary data sources relating to this study mandated by the Congress. AoA expects to transmit this report to the Congress during the early part of 1981.

—*The evaluation of advocacy programs funded under title III of the Older Americans Act:* This study, mandated by the Congress, is nearing the stage of completion. AoA plans to transmit the report on legal services to the Congress during the early part of 1981. A more comprehensive, technical report will become available in March 1981.

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[11] AoA devoted the following discretionary resources to the purposes described above related to improving capacity: Career preparation, $7,906,000; enhancing careers for minorities, $297,000; development of continuing education materials and technical assistance, $2,351,000; marshaling resources, $1,635,000; improving skills of personnel, $1,938,000; dissemination and utilization, $643,000.

A detailed listing of projects under this category can be found in appendix XI.

[12] A region-by-region summary of title VI grants may be found in appendix XII. A more detailed listing of grantees may be found in appendix IX.

APPENDIX I

FY 1980 BUDGET

ADMINISTRATION ON AGING

State and Area Agency Activities 1/	$ 22,500.000
Social Services & Senior Centers 1/	246,970,000
Nutrition Services 1/	
Congregate Nutrition Services.....	270,000,000
Home Delivered Nutrition Services.	50,000,000
Subtotal.....	320,000.000
Grants to Indian Tribes	6,000,000
Training Research & Discretionary Projects and Programs	
Training	17,000,000
Research.....	8,500,000
Discretionary Projects & Programs.....	25,000,000
Multidisciplinary Centers.....	3,800,000
Subtotal.....	54,300,000
Federal Council on Aging..	450,000
National Clearinghouse on Aging.....	2.000.000
TOTAL.....	652,220,000

1/ Up to 8.5% of the funds for Social Services and Senior Centers and Nutrition Services may be used for Area Agency Activities.

FY 1980 - State Allotment Amounts under Title III-B, Social Services of the Older Americans Act of 1965, as amended, after Reallotment (Available for obligation through September 30, 1980 - Reallotted amounts must be obligated by September 30, 1981) Amounts do not reflect transfers.

APPENDIX II

13.633 57 States	Allotment FY-80-2	Amount Reallotted	Amount Released	Final Allotment After Reallotment
TOTALS	$244,500,300	680,455	(200,455)	244,980,300
Alabama	3,922,708	16,813		3,939,521
Alaska	1,222,501	5,000		1,227,501
Arizona	2,559,887	3/10,972		2,570,859
Arkansas	2,731,743	11,709		2,743,452
California	22,094,560			22,094,560
Colorado	2,283,354	9,787		2,293,141
Connecticut	3,444,095	14,762		3,458,857
Delaware	1,222,501			1,222,501
Dist of Col.	1,222,501	5,000		1,227,501
Florida	13,556,573			13,556,573
Georgia	4,582,728	19,642		4,602,370
Hawaii	1,222,501			1,222,501
Idaho	1,222,501	5,000		1,227,501
Illinois	11,798,423			11,798,423
Indiana	5,432,319	23,284		5,455,603
Iowa	3,535,264			3,535,264
Kansas	2,783,610	11,931		2,795,541
Kentucky	3,714,388	15,920		3,730,308
Louisiana	3,590,046			3,590,046
Maine	1,263,051	5,414		1,268,465
Maryland	3,731,311			3,731,311
Massachusetts	6,726,878	28,832		6,755,710
Michigan	8,552,513	36,657		8,589,170
Minnesota	4,345,997	18,627		4,364,624
Mississippi	2,498,420			2,498,420
Missouri	5,838,470			5,838,470
Montana	1,222,501	5,000		1,227,501
Nebraska	1,865,742			1,865,742
Nevada	1,222,501	5,000		1,227,501
New Hampshire	1,222,501			1,222,501
New Jersey	8,183,013	35,073		8,218,086
New Mexico	1,222,501	1/ 5,000		1,227,501
New York	20,361,813	87,273		20,449,086
North Carolina	5,389,394			5,389,394
North Dakota	1,222,501			1,222,501
Ohio	10,978,222	47,054		11,025,276
Oklahoma	3,348,442	14,352		3,362,794
Oregon	2,768,595	11,867		2,780,462
Pennsylvania	14,347,995	61,497		14,409,492
Rhode Island	1,222,501			1,222,501
South Carolina	2,553,480	10,944		2,564,424
South Dakota	1,222,501			1,222,501
Tennessee	4,603,969	19,733		4,623,702
Texas	12,186,922	52,235		12,239,157
Utah	1,222,501	1/ 5,000		1,227,501
Vermont	1,222,501			1,222,501
Virginia	4,680,943	20,063		4,701,006
Washington	3,859,416	16,542		3,875,958
West Virginia	2,190,891	9,391		2,200,382
Wisconsin	5,207,569	22,320		5,229,869
Wyoming	1,222,501			1,222,501
American Samoa	152,813	1/		152,813
Guam	611,251	1,000		612,251
Puerto Rico	2,510,582	10,761		2,521,343
Trust Territory	611,251		(200,455)	410,796
Virgin Islands	611,251			611,251
N.Mariana Is.	152,813	1,000		153,813

1/ Amounts adjusted on Statement of Grant Award to represent transfers to Interstate Planning and Service Areas in Arizona, New Mexico and Utah. See Grant Award.

2/ Additional funds have been awarded to American Samoa in order to provide funding at the FY 1978 level. These additional funds have been withheld from the amount reserved for evaluation. See Grant Award $325,862.

3/ $200,455 released for reallotment. $480,000 reallotted from amount originally earmarked for evaluation.

Administration on Aging, OHD
Office of Health and Human Services

FY 1980 - [illegible] amounts under Title III-C 1, Congregate Meals Older Americans Act of 1965, as amended, after Reallotment (available for obligation through September 30, 1980 - Reallotted amounts must be obligated by September 30, 1981) Amounts do not reflect transfers.

APPENDIX II (cont)

13.633 57 States	Allotment PI-80-3	Amount Reallotted	Amount Released	Final Allotment After Reallotment
TOTALS	$267,300,000	$503,844	(503,844)	267,300,000
Alabama	4,288,501	12,670		4,301,171
Alaska	1,336,500			1,336,500
Arizona	2,798,597	1/ 8,268		2,806,865
Arkansas	2,986,479	8,823		2995,302
California	24,154,879			24,154,879
Colorado	2,496,277	7,375		2503,652
Connecticut	3,765,258	11,124		3,776,382
Delaware	1,336,500			1,336,500
Dist. of Col	1,336,500	5,000		1,341,500
Florida	14,820,726			14,820,726
Georgia	5,010,068	14,801		5024,869
Hawaii	1,336,500			1,336,500
Idaho	1,336,500	5,000		1,341,500
Illinois	12,898,628			12,898,628
Indiana	5,938,884			5,938,884
Iowa	3,864,928	11,418		3,876,346
Kansas	3,043,182	8,991		3,052,173
Kentucky	4,060,755	11,997		4,072,752
Louisiana	3,924,818			3,924,818
Maine	1,380,831	5,000		1,385,831
Maryland	4,079,257			4,079,257
Massachusetts	7,354,161	21,726		7375,887
Michigan	9,350,036	27,623		9377,659
Minnesota	4,751,262	14,037		4765,299
Mississippi	2,731,399	8,069		2739,468
Missouri	6,382,909			6,382,909
Montana	1,336,500	5,000		1,341,500
Nebraska	2,039,723			2,039,723
Nevada	1,336,500	5,000		1,341,500
New Hampshire	1,336,500			1,336,500
New Jersey	8,946,080	26,430		8,972,510
New Mexico	1,336,500	1/ 5,000		1,341,500
New York	22,260,556	65,765		22,326,321
North Carolina	5,891,955			5,891,955
North Dakota	1,336,500			1,336,500
Ohio	12,001,943	35,458		12,037,401
Oklahoma	3,660,685	10,815		3,671,500
Oregon	3,026,767	8,942		3,035,709
Pennsylvania	15,685,948	46,341		15,732,289
Rhode Island	1,336,500	5,000		1,341,500
South Carolina	2,791,592	8,247		2,799,839
South Dakota	1,336,500	5,000		1,341,500
Tennessee	5,033,290	14,870		5,048,160
Texas	13,323,354	39,361		13,362,715
Utah	1,336,500	1/ 5,000		1,341,500
Vermont	1,336,500			1,336,500
Virginia	5,117,441	15,119		5,132,560
Washington	4,219,107	12,465		4,231,772
West Virginia	2,395,101			2,395,101
Wisconsin	5,693,153			5,693,153
Wyoming	1,336,500			1,336,500
American Samoa	167,063	2/		167,063
Guam	668,250			668,250
Puerto Rico	2,744,694	8,109		2,752,803
Trust Territory	688,250		(503,844)	184,406
Virgin Islands	668,250			668,250
N.Mar. Islands	167,063			167,063

1/ Amounts adjusted on Statement of Grant Award to represent transfers to Interstate Planning and Services Areas in Arizona, New Mexico and Utah. See grant award.

2/ Additional funds have been awarded to Americans Samoa in order to provide funding at the FY 1980 level. These additional funds have been withheld from the amount reserved for evaluation. See grant award $420.750.

3/ $503,844 released for reallotment.

October 1980

Office [illegible] and Human Services

FY 1980 - State Allotments under Title III-C-2- Home Delivered Meals Older Americans Act of 1965, as amended, after Reallotment (Available for obligation through September 30, 1980 - Reallotted amounts must be obligated by September 30, 1981) Amounts do not reflect transfers.

APPENDIX II (cont)

13.633 57 States	Allotment FI-80-2	Amount Reallotted	Amount Released	Final Allotment After Reallotment
TOTALS	$49,500,000	100,702	(100,702)	49,500,000
Alabama	794,167	2,500		796,667
Alaska	247,500	2,500		250,000
Arizona	518,259	172,500		520,759
Arkansas	553,052	2,500		555,552
California	4,473,126			4,473,126
Colorado	462,273	2,500		464,773
Connecticut	697,270	2,500		699,770
Delaware	247,500			247,500
Dist. of Col.	247,500			247,500
Florida	2,744,579			2,744,579
Georgia	927,790	2,500		930,290
Hawaii	247,500	2,500		250,000
Idaho	247,500	2,500		250,000
Illinois	2,388,635			2,388,635
Indiana	1,099,793	2,500		1,102,293
Iowa	715,727	2,500		718,227
Kansas	563,552			563,552
Kentucky	751,992	2,500		754,492
Louisiana	726,818			726,818
Maine	255,709			255,709
Maryland	755,418			755,418
Massachusetts	1,361,882	3,093		1,364,975
Michigan	1,731,488	3,933		1,735,421
Minnesota	879,863			879,863
Mississippi	505,815			505,815
Missouri	1,182,020			1,182,020
Montana	247,500	2,500		250,000
Nebraska	377,727			377,727
Nevada	247,500	2,500		250,000
New Hampshire	247,500			247,500
New Jersey	1,656,682	3,763		1,660,445
New Mexico	247,500	1/ 2,500		250,000
New York	4,122,325	9,363		4,131,688
North Carolina	1,091,103			1,091,103
North Dakota	247,500			247,500
Ohio	2,222,582	5,048		2,227,630
Oklahoma	677,905	2,500		680,405
Oregon	560,512	2,500		563,012
Pennsylvania	2,904,805	6,598		2,911,403
Rhode Island	247,500	2,500		250,000
South Carolina	516,962	2,500		519,462
South Dakota	247,500	2,500		250,000
Tennessee	932,091	2,500		934,591
Texas	2,467,288	5,604		2,472,892
Utah	247,500	1/		247,500
Vermont	247,500			247,500
Virginia	947,674	2,500		950,174
Washington	781,353	2,500		783,853
West Virginia	443,574			443,574
Wisconsin	1,054,288	2,500		1,056,788
Wyoming	247,500			247,500
American Samoa	30,937	2/		30,937
Guam	123,750	800		124,550
Puerto Rico	508,277	2,500		510,777
Trust Territory	123,750		(100,702)	23,048
Virgin Islands	123,750			123,750
N.Mariana Is.	30,937			30,937

1/ Amounts adjusted on Statement of Grant Award to represent transfers to and Service Areas in Arizona, New Mexico and Utah. See grant awards.

2/ $100,702 released for reallotment.

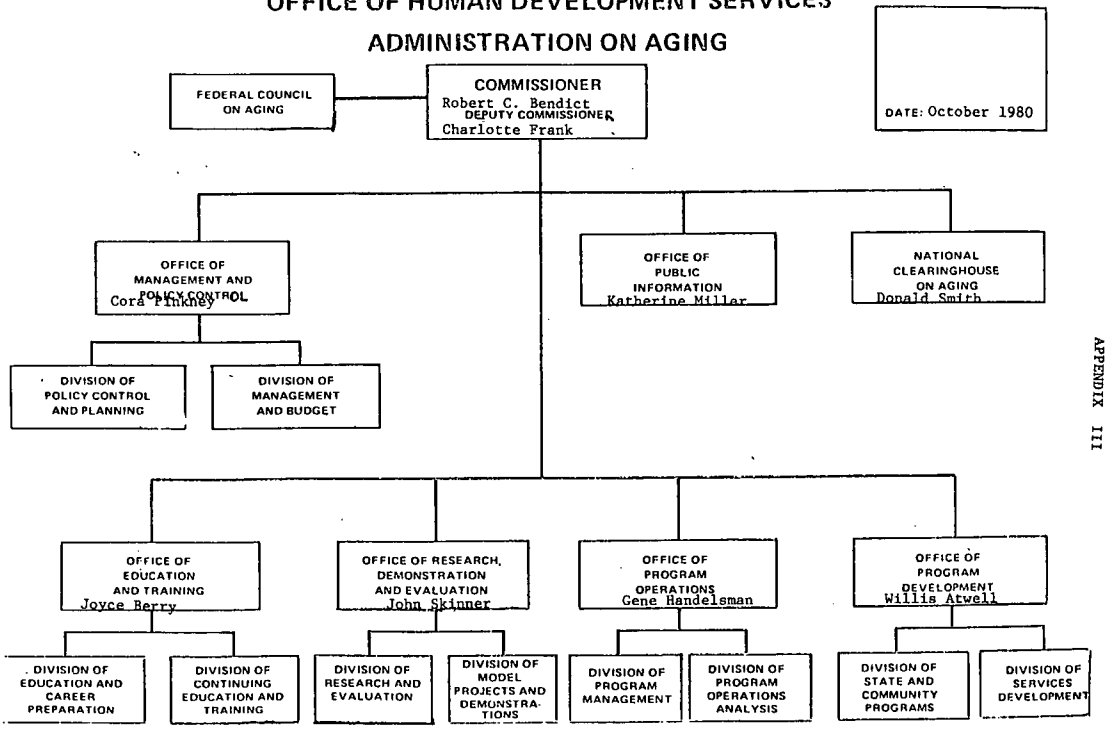
October 1980

Office Health Human Services
Administration on Aging, OHDS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF HUMAN DEVELOPMENT SERVICES

ADMINISTRATION ON AGING



APPENDIX IV

AoA REGIONAL OFFICE LISTINGS

1 Frank Ollivierre
John F. Kennedy Federal Bldg., Room 2007
Boston, Massachusetts 02203
FTS 223 - 1880
8:30 - 5:00
RI, VT, CONN, Maine, Mass., NH
01
Regional Program Director, AoA
Department of Health and Human Services

2 Judith Rackmill
26 Federal Plaza Room 4149
Broadway and Worth Streets
New York, NY 10007
FTS 264 - 4592
8:30 - 5:00
NJ, NY, Puerto Rico, Virgin Islands
02
Regional Program Director, AoA
Department of Health and Human Services

3 Paul E. Ertel, Jr.
P.O. Box 13716 (3535 Market Street)
Philadelphia, PA 19101
FTS 596 - 6892
8:45 - 5:15
DC, MD, VA, Del. PA, W.Va.
03
Regional Program Director, AoA
Department of Health and Human Services

4 Frank Nicholson
101 Marietta Towers, Suite 901
Atlanta, Georgia 30323
FTS 242 - 2972
8:00 - 4:30
Ala., Fla., Miss., S.C., Tenn., N.C., KY, GA
04
Regional Program Director, AoA
Department of Health and Human Services

5 Marian Miller
300 South Wacker Drive -- 15th Floor
Chicago, Illinois 60606
FTS 353 - 3141
8:15 - 4:15
Ill., Ind., Mich., Minn., Ohio, Wisc.
05
Regional Program Director, AoA
Department of Health and Human Services

6 John Diaz
1200 Main Tower Building, Room 2060
Dallas, Texas 75201
FTS 729 - 2971
8:00 - 4:30
Ark., LA, Okla., NM, Texas
06
Regional Program Director, AoA
Department of Health and Human Services

7 Ann Kennedy, Acting
610 East 12th Street
Kansas City, Missouri 64106
FTS 758 - 2955
8:00 - 4:30
Iowa, Kansas, Missouri, Nebraska
07
Regional Program Director, AoA
Department of Health and Human Services

8 Clint Hess
Federal Office Building, Room 7430
19th and Stout Streets
Denver, Colorado 80202
FTS 327 - 2951
7:15 - 5:00
Colo., Mont., Utah, Wyo.,ND, SD
08
Regional Program Director, AoA
Department of Health and Human Services

9 Jack McCarthy
50 United Nations Plaza, Room 443
San Francisco, California 94102
FTS 556 - 6003
8:00 - 4:30
Cal., Nev., Ariz., Hawaii, Guam, TTP, Northern Marianas, Samoa
09
Regional Program Director, AoA
Department of Health and Human Services

10 Chisato "Chazz" Kawabori
Arcade Plaza Bldg --1321 2nd Ave.
Mail Stop 809
Seattle, Washington 98101
FTS 399 - 5341
8:00 - 4:30
Alaska, Idaho, Oregon, Washington
10
Regional Program Director, AoA
Department of Health and Human Services

APPENDIX V

DIRECTORY OF STATE AGENCIES DESIGNATED TO ADMINISTER TITLE III OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED

ALABAMA

*#		
Commission on Aging	Chairman	Mr. Jesse T. Todd
Executive Park		
2853 Fairlane Drive	Director	Mrs. Kay K. Kelly
Bldg., "G" Suite #63		
Montgomery, Ala. 36130		(205) 832-6640

ALASKA

*		
Department of Health & Social Services	Commissioner	Dr. Helen Beirne
Pouch H, OIC		
Juneau, Alaska 99811		
#		
Office on Aging	Coordinator	M. D. Plotnick
Department of Health & Social Services		(907) 465-4903/04/05/06
Pouch H, OIC		
Juneau, Alaska 99811		

ARIZONA

*		
Department of Economic Security	Director	Mr. Bill Jamieson, Jr.
1717 West Jefferson		(602) 271-5678
Phoenix, Arizona 85007		
#		
Aging and Adult Administration	Administrator	Mr. Michael Slattery
1400 W. Washington Street		
P. O. Box #6123		(602) 271-4446
Phoenix, Arizona 85007		

ARKANSAS

*		
Deptment of Human Services	Director	Mr. David Day
406 National Old Lind Bldg.		
Little Rock, Arkansas 72201		
#		
Office on Aging and Adult Services	Director	Ms. Betty King
Dept. of Human Services		
1428 Donaghey Bldg., #1031S		(501) 371-2441
7th and Main Street		
Little Rock, Arkansas 72201		

* Umbrella Agency # State Agency on Aging

CALIFORNIA

* Health & Welfare Agency 926 "J" Street, Rm. 917 Sacramento, Calif. 95811	Director	Mr. Mario Obledo
# Dept. of Aging Health & Welfare Agency 918 "J" Street Sacramento, Calif. 95814	Director	Mrs. Janet J. Levy (916) 322-5290

COLORADO

* Department of Social Services 1575 Sherman Street Denver, Colorado 80203	Exec. Director	Mr. Armando R. Atencio
# Division of Services for the Aging Department of Social Services 1575 Sherman Street Denver, Colorado 80203	Director	Mrs. Dorothy D. Anders (303) 839-2651/2586

CONNECTICUT

*# Department on Aging 80 Washington St., Rm. 312 Hartford, Connecticut 06115	Commissioner	Mrs. Marin J. Shealy (203) 566-3867

DELAWARE

* Department of Health & Social Services Delaware State Hospital 3rd Floor - Administration Bldg. New Castle, Delaware 19720	Acting Secretary	Mr. John L. Sullivan (302) 421-6791
# Division of Aging Department of Health & Social Services Delaware State Hospital 3rd Floor - Administration Bldg. New Castle, Delaware 19720	Director	Ms. Eleanor L. Cain (302) 421-6791

DISTRICT OF COLUMBIA

# Office of Aging Office of the Mayor 1012-14th St., N. W., Suite #1106 Washington, D. C. 20005	Exec. Director	Mr. D. Richard Artis (202) 724-5623

FLORIDA

* Dept. of Health & Rehabilitation Services 1323 Winewood Blvd. Tallahassee, Florida 32301	Secretary	Mr. Emmett S. Roberts (904) 488-2650
# Aging & Adult Services Dept. of Health & Rehabilitation Services 1323 Winewood Blvd. Tallahassee, Florida 32301	Program Staff Director	Mr. James P. Doyle (904) 488-2650

GEORGIA

* Dept. of Human Resources 618 Ponce de Leon Avenue, N. E. Atlanta, Georgia 30308	Commissioner	Dr. W. Douglas Skelton (404) 565-5680
# Office of Aging Dept. of Human Resources 618 Ponce de Leon Avenue, N. E. Atlanta, Georgia 30308	Director	Mr. Troy A. Bledsoe (404) 894-5333

GUAM

* Dept. of Public Health & Social Services Government of Guam P. O. Box 2816 Agana, Guam 96910	Director	Ms. Arlene Santos (9-0, ask for Oakland Overseas Operator (746) 4158/2191/4438
# Office of Aging Social Service Dept. of Public Health Government of Guam P. O. Box 2816 Agana, Guam 96910	Director	Mr. Joaquin Camacho 749-9901 X-324

HAWAII

*#

Executive Office on Aging Office of the Governor	Chairman	Mr. Masaichi Tasaka
State of Hawaii 1149 Bethel St., Rm. 307 Honolulu, Hawaii 96813	Director	Mr. Renji Goto (808) 548-2593

IDAHO

*#

Idaho Office on Aging Statehouse Boise, Idaho 83720	Director	Ms. Rose Bowman (208)964-3833 FTS: 8-554-3833

ILLINOIS

*#

Department on Aging 421 East Capitol Ave. Springfield, Illinois 62706	Director	Ms. Peg Blazer (217) 785-3341

INDIANA

*#

Commission on Aging and Aged Graphic Arts Bldg. 215 North Senate Ave. Indianapolis, Indiana 46202	Chairman Exec. Director	Mr. Sidney Levin Mr. Maurice E. Endwright (317) 232-1190

IOWA

*#

Commission on Aging 415 West 10th Street Jewett Bldg. Des Moines, Iowa 50319	Chairman Exec. Director	Mrs. Colleen W. Shaw Mr. Glenn R. Bowles (515) 281-5187

KANSAS

*#

Department of Aging 610 West 10th St. Topeka, Kansas 66612	Secretary	Mrs. Barbara J. Sabol (913) 296-4986

KENTUCKY

*
Department for Human Resources — Secretary — Mr. Leslie C. Dawson
Capital Annex, Rm. 201
Frankfort, Kentucky 40601

#
Center for Aging Services — Director — Mrs. Fannie B. Dorsey
Bureau of Social Services
Human Resources Bldg., 5th Flr.,West — (502 564-6930
275 East Main Street
Frankfort, Kentucky 40601

LOUISIANA

*
Governors Office — Secretary — William A. Cherry, M.D.
P. O. Box 44215, Capitol Station
Baton Rouge, Louisiana 70804

#
Office of Elder Affairs — Exec. Director — Mr. James L. Stovall
P. O. Box 44282, Capital Station
Baton Rouge, Louisiana 70804 — (FTS) 8-689-2747

MAINE

*
Department of Human Services — Commissioner — Mr. David E. Smith
State House
Augusta, Maine 04333

#
Bureau of Maine's Elderly — Director — Ms. Patricia Riley
Dept. of Human Services
State House — (207) 289-2561
Augusta, Maine 04333

MARYLAND

*#
Office on Aging — Director — Matthew Tayback, SC.D.
State Office Bldg. — (301) 383-5064
301 West Preston St.
Baltimore, Maryland 21201 — Deputy Director — Mr. Harry F. Walker
(301) 383-2100

MASSACHUSETTS

*#

Department of Elder Affairs 110 Tremont Street Boston, Mass. 02108	Secretary	Dr. Thomas H.D. Mahoney (617) 727-7750/7751/7752

MICHIGAN

*#

Office of Services to the Aging 300 East Michigan P. O. Box 30026 Lansing, Michigan 48909	Director	Mr. Peter Kok (517) 373-8230

MINNESOTA

*#

Minnesota Board on Aging 204 Metro Square Bldg. 7th & Robert Street St. Paul, Minnesota 55101	Chairman Exec. Secretary	Mr. Cy Carpenter Mr. Gerald A. Bloadow (612) 296-2544

MISSISSIPPI

*#

Council on Aging P. O. Box 5136 Fondren Station 510 George Street Jackson, Mississippi 39216	Exec. Director	Mr. Norman Harris (601) 354-6590

MISSOURI

*

Department of Social Services Broadway State Office Bldg. P. O. Box 570 Jefferson City, Missouri 65101	Director	Mr. James S. Walsh

#

Office of Aging Department of Social Services Broadway State Office Bldg. P. O. Box #570 Jefferson City, Missouri 65101	Director	Mr. David B. Monson (314) 759-3082

MONTANA

* Department of Social & Rehabilitation Services P. O. Box 1723 Helena, Montana	Director	Mr. Keith L. Colbo
# Aging Services Bureau Department of Social & Rehabilitation Services P. O. Box 4210 Helena, Montana	Chief	Ms. Holly Luck 8-587-5650

NEBRASKA

*# Commission on Aging State House Station 95044 Lincoln, Nebraska 68509	Chairman Exec. Dir.	Mr. Charles Evans Mr. James C. Wiley FTS: 8-967-2307 (402) 471-2307

NEVADA

* Department of Human Resources 505 East King Street Room 600 Carson City, Nevada 89710	Director	Mr. Michael L. Melner
# Division for Aging Services Department of Human Resources 505 East King Street Kinkead Bldg., Rm. 600 Carson City, Nevada 89710	Administrator	Mr. John B. McSweeney (702) 885-4210

NEW HAMPSHIRE

*# Council on Aging P. O. Box #786 14 Depot Street Concord, New Hampshire 03301	Chairman Director	Mr. Francis T. Malloy Mrs. Claira P. Monier (603) 271-2751

NEW JERSEY

*#

Division on Aging Dept. of Community Affairs P. O. Box 2768 363 West State Street Trenton, New Jersey 08625	Director	Mr. James J. Pennestri (609) 292-4833

NEW MEXICO

*#

State Agency on Aging Chamisa Hill Building 440 St. Michaels Drive Santa Fe, New Mexico 87501	Chairman Director	Mr. Clifford Whiting Mr. Ernesto Ramos (505) 827-2802

NEW YORK

*#

Office for the Aging Agency Bldg. #2 Empire State Plaza Albany, New York 12223	Chairman Director	Mr. Robert Popper Mrs. Lou Glasse (518) 474-5731
NEW YORK CITY FIELD OFFICE FYI 2 World Trade Center Rm. 5036 New York, New York	Administrator	Mr. Harold Scher (212) 488-6405

NORTH CAROLINA

*

Department of Human Resources Albermarle Bldg. Raleigh, North Carolina 27603	Secretary	Sarah T. Morrow, M.D. (919) 829-4534

#

Division of Aging Department of Human Resources 708 Hillsborough St., Suite #200 Raleigh, North Carolina 27603	Assistant Secretary	Mr. Nathan H. Yelton (919) 733-3983

NORTH DAKOTA

*
Social Services Board of N. D.
State Capitol Bldg.
Bismarck, North Dakota 58505

Exec. Director — Mr. T.N. Tangadahl
(701) 224-2310

#
Aging Services
Social Services Board of N. D.
State Capitol Bldg.
Bismarck, N D. 58505

Supervisor — Mr. Gerald D. Shaw
(FTS) 8-783-4011
224-2577

OHIO

*#
Commission on Aging
50 West Broad Street, 9th Fl.
Columbus, Ohio 43216

Chairman — Mr. A. Donald Campbell
Exec. Director — Mr. Martin A. Janis
(614) 466-5500/5501

OKLAHOMA

*
Department of Institutions
Social & Rehabilitative Services
P. O. Box #25352
Oklahoma City, Oklahoma 73125

Director — Mr. Lloyd E. Rader

#
Special Unit on Aging
Department of Institutions
Social & Rehabilitative Services
P. O. Box 25352
Oklahoma City, Oklahoma 73125

Director — Mr. Roy Keen
(405) 521-2281

OREGON

*
Human Resources Department
318 Public Service Bldg.
Salem, Oregon 97310

Director — Mr. Leo T. Hegstrom
(503) 378-3035

#
Office of Elderly Affairs
Human Resources Department
772 Commercial St., S. E.
Salem, Oregon 97301

Administrator — Mr. Robert S. Zeigen, Ph.D.
(FTS) 530-4728
(503) 378-4728

PENNSYLVANIA

* Department of Public Welfare Health & Welfare Bldg. Harrisburg, Penna. 17120	Secretary	Ms. Helen O'Banon
# Department of Aging Rm. 307 Finance Bldg. Harrisburg, Penna. 17120	Secretary	Mr. Gorham L. Black (717) 783-1550

PUERTO RICO

* Department of Social Services P. O. Box 11398 Santurce, Puerto Rico 00910	Secretary	Hon. Jenaro-Collazo-Collazo (809) 273-9834
# Gericulture Commission Dept. of Social Services P. O. Box 11398 Santurce, Puerto Rico 00910	Exec. Director	Ms. Alicia Ramiraz Suarez (809) 722-2429 (overseas operator)

RHODE ISLAND

*# Dept. of Elder Affairs 79 Washington Street Providence, Rhode Island 02903	Director	Mrs. Anna M. Tucker (401) 277-2858

SAMOA

*# Territorial Administration on Aging Government of American Samoa Pago Pago, American Samoa 96799	Director	Mr. Tali Maae Phone 9-0 (ask for Oakland overseas operator Samoa 3-2121)

SOUTH CAROLINA

*# Commission on Aging 915 Main Street Columbia, South Carolina 29201	Chairman Exec. Director	Dr. Ernest A. Finney Mr. Harry R. Bryan (803) 758-2576

SOUTH DAKOTA

*

Dept. of Social Services — Acting Secretary — Mr. Donald D. Foreman
Office of the Secretary
Richard F. Kneip Bldg. — (605) 773-3165
Illinois Street
Pierre, South Dakota 57501

\#

Office of Adult Services and — Administrator — Ms. Sylvia Base
and Aging
Division of Human Development — (FTS) 588-5500
Department of Social Services — 533-6422
Richard F. Kneip Bldg.
Pierre, South Dakota 57501

TENNESSEE

*\#

Commission on Aging — Acting Director — Mrs. Emily Wiseman
703 Tennessee Buildong
535 Church Street — (615) 741-2056
Nashville, Tennessee 37219

TEXAS

*\#

Governor's Committee on Aging — Coordinator — Mrs. Chris Kyker
Capitol Station
P. O. Box 12786 — (512) 475-2717
Austin, Texas 78711

TRUST TERRITORY OF THE PACIFIC

*\#

Office of Aging — Administrator — Ms. Leona Peterson
Community Development Division
Government of the Trust Territory — Overseas Operator
of the Pacific Islands — 9-0/2134
Saipan, Mariana Islands 96950

UTAH

*
Department of Social Services — Exec. Director — Dr. Tony W. Mitchell
221 State Capitol Bldg.
Salt Lake City, Utah 84102

#
Division of Aging — Director — Mr. F. Leon PoVey
Dept. of Social Services
150 West North Temple, 3rd Fl. — (FTS) 8-588-5500
Salt Lake City, Utah 84102 — (801) 533-6422

VERMONT

*
Agency of Human Services — Secretary — Sister Elizabeth Candon
103 South Main Street
Waterbury, Vermont 05676 — (802) 828-2471

#
Office on Aging — Director — Ms. Mary Ellen S. Spencer
103 South Main Street
Waterbury, Vermont 05676 — (FTS) 8-832-6501

VIRGINIA

*#
Office on Aging — Director — Ms. Wilda Ferguson
830 East Main St.
Suite #950 — (804) 786-7894
Richmond, Virginia 23219

VIRGIN ISLANDS

*#
Commission on Aging — Exec. Secretary — Mrs. Gloria M. King
P. O. Box 539
Charlotte Amalie — (809) 774-5884
St. Thomas, Virgin Islands 00801

WASHINGTON

*
Dept. of Social & Health Services — Secretary — Mr. Gerald J. Thompson
OB-44
Olympia, Washington 98504

#
Bureau of Aging — Director — Mr. Charles Reed
Dept. of Social & Health Services
OB-43G — (206) 753-2502
Olympia, Washington 98504 — FTS. 8-434-2502

WEST VIRGINIA

*#
Commission on Aging — Exec. Director — Mr. Raymond M. Leinbach
State Capitol — 304-348-3317
Charleston, West Virginia 25305

WISCONSIN

*
Department of Health & Social Services — Secretary — Mr. Donald E. Percy
State Office Bldg., Rm. 700
1 West Wilson St.
Madison 53703

#
Division on Aging — Administrator — Ms. Donna McDowell
Department of Health & Social Services
1 West Wilson St., Rm. 686 — (608) 266-2536
Madison 53703

WYOMING

*#
Office on Aging
Department of Health & Social Services — Manager — Mr. J. Atkins
Hathaway Bldg. 720 W. 18th ST — (307) 777-7561 (7986)
Cheyenne 82002 — FTS: 8-328-9561

NORTHERN MARIANA ISLANDS

Dept. of Community & Cultural Affairs — Administrator — Mr. Edward M. Cabrera
Commonwealth of the
Northern Mariana Islands
Civic Center, Susupe
Saipan, Mariana Islands 96950

APPENDIX VI

FY 1980 ALLOTMENTS FOR

STATE PLAN ADMINISTRATION

	%	$
Total 57 States	100.0000	$22,500,000
ALAB	1.66874	300000.
ALAS	0.05450	300000.
ARIZ	1.08399	300000. 1/
ARK	1.16210	300000.
CAL	9.39912	1560256.
COLO	0.97135	300000.
CONN	1.46513	300000.
DEL	0.23022	300000.
DC	0.29396	300000.
FLA	5.76703	957327.
GA	1.94951	323619.
HAW	0.29376	300000.
IDA	0.37129	300000.
ILL	5.01910	833171.
IND	2.31093	383615.
IOWA	1.50392	300000.
KANS	1.18416	300000.
KY	1.58012	300000.
LA	1.52722	300000.
ME	0.53731	300000.
MD	1.58732	300000.
MASS	2.86164	475033.
MICH	3.63823	603954.
MINN	1.84881	306902.
MISS	1.06284	300000.
MO	2.48371	412296.
MONT	2.34948	300000.
NEBR	0.79369	300000.
NEV	0.24797	300000.
NH	0.39147	300000.
NJ	3.48109	577861.
NM	0.43740	300000. 1/
NY	8.66200	1437894.
NC	2.29267	380684.
ND	0.32182	300000.
OHIO	4.67018	775251.
OKLA	1.42444	300000.
ORE	1.17777	300000.
PA	6.10370	1013215.
RI	0.49344	300000.
SC	1.08526	300000.
SD	0.35884	300000.
TENN	1.95835	325119.
TEX	5.18437	860606.
UTAH	0.42655	300000. 1/
VT	0.21852	300000.
VA	1.99129	330555.
WASH	1.64181	300000.
WVA	0.93206	300000.
WISC	2.21531	367742.
WYO	0.16057	300000.
PR	1.06801	300000.
GUAM	0.00898	75000.
TTER	0.02139	75000.
V.IS	0.01300	75000.
AMER	0.00350	75000.
N.MA	0.00259	75000.

1/ Amounts adjusted on Statement of Grant Award to represent transfers to Interstate Planning and Service Areas in Arizona, New Mexico, and Utah

Appendix VII

SOCIAL INTEGRATION OF OLDER PEOPLE - A
KEY TO THE 21st CENTURY
NATIONAL POLICY DEVELOPMENT
POLICY CONFERENCES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Illinois Institute of Technology	Nat'l Conf. on Constitutional and Other Legal Issues Relating to the Age Discrimination Act	90-AT-0008	$ 58,039
Legal Research and Services for the Elderly, Inc.	Nat'l Conf. on Abuse of Older Persons	90-AT-0007	55,138
Research Foundation of State University of New York	Health Issues of Older Women: A Projection for the Year 2000	90-AT-0021	20,941
University of Hawaii	Cross Cultural Sensitivity to the Needs of the Asian/Pacific Elderly	90-AT-0018	34,499
American Hospital Association	Role of Community Hospitals in Providing Appropriate Care for Older Person	90-AT-0009	55,578
American Psychological Association	Mini-Conf on Mental Health Needs of the Elderly	90-AT-0022	39,474
University of Nebraska at Omaha	Energy and the Elderly: A Policy Response	90-AT-0028	28,968
International Center for Social Gerontology	Nat'l Conf: Housing the Deinstitutionalized Mentally Ill	90-AT-0019	33,023
National Council of Senior Citizens	Conference Program on Key Issues Affecting the Elderly Poor	90-AT-0029	225,000
International Center for Social Gerontology	Symposium: WHCOA's as Potential Agents for Social Change	90-A-1799	63,921
To Be Awarded in FY 1981	Interagency Symposium on Mental Health and the Elderly (with NIMH		110,000
University of Wisconsin	Conference: Social Security and the Changing Roles of Women	SA-80-5292	4,000

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
National Coalition of Hispanic Mental Health and Human Services Organizations	National " Hispanic Blue Print for the 80's " Conference	90-AT-0030	4,000
National Institute of Advanced Studies	Regional White House Conference Support		1,200,000
Urban Elderly Coalition	Provision of Effective Planning, Support and Services for Urban Elderly and Network	90-AM-0004	35,000
Western Gerontological	White House Conf. on Aging Mini Conf: Impact of Changing Demographics on Corporations and National Conf. on Older Women	90-AM-0002	44,996
National Indian Council on Aging	1980 National Indian Conf. on Aging	90-AM-2192	40,000
National Center on Black Aged	National Center on Black Aged 1981 White House Conf. on Aging Mini Conf. Series on Black Aging	90-AM-2197	40,000
Asociacion Nacional Pro Personas Mayores	Mini White House Conf. on Hispanic Aging	90-AM-2196	40,000
Special Services for Group, Inc. (National Pacific Asian Elderly Resource Center)	Pacific Asian Mini Conf.	90-AM-2199	40,000
National Interfaith Coalition on Aging	National Symposium for Religious Sector Involvement in the White House Conf. on Aging	90-AT-0006	60,000
State Agencies on Aging (57 Awards)	White House Conf. on Aging		600,000
John Hopkins University	Maintaining State Activities for the White House Conference on Aging	90-AR-0030	9,000

POLICY RESEARCH AND DEMONSTRATIONS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Fall River Housing Authority	A Study of the Specialized Housing Needs of Diverse Groups	90-A-1651	$ 70,000
Portland State University	Transition from Work to Retirement Innovative Business Practices	90-AR-0021	75,000
Regents of the University of Michigan	Supporting Facilities for Research and Policy Development and Evaluation of the Field of Aging	90-A-1279	267,000
Hunter College	The Older Job Seeker: Barriers and Supports in Job Search	90-AR-0020	133,000
University of Iowa	Analysis of Factors Influencing the Housing Choices of Older People	90-AR-2118	3,000
Hunter College (CUNY)	Seasonal Vulnerability of the Old and Cold	90-AR-0010	66,000
Urban Institute	Impact of Inflation on Income and Expenditures of Older Americans	90-AR-2125	80,000
Urban Institute	Impact of Suburbanization on the Needs of Older Americans	90-A-1366	132,000
University of California	Fiscal Crisis and Tax Revolt: Impact on Aging Services	90-AR-0016	195,000
Wisconsin State Department of Health and Social Services	Home Equity Conversion Project	90-AR-0001	139,000
Hebrew Rehabilitation Center for Aged	Nationwide Study of Domiciliary Care	90-A-1659	185,000
Massachusetts Institute of Technology	Determinats of Housing Choice Among Elderly: Policy Implications	90-AR-2116	10,000

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RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
American Association of Community and Junior College	Community College Demonmonstration Project to Increase Small Business Ownership and Employment Opportunities for Older Persons	90-AD-0003	249,985
Gerontological Society	National Research Conference on Technology and the Aged	90-AR-0025	141,000

POLICY CENTERS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Southern California	National Aging Policy Study Center on Employment and Retirement	90-AP-0002	$ 159,955
National Council on Aging	NAPSC on Education, Leisure and Continuing Opportunities for Older Persons	90-AP-0001	159,976
University of Maryland	NAPSC for the Study of Women and Aging	90-AP-0006	159,597
Brandeis University	NAPSC on Income Maintenance	90-AP-0005	159,991
University of California	NAPSC on Health	90-AP-0003	159,892
Universtiy of Michigan	NAPSC on Housing and Living Arrangements for Older Americans	90-AP-0004	160,000

Appendix VIII

INDIVIDUAL RIGHTS AND RESPONSIBLITIES
GRANTS TO STATE AGENCIES ON AGING TO
PROVIDE SPECIALIZED STAFF TO DEVELOP
AND SUPPORT ADVOCACY AND LEGAL SERVICES
IN EACH AAA IN THE STATE

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Alabama	Advocacy Assistance Grant		$ 50,000
Arizona	" "		50,000
Colorado	" "		41,500
Connecticut	" "		45,042
Delaware	" "		50,000
District of Columbia	" "		50,000
Florida	" "		76,000
Idaho	" "		100,000
Illinois	" "		73,000
Indiana	" "		50,000
Kansas	" "		50,000
Louisiana	" "		50,000
Maine	" "		46,000
Maryland	" "		50,000
Massachusetts	" "		50,000
Minnesota	" "		50,000
Missouri	" "		50,000
Nebraska	" "		50,000
Nevada	" "		50,000
New Hampshire	" "		47,700
New Jersey	" "		50,926
North Dakota	" "		32,000
Ohio	" "		68,535

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Oklahoma	Advocacy Assistance Grant		50,000
Oregon	" "		100,000
Rhode Island	" "		49,000
South Carolina	" "		50,000
South Dakota	" "		18,000
Tennessee	" "		47,000
Texas	" "		33,000
Utah	" "		42,000
Vermont	" "		50,000
Washington	" "		100,000
Wisconsin	" "		50,000
American Samoa	" "		22,000
Puerto Rico	" "		50,000

BI-REGIONAL ADVOCACY ASSISTANCE
CENTERS TO PROVIDE SPECIALIZED
TRAINING AND ASSISTANCE TO STATE AND
AAA LEGAL SERVICES PROGRAMS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Michigan Institute of Gerontology Ann Arbor, Michigan	Bi-Regional Advocacy Assistance Resource and Support Center Regions V and VII	HEW-105-79 3003	415,806
National Paralegal Institute Washington, D.C.	Bi-Regional Advocacy Assistance Resource and Support Center Regions III and IV	HEW-105-79 3002	627,182
National Paralegal Institute of California San Francisco, California	Bi-Regional Advocacy Assistance Resource and Support Center Regions IX and X	HEW-105-79 3005	428,706
Boston University Boston, Massachusetts	Bi-Regional Advocacy Assistance Resource and Support Center Regions I and II	HHS-165-80 C-013	495,000
Center for Public Interest Alston, Texas	Bi-Regional Advocacy Assistance Resource and Support Center, Regions VI and VIII	HHS-105-80 -C-043	460,630

NATIONAL LEVEL GRANTS TO DEVELOP
TRAINING MATERIALS AND RESEARCH AREAS
OF LAW OF PARTICULAR CONCERN TO THE
ELDERLY

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Legal Services Corporation	National Support System for Advocacy Assistance Initiative	90-AD-0002	$ 379,150
National Citizens Coalition for Nursing Home Reform	Community Involvement in Improving the Nursing Home System	90-A-1821	240,970
American Bar Association	Bar Activation Project for the Elderly	90-AD-0001	80,638
Colorado Congress of Senior Organizations	Cooperative Senior Advocacy Project	8-AD-0007	6,666

Appendix IX

SERVING THOSE IN NEED - JOINING PUBLIC AND PRIVATE SECTORS

IMPROVING SYSTEMS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
County of L.A. - Area Agency on Aging	Community Analysis Techniques	90-A-1328	80,000
University of California	Self-Help and Advocacy for the Underserved Elderly	90-AR-0013	99,000
Scientific Analysis Corporation	Services to the Elderly Under Title XX: An Analysis of National Trends 1975-1979	90-A-1677	62,000
University of California, San Francisco	Study of the Interactions between Health Planning Agenices & AAA's	90-AR-0028	190,000
University of Kentucky	AAA's and the Provision of Mental Health Services for the Elderly	90-AR-0026	143,000
Portland State University	Effective Community Intervention for the Elderly	90-AR-0019	160,000
University of California, San Francisco	Funding Practices, Policies, and Performance of SUAs and AAAs	90-A-979	142,000
State of Texas, Governor's Committee on Aging	Texas Management Information System Project	90-AM-0008	52,650
New York State Office for Aging	An Integrated Statewide Infor-System for Aging Services in N.Y.	90-AM-0010	85,015
State of Connecticut, Dept of Aging	Model Statewide Service Data Reporting System	90-AM-0007	125,475
Ohio Commission on Aging	Ohio Aging Services Information System	90-AM-0009	85,240
Jefferson County, Alabama, Office of Senior Citizens Activities	Service Data Reporting System	90-AM-0011	97,494
Urban Health Institute, East Orange, N.J.	Experimental AAA/HSA Integration Project	90-A-1183	87,108
University of Illinois	Data Base Development for State Agencies on Aging	90-A-1603	90,000
The Assistance Group, Silver Spring, Maryland	Comprehensive Care System for Older People	90-A-1618	302,208
National Association of State Units on Aging	Aging Units Information System Project - Codifying and Disseminating Information	90-A-1657	70,000

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of D.C.	Yoga Relaxation - Meditation as Preventive Health Care	90-AR-2056	16,000
University of Michigan	Changing Properties of Retirement Communities	90-AR-0011	137,000
Mid Peninsula Health Services, Palo Alto, CA	Comprehensive Community Day Care Program for Frail Elderly	90-A-1836	120,621
Waxter Center, Baltimore, Maryland	Senior Center Care System	90-A-1820	165,048
Northern Kentucky Mental Health Retardation Regional Board, Covington, KY	The PIAC Senior Center	90-A-1607	79,794
Foundation for Comprehen-Health Services, Sacramento California	Model Medical and Health Care System for the Older Citizen of Sacramento	90-A-1610	128,000
Jamaica Service: Program for Older Adults, Inc. Jamaica, New York	Local CCS and Management Demonstration Project	90-A-1615	227,235
National Council on the Aging, Washington, D.C.	The Senior Center and the Community Care System	90-A-1736	89,336
University of Washington, Seattle, Washington	Service Demonstration Social Services to Low Income Elderly	90-A-1822	141,263
National Council on the Aging, Washington, D.C.	National Voluntary Organizations for Independent Living for the Aged	90-A-1184	162,250
Benjamin Rose Institute	Effects on Families of Caring for Impaired Elderly in Residence	90-AR-2112	46,000
Brandeis University	Decision Making for Home Care	90-A-1679	140,472
Philadelphia Corporation on the Aging, Philadelphia, Pa.	Service Management and In-Home Services for Frail Elderly	90-A-1081	178,596
Soma Clinic, Cambridge Massachusetts	Resocialization of Older Persons in the Older Role	90-A-1641	204,846
Community Social Services of Miami Valley	Adult Foster Living Project, Xenia, Ohio	90-A-1829	131,769
New York City Housing Authority, New York	Senior Resident Advisor Program -2a	90-A-1639	139,547

IMPROVING COMMUNITY SERVICES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Southern California	Alternative Designs for Comprehensive Service Delivery to the Elderly	90-A-1280	138,000
University of Michigan	Simulated Site Visits: Preparation for Relocation	90-AR-2059	600
Institute of Public Administration	Improving Transportation for Elderly: Study of Problems and Potential	90-AR-2114	10,000
Center for Studying Social Welfare and Community Development	Subsidized Taxi Programs	90-AR-0007	24,000
Human Services Coordination Alliance	Building Client Capacity to Access and Utilize Services	18-P-00158	272,000
University of Pennsylvania	Data Base on Emerging Services and the Elderly	90-A-1658	118,000
Miami Jewish Home and Hospital, Miami, Florida	Service Worker for Aged in Trouble	90-A-1835	179,534
The Caring Community, New York, Inc.	A Model in Community Integration	90-A-1815	98,516
Georgetown University	Maintaining the Elderly in the Community	90-A-1381	162,000
American Dietetic Association	Food Technologies and Service System and Technical Assistance for Nutrition Program	90-AR-0018	108,000
National Center on Black Aged	Community Revitalization as Perceived by Resident Older Persons	90-AR-0009	34,000
University of California	Effects of Retirement on the Utilization of Health Services	90-A-1669	14,000
Temple University	Assessment of Recent AoA Demonstrations: Social and Community Services	90-AR-0023	112,000
Temple University	Analysis and Dissemination of Community Care Systems Demonstration Results	90-AR-0004	146,000

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Washington, Seattle, Washington	Community-Based Comprehensive Care for the Elderly	90-A-1817	193,802
Columbia University	Cross National Study of Cost Benefits of Alternative Service Treatment Modalities	90-A-1649	205,000
Philadelphia Geriatric Center	Changing Service Needs of Older Tenants	90-AR-0006	138,000
University of Chicago	Nursing Home Information Dissemination Project	90-AR-0029	40,000
American Association of Homes for the Aging	Resident Participation in Governance of Homes for the Aging	90-A-0017	160,000
Community Research Applications	Cost Effect and Benefits Associated with Domiciliary and Intermediate Care	90-A-1672	153,000
Columbia University	Characteristics of Institutions Successful in Promoting Innovative Programs for the Aged	90-AR-0005	115,000
Southwest Mississippi AAA	Clairborne County Demonstration Rural Elderly Housing Project	90-AM-2126	20,500
Area Agency on Aging of Western Michigan	Lake County Congregate Housing Demonstration Project	90-AM-2129	60,000
South Dakota Department of Social Services	To Provide service to residents of Congregate Housing Project in Charles Mix County	90-AM-2134	55,000
Eastern Oregon County Development Council	Support Services to FmHA/AoA Sponsored Demonstrations Congregate Housing for Rural Elderly	90-AM-2135	50,171
Eastern Shore Community Development Group (Virginia)	Support Service for Congregate Housing for Elderly in Accomack	90-AM-2128	40,793

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Rio Grande Council of Governments, Area Agency on Aging (New Mexico)	Elderly Congregate Housing Project	90-AM-2130	30,359
Southern Iowa Council of Governments, Area XIV Agency on Aging	Congregate Housing Demonstration Program	90-AM-2131	85,000
New Hampshire State Council on Aging	Carrol County Rural Congregate Housing Demonstration	90-AM-2132	26,985
County of Riverside Office on Aging (California)	A Program of Supportive Services for a Rural Congregate Housing	90-AM-2133	-0-
Chautaugua County Office for the Aging (New York)	Congregate Housing for the Elderly (Supportive Services)	90-AM-2127	-0-

STRENGTHENING FAMILY SUPPORT

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Southern California	A Youth Support System for the Frail Elderly	90-AR-2191	$ 71,000
National Bureau of Economic Research	Measurement of Intrafamily Transfers and their Effects on Individual Behavior	90-AR-2119	8,000
Fordham University	The Impact of the Entry of the Formal Organization on Existing Informal Networks of Older Americans	90-A-1329	145,000
Hebrew Rehabilitation Center for the Aged	A Study of Informal Support Network of the Needy Elderly	90-A-1294	118,000
Dartmouth College	Demonstration of Self-Help Approach to the Coordination of Human and Health Services	90-AR-1949	141,000
University of Michigan, Ann Arbor, MI	Development and Evaluation of Community-Based Support Groups for Families of Aged Persons	90-A-1608	79,000
Community Service Society of New York, New York, N.Y.	Natural Supports Program Community Development Groups	90-A-1609	150,802
University of Michigan, Ann Arbor, MI	Peer Support System	90-A-1617	33,733
Department of Elderly Affairs, Providence, R.I.	Family and Community Support System Project	90-A-1813	95,835
University of Maryland Baltimore, Maryland	A Controlled Trial of Caregiver Training for the Elderly Impaired in Urban and Rural Settings	90-A-1824	193,428
New York University School of Medicine, N. Y., N. Y.	Providing a Missing Link in the Chain of Support Systems	90-A-1825	146,428

STRENGTHENING FAMILY SUPPORT (CONT.)

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Southern California, Wash., D.C.	Requisites for Neighborhood Capacity Building	90-A-1830	$ 88,325
Franklyn/Hampshire CMHC	Natural Support System of the Non-Institutionalized Rural Elderly	90-A-1834	89,550

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Cherokee Nation of Okla.	Title VI	AI-8	$ 65,000
Mescalero Apache Tribe	"	AI-27	65,000
Citizen Band Potawatomi	"	AI-25	70,000
Pueblo of Laguna	"	AI-29	70,000
Osage Tribe of Oklahoma	"	AI-31	100,000
Jicarilla Apache Tribe	"	AI-34	65,000
Seminole Nation of Okla.	"	AI-35	75,000
Pueblo of Zuni	"	AI-38	87,500
Seneca-Cayuga Tribe of Oklahoma	"	AI-41	70,000
Pueblo of Isleta	"	AI-42	65,000
San Juan Pueblo Tribe	"	AI-45	70,000
Santa Clara Pueblo	"	AI-47	65,000
The Chickasaw Nation	"	AI-53	65,000
Eight Northern Indian Pueblos Council	"	AI-54	65,000
Creek Nation of Oklahoma	"	AI-59	100,000
Miami Tribe of Oklahoma	"	AI-63	80,000
Six Sandoval Indian Pueblos, Inc.	"	AI-67	87,500
Quapaw Tribe of Oklahoma	"	AI-71	75,000
Otoe-Missouria Tribe	"	AI-75	70,000
Pawnee Tribe of Oklahoma	"	AI-77	80,000
Kickapoo Tribe of Okla	"	AI-78	100,000
Pueblo of Taos	"	AI-82	75,000
Santo Domingo Tribe	"	AI-87	70,000

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
The Kiowa Tribe of Oklahoma	Title VI	AI-88	$ 70,000
Omaha Tribe	"	AI-16	70,000
Prairie Band of Potawatomi	"	AI-20	65,000
Santee Sioux Tribes	"	AI-7	65,000
Kickapoo Tribe of Kansas	"	AI-60	65,000
United Tribe of Kansas and Southeast Nebraska Inc.	"	AI-76	65,000
Confederated Salish & Kootenai Tribes	"	AI-13	70,000
Standing Rock Sioux Tribe	"	AI-22	65,000
Yankton Sioux Tribe	"	AI-26	65,000
Northen Cheyenne Tribe	"	AI-39	65,000
Southern Ute Community	"	AI-57	65,000
Assiniboine and Sioux Tribes	"	AI-85	65,000
Blackfeet Tribe	"	AI-55	70,000
Uintah and Ouray	"	AI-58	70,000
Chippewa-Cree Tribe	"	AI-62	70,000
Ute Mountain Ute Tribe	"	AI-66	70,000
Cheyenne River Sioux Tribe	"	AI-70	65,000
Oglala Sioux Tribal	"	AI-83	70,000
Hupa Health Association	"	AI-12	70,000
White Mountain Apache Tribe	"	AI-17	70,000
Salt River Indian Community	"	AI-4	65,000
Papago Tribe	"	AI-28	70,000

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
The Navajo Tribe	Title VI	AI-3	$ 70,000
Pascua Yaqui Tribe	"	AI-30	70,000
Inter-Tribal Council & Nevada, Inc.	"	AI-32	65,000
San Carlos Apache Tribe	"	AI-46	65,000
Hopi Tribal Council	"	AI-73	75,000
Washoe Tribe of Nevada & California	"	AI-79	65,000
Shoshone-Bannock Tribe	"	AI-11	70,000
South Puget Intertribal	"	AI-21	70,000
North West Washington	"	AI-5	70,000
Ketchikan Indian Corp.	"	AI-2	65,000
Yakima Indian Nation Area Agency on Aging	"	AI-40	65,000
Lower Elwha Tribal Council Tribal Elders Program	"	AI-43	65,000
Quinault Indian Nation	"	AI-44	65,000
Puyallup Tribal Health Authority	"	AI-56	75,000
Kodiak Area Native Assoc.	"	AI-9	70,000
Confederated Tribes of the Umatilla Indian Res.	"	AI-33	75,000
Muckleshoot Indian Tribe	"	AI-49	65,000
Lummi Indian Business Council	"	AI-64	70,000
Colville Confederated Tribes	"	AI-65	70,000

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REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Passamaquaddy Tribe	Title VI	AI-81	$ 65,000
Tonawanda Band of Senecas	"	AI-61	65,000
Mississippi Band of Choctaw Indians	"	AI-48	75,000
Eastern Band of Cherokee Indians	"	AI-52	70,000
Keweenaw Bay Indians	"	AI-14	65,000
Inter-Tribal Council of Michigan	"	AI-19	70,000
Stockbridge-Munsee	"	AI-15	70,000
Red Cliff Band of Lake Superior	"	AI-18	65,000
Wisconsin Winnebago Business Community	"	AI-24	70,000
Mille Lacs Reservation Business Community	"	AI-10	70,000
Bad River Tribe	"	AI-36	65,000
Red Lake Band of Chippewa Indians	"	AI-37	75,000
Menominee Indian Tribe of Wisconsin	"	AI-51	65,000
St. Croix Tribal Council	"	AI-89	65,000
Sault Ste. Marie Tribe of Chippewa	"	AI-68	70,000
Foud du Lac Reservation Business Committee	"	AI-69	70,000
Lac Courte Oreilles Tribal Governing Board	"	AI-80	70,000
Choctaw-Nation Of Oklahoma	"	AI-23	100,000
Pueblo of Acoma Tribal	"	AI-6	70,000

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Eastern Washington Indian Consortium	Title VI	AI-84	$ 70,000
Nez Perce Tribe of Idaho	"	AI-86	70,000

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
California State University	The Minority Elderly: "Equal Opportunity" Myth or Reality	90-A-1665	$ 14,000
International Institute of L. A.	Spanish Language Research Project for Older Persons	90-AR-0003	138,000
Asociacion Nacional Pro Personas Mayores	Hispanic Support Systems and the Chronically Ill Older Hispanic	90-AR-0014	192,000
University of Michigan	Factors Impacting on the Well-Being of Elderly Black Women	90-AR-2183	800
National Center on Black Aged	Informal Social Networks in Support of Elderly Blacks in the Black Belt	90-A-1290	23,000
San Diego State University Foundation	Codification of Research on Minority Elderly	90-AR-0022	184,000
National Indian Council on Aging	National Advocacy to Assist Access of Older American Indians to Services and Entitlements of the Older Americans Act and Other Public Programs	90-AM-2192	336,398
National Center on Black Aged	National Aging Organization Projects Program	90-AM-2197	349,857
Asociacion Nacional Pro Personas Mayores	Project "Mano A Mano"	90-AM-2198	349,052
Special Service for Groups	Pacific/Asian Elderly Coalition	90-AM-2199	284,692
The Mexican-American Community Agency	The Hispanic Service Advocate Program (HSAP)	HAS-210	107,000
New Mexico State Agency on Aging	Economic and Resource Development Activities for Elderly New Mexicans	HAS-202	60,000
Amigos Del Valle	Amigos Del Valle Information and Referral Model Project to Increase Hispanic Access to Service	HAS-212	85,000

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Little Havana Activity Center	Hispanic Opportunities Program	HAS-201	$ 60,000
Amigos De Valle - Phar, Texas	Resocialization and Rehabilitation of High Risk Elderly	90-A-1091	133,103
New York City Department for Aging, NYC, NY	Minority Service Enhancement Proj.	90-AM-204	80,000
Area Agency on Aging, Region I, Phoenix, AZ	Centro de Los Ancianos	09-AM-030	80,000
Area Agency County of San Diego, California	Prototype for Area Agency on Aging	09-AM-029(01)	130,000
Inter Tribal Council of Arizona, Phoenix, AZ	Alternative Models for Operation Comprehensive, Coordinated Services to Elderly on Indian Reservations	09-AM-028	54,617
University of Louisville Foundation, Louisville, KY	Community Education Model for Network Building Among Minority Elderly	90-A-1826	89,814

SPECIAL POPULATIONS AND SPECIAL PROBLEMS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
American Foundation for the Blind	Uses of Self-Help and Mutual Aid in Compensating for Sensory Changes in Old Age	90-AR-0012	$ 101,000
Metropolitan Commission on Aging of Syracuse and Onandago County, New York	Demonstration Project on Elderly Abuse	AT-2A57-A	66,000
Rhode Island Department of Elder Affairs	Elder Abuse Program	01AM-00017	55,000
Mon Valley Health and Welfare Council, Inc. Monessen, Pa.	Community Support Systems for Rural Frail Elderly	03-AD-204	83,447
Area Agency on Aging V. Lacrosse, Wisconsin	Rural Western Wisconsin Service Delivery System	WI-0-244	51,712
Illinois Department on Aging Springfield, Il.	Rural Day Care for Elders	IL-0-0264	73,355
Gateway Area Development District Owingsville, KY	Gateway Focus on Elderly Health & Social Services Rural Elderly	04-AMO-0305	47,523
New York State Office for Aging, Albany, NY	Rural Aging Services Project	90-AMO-012	83,488
Luthern Welfare Services of NE Pennsylvania	Hospice Demonstration Project	90-A-1828	160,000
Seattle King County Div. on Aging, Seattle, Washington	Pacific/Asian Elderly Service Development Project	10AG-0009(01)	118,213
Denver Regional Council of Governments	Model to provide access to medical care and social services for Immigrant Elderly	8-AM-8 (01)	60,000
North Central Regional Planning Commission, Ridgeway, Pennsylvania	Health Education and Social Services	90-A-1511	100,000
Santa Monica Hospital Medical Center for the Partially Sighted, Santa Monica, CA.	Comprehensive Community Care System Partially Sighted Older Persons	90-A-1600	97,213

SPECIAL POPULATIONS AND SPECIAL PROBLEMS (CONT.)

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Hospice of the Valley, Phoenix Arizona	Hospice Project Core	90-A-1612	$ 100,000
Hospice of Santa Barbara, CAL	Hospice Outreach Program Elderly Terminally Ill	90-A-1827	126,121
University of Michigan, Lansing, Michigan	Capacity Building on Mental Health and Substance Abuse	90-A-1818	93,678
Continental Asso. Funeral & Memor. Societies, Inc. Washington, D. C.	Model Consumer Education Project and Funeral & Burial Costs	90-A-1816	77,000
Ohio State School for the Deaf Alumni (Columbus Colony) Westerville, Ohio	Providing for the Elderly Deaf in Total Community Planning	90-A-1640	167,000
U.S. Conference of Mayors	Project TEAM - (Techniques for Effective Administration and Management in Aging)	90-AM-5	181,733
National Association of Counties Research Inc.	County Resource Development for Older Americans	90-AM-3	119,779
United Neighborhood Centers of America	Improving Programs and Services to the Elderly	90-AM-6	74,984
Western Gerontological Society	Mobilizing Resources for Under-served Elders	90-AM-2	175,231
Urban Elderly Coalition	Urban Elderly National Aging Program	90-AM-4	162,920
National Association of State Units on Aging	State and Area Agency Planning and Program Development	90-AM-1	378,995
Commonwealth of Massachusetts Department of Elder Affairs	Massachusetts Elder Abuse Project	01AM-000018	125,000

Appendix X

LONG TERM CARE - MOVING TOWARD A CONTINUUM OF CARE FOR THE FUNCTIONALLY DISABLED

LONG TERM CARE GERONTOLOGY CENTERS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Southeastern New England LTCGC, Brown University Providence, R.I.	Long Term Care Gerontology Center	90-AT-2164	$425,000
UCLA/USC LTCGC Los Angeles, Calif.	"	90-AT-2167	$424,839
Columbia University Center for Geriatrics & Gerontology New York, N.Y.	"	90-AT-2155	$425,000
Suncoast Gerontology Center for Health and LTC, Univ. of South Florida, Tampa, Florida	"	90-AT-2157	$424,996
Univ. of Washington LTCGC Seattle, Washington	"	90-AT-2152	$424,692

LTC GERONTOLOGY CENTERS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Arizona Tucson, AZ.	Long Term Care Gerontology Center	90-AT-2166	$109,652
Benjamin Rose Institute Cleveland, Ohio	"	90-AT-2153	$103,032
University of Kansas College of Health Sciences & Hospital, Kansas City, KAN.	"	90-AT-2154	$105,842
State University of New York - LTC Consortium Syracuse, N.Y.	"	90-AT-2158	$109,652
Univ. of Arkansas for Medical Sciences, Little Rock, Ark.	"	90-AL-0005	$145,127
Duke Univ. Medical Center Durham, N.C.	"	90-AL-0001	$155,000
Mcharry Medical College Nashville, TN.	"	90-AL-0007	$154,858
Univ. of Oregon Health Sciences Center, Portland, Oreg.	"	90-AL-0002	$154,999
Univ. of Pittsburgh Pittsburgh, Pa.	"	90-AL-0004	$153,031

LTC GERONTOLOGY CENTERS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Univ. of Tennessee for Health Sciences Memphis, TN.	Long Term Care Gerontology Center	90-AL-0003	$150,968
Virginia Center on Aging Virginia Commonwealth Univ., Richmond, Va.	"	90-AL-0006	$153,762
Association of American Medical Colleges	Coordination and Support for LTC Centers	90-AL-0009	$339,822
ELM	Technical Assistance To LTC Centers		$ 63,000

GERIATRIC FELLOWSHIPS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of California at Los Angeles	Geriatric Fellowship Program	90-AT-2050	$100,000
Mt. Zion Hospital & Medical Center San Francisco, Ca.	"	90-AT-2049	$100,000
Harvard Univ. Medical School	"	90-AT-2051	$100,000
Boston Univ. School of Medicine	"	90-AT-2054	$100,000
Duke Univ. Medical Center	"	90-AT-2053	$100,000
University of Washington	"	90-AT-2052	$ 85,361

CHANNELING DEMONSTRATIONS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
1) State of Florida	Channeling Demonstration Project		932,896
2) State of Hawaii	"		850,000
3) State of Kentucky	"		1,009,085
4) State of Maine	"		780,270
5) State of Maryland	"		976,778
6) State of Massachusetts	"		691,499
7) State of Missouri	"		765,061
8) State of New Jersey	"		985,534
9) State of New York	"		729,693
10) State of Ohio	"		903,883
11) State of Pennsylvania	"		1,025,310
12) State of Texas	"		759,015
	Jointly funded with HCFA AoA Total		5,385,243
Mathematica Policy Research	Evaluation of the National LTC Channeling Demonstrations		2,414,260
Temple University	Technical Assistance to National LTC Channeling Demonstration Projects		750,000

STATE SYSTEM DEVELOPMENT

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
California/Hlth. & Welfare Agency	State System Development Grant	90-AS-0010	$115,000
Delaware/Dept. of Hlth. & Social Services	"	90-AS-0011	83,467
Illinois/Dept. of Public Aid	"	90-AS-0008	104,549
Idaho/Office of Aging	"	90-AS-0004	91,560
Colorado/Dept. of Social Services	"	90-AS-0005	100,282
Washington/Dept. of Hlth. & Social Services	"	90-AS-0014	110,905
Oregon/Dept. of Human Resources	"	90-AS-0007	100,126
Minnesota/Dept. of Hlth.	"	90-AS-0013	115,000
Rhode Island/Dept. of Social & Rehabilitation Services	"	90-AS-0001	99,505
Wisconsin/Dept. of Hlth. & Social Services	"	90-AS-0006	96,457
Arkansas/Office on Aging	"	90-AS-0009	81,170
District of Columbia/Dept. of Human Services	"	90-AS-0015	85,000
S. Dakota/Dept. of Hlth.	"	90-AS-0003	100,924
N. Carolina/Dept. of Human Resources	"	90-AS-0002	110,000
New Hampshire/Division of Welfare	"	90-AS-0012	84,168
Arkansas Office on Aging Little Rock, Ark.	Service Management/Screening Project	90-A-1737	200,680
Pennsylvania Office for the Aging Harrisburg, PA.	Long Term Care Planning and Development	90-A-1598	90,000

STATE AND COMMUNITY MODEL BUILDING

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Grace Hill Neighborhood Health Center St. Louis, Missouri	AoA/HSA Demonstration Project	90-AR-2090	$ 99,944
East Harlem Council for Human Services New York, N.Y.	"	90-AR-2092	-0-
Providence Ambulatory Health Care Foundation Providence, R.I.	"	90-AR-2089	$100,000
District of Columbia General Hospital	"	90-AR-2091	-0-
Centro de Salud de la Communidad de San Ysidro	"	90-AR-2088	$ 94,500
Yakima Indian Nation Area Agency on Aging Toppenish, Washington	"	90-AR-2094	$ 84,306
Cherokee Nation Health Department Tahlequah, Oklahoma	"	90-AR-2095	$ 53,924
Navajo Tribe Fort Defiance, Arizona	"	90-AR-2093	-0-
U.S. PHS Hospital Baltimore, Maryland	"		$100,000
U.S. PHS Hospital Brighton, Mass.	"		$100,000
U.S. PHS Hospital Seattle, Washington	"		$ 95,406
On Lok Senior Health Services	On Lok Community Care Organization for Dependent Adults	18-P-00156	$248,000

STATE AND COMMUNITY MODEL BUILDING

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Monroe County, Inc Program, Inc. Rochester, N.Y.	Extending Access	90-A-1602	$176,400
Oregon Department of Human Resources Salem, Oregon	Oregon Senior Resources Continuum Demonstration	90-A-1606	$148,781
Senior Citizens Services Inc. Memphis, Tn.	Deinstitutionalization Program	90-A-1619	$177,069
Edgerton Medical Research Foundation Wichita, Kansas	Adult Restorative Services	90-A-1620	$107,717
Mental Health Program Inc. Boston, Mass.	Geriatric Assessment and Resource Center Model Project	90-A-1621	$174,300
Pima County Board of Supervisors Tucson, AZ.	Community Services Program	90-A-1643	$244,748
Multidisciplinary Gerontology Center of Iowa, Ames, Iowa	The Assessment and Evaluation of the Functionally Dependent Elderly: A Community Project	90-A-1645	$150,000
Family Hospital Milwaukee, Wis.	Wisconsin Regional Geriatric Center	90-A-2186	$ 88,000
NYC Dept. for the Aging New York, N.Y.	The Delivery of Medical Social Services to the Home Bound Elderly: A Demonstration of Intersystem Coordination	90-AM-2187	$329,000

POLICY FORMULATION AND INFORMATION EXCHANGE 338,000

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
National Conference on Social Welfare	Knowledge Dissemination on Long Term Care	90-AL-0008	$338,283

Appendix XI

IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Florida	Focusing on Training for Careers in Services to the Frail & Vulnerable Elderly	04AG000017	101,111
University of So. Florida	Career Training for Community Services Administrators in Gerontology	04AG000009	92,360
Georgia State University	Community Geron Specialists Training	04AG000008	138,036
Duke Medical Center	Multidisciplinary Prep for Careers in Geriatric Care	04AG000006	120,717
Memphis State University	University-wide Degree Program in Human Services Aging	04AG000019	48,958
University of Michigan	Gerontology Career Preparation Program	AA00P MI902	145,741
Wayne State University	same as above	AAGCPM19	150,889
Maimi University	Multiple Career Tracks for Working with Older American		120,469
Ohio University	Gerontology Career Prep Pgm	AACCPOM902	106,460
No. Texas State University	Same as above	6AG133	117,200
University of Texas at Arlington	Training of Personnel in Service Delivery to the Mexican-American Elderly	6AG138	123,841
University of Rhode Island	Specialized Career Training in Aging	o1AT000005	95,844
Rutgers University	Same as Above	AT2A36B	135,487
Hunter College	Geron Career Preparation	H2A41B	137,131

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IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Syracuse University	Geron Career Preparation	AT2A42-B	141,498
University of Maryland Center on Aging	Same as Above	03AT106	125,390
Pennsylvania State University	Multidisciplinary Training for Specialized Careers in Aging Services	03AT101	117,786
Temple University	Gerontology Career Prep.	09AT110	109,082
University of Pennsylvania	Same as Above	03AT104	113,957
Virginia Commonwealth	Same as Above	08AT106	116,074
University of District of Columbia	Multidisciplinary Undergraduate & Graduate Career Training	08AT112	115,045
West Virginia University	Multidisciplinary Geron Career Training in the Rural Setting	03AT111	90,435
University of Alabama	Geron. Career Prep	04AG000015	112,632
Wichita State University	Same as Above	90AT2194	82,550
University of Utah	Integrated Geriatric/Geron Curriculum in the Health Sciences	8AT2	93,107
Dan Diego State University	Career Prep with an Emphasis on Serving the Minority Elderly	09AT015	124,197
University of Calif.	Training Program in Multidisciplinary Applied Geron.	09AG014	104,673
Oregon State University	Geron Career Preparation	10AT0003	132,893

IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Oregon	Geron Career Preparation	10AT0002	117,731
University of Washington	" " "	10AT0001	137,276
University of So. California	" " "	09AT021	
University of Massachusetts	Development for Careers in Gerontology	01AT000004	152,051
National Center for Black Aged	Capacity Building for Minority Institutions in Geriatrics & Gerontology	08AT100	174,488
Norfolk State University	Geron Career Preparation	08AT113	95,325
University of Alabama in Birmingham	" " "	04AG00005	162,872
University of Kansas/Kansas State U	Kansas Consortium	07AT0179	156,411
University of Missouri/Joint Centers on Aging Studies	Gerontology Career Prep.	07AT0180	95,585
Northeastern California Higher Education Council	Model Gerontological Training for Rural Areas	09AT017	113,418
University of Hawaii	Geron Career Preparation	09AT019	170,000
University of Connecticut	Training Program to Train Social Work Students for Career in Aging	01AT000003	77,537
Brandeis University	Training for Policy and Management Careers in Aging	01AT000001	114,151

IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
New York University	Medical Training in Geriatrics and Geron - A Decol Approach	H2A38B	98,878
University of MD. School of Medicine	Physical Therapy Training to Care for the Vulnerable Elderly: An Operational Model	03AT102	84,935
University of MD. School of Social Work and Community Planning	Specialization in Aging Administration	03AT108	101,692
George Washington University	Service Providers Legal Training	08AT109	101,089
University of Miami	Training Program in Geron-tological Clinical Psychology	04AG000011	69,116
Fisk University	Graduate Master of Arts Pgm in Gerontology	04AG000012	114,768
Northwestern Univer-sity	Geron Career Prep	A00TI19	52,096
University of New Mexico	Train Elderly Minorities as Paralegals and Minority Law Students to Serve Elderly, Minority Rural People	6AG137	114,786
University of Texas	Undergraduate Ed for Persons Projected to Work in AoA Supported/Stimulated Areas of Aging	6AG134	63,608
University of Nebraska	Special Career Prep Pgm in Geron for Allied Health Professionals	07AT0181	99,929
University of Arizona	Long Term Care Admin Pgm	09AT018	89,236
University of Calif.	Geron Career Prep	09AT016	113,418
University of Bridgeport	Career Enhancement in Mental Health Work with the Aged	01AT000002	31,769
Springfield Tech-nical Community Coll	Geron Career Prep	01AT000006	69,998

IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
College of St. Elizabeth	Geron Career Prep	AT2A40B	59,749
Union College	Geron Aide Pgm	AT2A43B	51,544
Medgar Evers College	Cultural/Social Approach to Health Care Needs of the Aging Individual and Family in the Inner City	AT2A39B	92,084
Rockland Community College	Development of Career Training in Geron for Minority Group Students	AT2A45B	72,983
St. Thomas Aquinas College	Geron Career Prep	AT2A37B	70,060
North Country Community College	Multi-Faceted Pgm in Rural Geron	AT2A46B	79,116
Virginia Union University	Geron Career Prep	03AT107	77,541
Clark College	Geron Training Project	04AG000014	30,498
Murray State University	Career Training Aging for Social Planning and Helping Professions	04AG000004	75,537
Wayne Community College	Geriatric Technician Training Pgm	04AG000010	83,011
LeMoyne-Owen College	Geron Career Prep	04AG000016	66,656
Tennessee State University	Career Prep for Human Services Practitioners in Geron	04AG000018	55,630
Tusculum College	Geron Career Development Pgm	04AG000007	67,623
Madonna College	Activity Therapy in Geron Pgm	AA00PMI903	67,062

IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
College of St. Scholastica	Flexible Multidisciplinary Training Pgm in Aging at Undergraduate Level		67,062
Minneapolis Community College	Geron Career Prep	AA00PMN901	83,827
University of Minnesota Technical College	Services for the Rural Elderly	AA00PMN902	44,669
Southern University	Aging Studies Career Training Grant	6AG130	111,580
Paul Quinn College	Geron Career Prep Pgm for BA Level Social Workers and Other Professionals Working with the Aged	6AG132	38,875
Prairie View A&M University	Multidisciplinary Undergraduate Career Training Pgm Specializing in Rural Geron	6AG136	77,517
St. Edwards University	Geron Career Prep	6AG135	62,697
Weber State College	Geron Career Prep	8AT1	64,168
University of Arkansas at Pine Bluff	Geron Career Prep	6AG131	68,438
Tougaloo College	Geron Career Prep		60,800
Southside Virginia Community College	Geron Career Prep		28,000
Various Institutions	24 Grants to Prepare Dissertations in Aging		154,000
Gerontological Society	Continuum of LTC: Health Care of the Elderly	90AR0002	110,000

ENHANCING CAREERS FOR MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
San Diego State University Foundation	Minority Research Associates	90AT2	74,980
North Texas State University	MRAP in Hispanic Aging	90AT1	54,738
Scripps Foundation Gerontology Center Miami University	Social Science Schlors in Minority Gerontology: Training & Research	90AT0004	68,616
Syracuse University	MRAP	90AT0003	74,775
State University of New York at Buffalo	MRAP	90AT0005	23,816

DEVELOPMENT OF CONTINUING EDUCATION
AND TRAINING MATERIALS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Ohio State University	Working with Older People	90 AT 0014	24,732
National Council on Aging	Senior Center & Community Focal Point Staff Capacity Building	90 AT 0011	171,831
University of Iowa	Capacitating Personnel for Implementing Community Long Term Care Systems: Training the Trainers Workshop	90 AT 0023	39,949
Miami Dade Community College	Improvement of Service Delivery to Low Income Minority & Economically Disadvantaged Older Persons	90 AT 0027	83,754
Research & Foundation of SUNY	Dissemination & Utilization of Basic Adult Services: A Model Curriculum	90 AT 0010	23,066
Eastern Washington University	Gerontological Uses of History: Development, Testing & Dissemination of Training Materials	90 AT 0015	24,206
East Central Oklahoma State University	Utilization of Curricula & Instructional Materials Concerning the Older Handicapped Individual	90 AT 0013	17,021
National Council on Aging	Continuing Education for Group Program Personnel Working with the at Risk Elderly	90 AT 2098	135,230

DEVELOPMENT OF CONTINUING EDUCATION
AND TRAINING MATERIALS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
National Home Caring Council, Inc.	Supervisors in Home Services	90 AT 2099	157,079
University of Kentucky Research Foundation	Effective Patient Techniques for Use with the Aging Patient	90 AT 2097	17,307
Community Nutrition Institute	Technical assistance and training for aging organizations involved in management of nutrition service	HH 105 80 P 071	184,900
American Indian Professional Services	Training & technical assistance to Indian Tribal Organizations for development of comprehensive and coordinative service systems for older American Indians	HHS 105 80 P	238,792
International Center for Social Gerontology	Technical Assistance: Elderly Housing and Related Services	90 AT 1214	249,999
National Council of Senior Citizens	Educating Service Providers on How to Respond Effectively to Older Americans Adversely Affected by Crime	90 AT 0024	39,860
(To be awarded in FY 81)	Technical assistance for the aging network in the area of fiscal management	SA 80 3018	264,274

DEVELOPMENT OF CONTINUING EDUCATION
AND TRAINING MATERIALS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
National Association of State Units on Aging	Orientation of Aging Service Personnel to the Older Americans Act	90 AT 0012	98,000
National Association of State Units on Aging	NASUA Information System Development and Training	90 AT 0025	90,000
Washington School of Psychiatry	Delivering Services for Community Care of the Aged	90 AT 0017	108,972
National Association of Area Agencies on Aging	Continuing Education for Area Agencies on Aging: A Developmental Process	90 AT 0026	47,100
University of Washington	Health Promotion with the	90 AT 0016	85,774
Cemrel, Inc.	Training of Service Providers in Establishing Arts and Humanities Programs for Older Adults	90 AT 0020	79,034
American Personnel and Guidance Association	Gerontological Counseling: Continuing Education for Counselors and Related Personnel	90 AT 2100	169,864

MARSHALLING RESOURCES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Center for Public Management		HEW 105 79	4,293
Center for Public Management	National Assistance to AoA in the Development of the Regional Education and Training Program	HEW 105 80 3025 HHS 105 80	213,781
Ten Reg. Contractors			
Reg I, J. Snow Public Health	Coordination & Assistance for Education and Training	C-016	125,799
Reg. II, Kirschner Associates		C-021	136,837
Reg. III, Temple U		C-005	98,937
Reg. IV, Kirschner Associates		C-011	133,986
Reg. V, Kirschner Associates		C-012	149,977
Reg. VI, North Texas State		C-014	141,833
Reg. VII, University of Kansas		C-020	129,852
Reg. VIII, Devolop-ment Associates		C-018	113,742
Reg. IX, Western Gerontological Soc.		C-028	131,854
Reg. X, Kirschner Associates		C-004	140,967
Ten Regional Contractors	Amendment to Task for Long Term Care Workshops		143,218

IMPROVING SKILLS OF PERSONNEL

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Connecticut	State Education & Training	1A38	67,728
Maine	" " " "	1A45	30,000
Massachusetts	" " " "	1A40	130,000
New Hampshire	" " " "	1A41	30,000
Rhode Island	" " " "	1A42	30,000
Vermont	" " " "	1A43	30,000
Delaware	" " " "	3A70	30,000
District of Columbia	" " " "	3A71	30,000
Maryland	" " " "	3A72	73,313
Pennsylvania	" " " "	3A68	279,569
Virginia	" " " "	3A73	92,663
West Virginia	" " " "	3A74	42,448
Alabama	" " " "	4A2	76,966
Illinois	" " " "	A0A-IL-IVA-79	227,733
Indiana	" " " "	AoA-IN-IVA-79	105,504
Michigan	" " " "	AoA-MI-IVA-79	167,012
Minnesota	" " " "	AoA-MN-IVA-79	84,819
Ohio	" " " "	AoA-OH-IVA-79	213,284
Wisconsin	" " " "	AoA-WI-IVA-79	101,653
Louisiana	" " " "	6A32	70,383
Guam	" " " "	9A3	15,000
Office on Aging, Dept of Health & Social Service, State of Alaska	Title IV-A Training	10-A-406-79	10,000

DISSEMINATION AND UTILIZATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Franklin Research Center	Collect Training Materials in Aging for Dissemination	HEW 10579301C	31,303
Franklin Research Center	SCAN Resource Center on Social Behavioral/Social Practice	HHS 105 C 084 014	404,973
Sarage Information Service	To search and analyze selected un-line data bases to determine frequency and content of geron literature	SA 80 6601	4,950
University of Michigan	Dissemination & Utilization: Census Data as a Planning Tool	90 AR 0015	133,000
American Institute for Research	Gerontological Research Institute	90-AR-2173	49,000
University of Southern California	Psycho-Social Impacts of Alternative Transportation Choice of the Elderly	90 AR 0008	20,000

1980 Title VI Regional Information Chart

Region	Total Title V grants awarded by Region	Total Indian population being served by Title VI by region	Total grant budget under Title VI by region	States within region that received title VI funding	Number of Indian tribes by region/ State that received Title VI funding	Total Indian population being served by Title VI programs by States	Total Title VI funds awarded by States
I	1	80	$ 65,000	Maine	1	80	$ 65,000
II	1	93	65,000	New York	1	93	65,000
IV	2	402	145,000	Mississippi N. Carolina	1 1	272 130	75,000 70,000
V	13	1,608	890,000	Michigan Minnesota Wisconsin	3 3 7	332 522 754	205,000 215,000 470,000
VI	26	12,601	1,975,000	Oklahoma New Mexico	14 12	10,372 2,229	1,120,000 855,000
VII	5	464	330,000	Nebraska Kansas	2 3	213 251	135,000 195,000
VIII	12	1,237	810,000	Utah N. Dakota Colorado S. Dakota Montana	1 1 2 3 5	118 90 195 283 551	70,000 65,000 135,000 200,000 340,000
IX	10	1,233	685,000	California Nevada Arizona	1 2 7	135 155 943	70,000 130,000 485,000
X	15	2,087	1,035,000	Oregon Alaska Idaho Washington	1 2 2 10	262 250 346 1,229	75,000 135,000 140,000 685,000
	85	19,805	6,000,000	23 States	85	19,805	$ 6,000,000

ADMINISTRATION FOR NATIVE AMERICANS

HUD/HHS Specialized Indian Housing Project

In August 1978, the Intra-Departmental Council on Indian Affairs entered into a formal agreement with the Department of Housing and Urban Development for joint support of a project to provide specialized human care facilities and services on five Indian reservations. The five tribes selected to participate in the project were Navajo, Hopi, Zuni, White Mountain Apache and San Carlos Apache. The project was designed to maintain the traditional extended family concept by providing services and housing for tribal members of all ages—including components for service to the elderly as part of the overall specialized housing project.

HUD and HEW jointly funded a grant to build the capacity of the tribes to assess the housing and service needs of the elderly, the mentally and physically handicapped, and abandoned and neglected children on the five reservations; to consider alternatives for meeting priority needs; and to design and implement facilities and services to meet one or more needs identified. Tribal applications for housing facilities were reviewed and tentatively approved by HUD and HEW in August 1979.

The interagency agreement stipulated that during fiscal year 1980 the Administration for Native Americans (ANA) would provide assistance to the tribes for the development of operational and management plans and the identification of potential funding sources for the services.

To meet the ANA commitment ANA provided a supplemental award of up to $10,000 to the existing ANA grant for each of the five participating tribes.

The Council staff continues to work with the tribes as they move towards the process of entering into formal contract agreements with HUD for construction of the facilities.

Indian Access Project

In fiscal year 1979, ANA entered into an agreement with the Administration on Aging to provide support to the National Indian Council on Aging (NICOA) to initiate a demonstration project on a number of Indian reservations for the purpose of increasing the number of elderly Indians receiving cash and other benefits from entitlement programs.

The Administration for Native Americans agreed to provide a sum not to exceed $85,000 per year for up to 3 years to support the demonstration project to increase the receipt of entitlements by elderly Indian people. In fiscal year 1979, ANA transferred $85,000 to the Administration on Aging to provide first year support for the project. In fiscal year 1980, funds in the amount of $100,000 were transferred via memorandum to OHDS budget from ANA to AoA to carry out the second year of the 3-year interagency agreement.

Laguna Elderly Center

During fiscal year 1979, ANA entered into an agreement with the Indian Health Service to jointly provide management assistance, training and technical assistance to the Pueblo of Laguna in the initiation of its elderly center program. The Pueblo of Laguna, located in New Mexico, has developed a program which provides comprehensive health and social services to its elderly population. The project at Laguna includes residential units for the elderly as well as an elderly care facility.

In fiscal year 1979, ANA transferred $20,000 to the IHS to be used for training and technical assistance to the Laguna Elderly Center program. These funds were committed on a one time only basis.

ANA supports the Pueblo of Laguna's effort to automate its financial, vital and informational data needs. ANA encourages and has granted permission to Laguna to revise or redirect its current and future grants to support an automated data processing unit to complement the elderly project. However, no increase in funds is currently available.

ANA Activities Relative to AoA's Title VI Program

The 1978 amendments to the Older Americans Act estabilshed a new grants program under title VI which provides for direct Federal funding to Indian tribes for the provision of social and nutrition services to older Indian people.

The Administration on Aging (AoA) maintained close liaison with the Administration for Native Americans (ANA) throughout the process of policy and regulations development for the implementation of the title VI program. As part of this cooperative effort, ANA assigned a full time staff person to AoA for 3 months in fiscal year 1980 to provide assistance in the regulations development process and to provide a formal linkage between the two agencies. AoA and ANA concurred that this cooperative effort was a significant asset in the development of title VI policy and implementation strategy. The agencies anticipate continuing a close working relationship for the effective coordination of their respective program activities and maximizing the efficiency and impact of program administration.

TITLE XX

The Office of Human Development Services has responsibility for administering the social services programs authorized under titles I, IV–A, X, XIV, and XX of the Social Security Act, as amended. Except for Guam, Puerto Rico, and the Virgin Islands, title XX superseded all of the authorizing titles cited above as of October 1, 1975.

Under title XX, grants are made to States to deliver services under a comprehensive annual services program plan which is designed by each State to meet the needs of that State. At State option services are delivered to individuals whose eligibility is based on income or income maintenance status. States may offer services to persons with family incomes up to 115 percent of the State median family income for a family of four adjusted for family size. However an amount equal to at least 50 percent of the Federal share of State expenditures must be for recipients of aid to families with dependent children (AFDC), supplemental security income (SSI), essential persons or individuals eligible for medicaid. Specified services may also be offered on a group basis. States may choose the services to be provided, as long as each service is directed to at least one of the five title XX goals, and at least three services are directed toward SSI recipients.

A variety of services directed to assisting aged persons to attain or maintain a maximum level of self-care and independence are provided through the social services program. Included are such services as adult day care, adult foster care, protective services, health-related services, homemaker, chore, transportation, and other services that assist elderly persons to remain in their own homes or in community living situations. Services are also offered which facilitate entry into institutional care when necessary.

Since title XX data are collected by service and by category of eligibility of the recipients (e.g. AFDC and SSI), it is not possible to determine precisely total services recipients, and expenditures provided to the elderly. However, data on the number of recipients, and expenditures for services for those older persons eligible for SSI payments is available. The following are reported figures (for fiscal year 1977) and estimates for the number of primary recipients [1] and expenditures for the SSI-aged during fiscal years 1977, 1978, and 1979. Estimates for the number of primary recipients during fiscal year 1980 are not available.

Fiscal year	Number of SSI-aged primary recipients	Expenditures (Federal, State, local funds)
1977	466,000	$255,000,000
1978	451,000	262,000,000
1979	609,000	300,000,000

Since elderly persons other than SSI-aged qualify for, and receive services from each of the services reported, these data understate the total number of elderly recipients and expenditures for services to the aged under title XX. Expenditure increases have been reported for services which are usually associated

[1] Primary recipient: An individual with whom, or for whom, a specific goal is established and to whom services are provided for the purpose of achieving the goal. Services are considered to be provided to the primary recipient when they are provided to other members of the primary recipient's family to facilitate achievement of the primary recipient's goal.

with the needs of the aged. In particular, community based care services directed toward the title XX goal of preventing or reducing inappropriate institutional care have received increased program emphasis. Universal services such as information and referral, and protective services for adults, as well as group services, have been growing during the last few years. As with all services, these latter services include elderly recipients.

As is true of services delivery, research and demonstration projects funded through the Office of Human Development Services tend to address areas in which elderly persons are among the participants in the demonstration programs and may benefit from implementation of the research results.

In fiscal year 1980, we continued projects involved in fiscal year 1978 and 1979. One project, barriers to the development of community based long-term care for elderly and handicapped individuals, particularly emphasizes the elderly. This project is to develop and document methodology for State agency use in identifying barriers to community placements for long-term care.

Another 12 projects deal with such topics as hospice care, social services planning, the impact of Federal policies and services programs on families, transportation to human resource facilities, capacity building of Indian tribal governments to plan and administer comprehensive social services systems, and improved case management systems.

Among the concrete effects of these projects were the funding of a position of a case manager to coordinate social services for the elderly by a local county council on aging; the first national conference on case management; and the development of social services for elderly Indians in two areas. In addition, our transportation projects have established a method for securing insurance coverage for vehicles used to transport the elderly and other vulnerable populations.

SOCIAL SECURITY ADMINISTRATION

Programs Administered by the Social Security Administration

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 method in the United States of assuring 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 earmarked social security contributions (FICA taxes); the self-employed also contribute a percentage of 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. Current contributions are largely paid out in current benefits. However, at the same time, current workers build rights to future benefit protection.

SSA also administers the supplemental security income (SSI) program for aged, blind, and disabled people in financial need (title XVI of the Social Security Act). SSI provides a federally financed floor of income for eligible individuals with limited income and resources. In most cases, SSI supplements 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 in filing claims for medicare benefits. Overall, Federal administrative responsibility for the medicare program rests with the Health Care Financing Administration.

In addition, SSA has Federal administrative responsibility for aid to Indochinese, Cuban, Soviet, and other refugees.

Following is a summary of beneficiary levels today, selected program activities, study groups, social security-related legislation enacted in 1980 and related activities:

I. OASDI BENEFITS AND BENEFICIARIES

At the beginning of 1980, about 94 percent of all Americans age 65 and over were drawing social security benefits or were eligible to draw benefits if they

or their spouses retired; about 95 percent of the people who reached 65 in 1980 were eligible for benefits. It is expected that 96 to 98 percent of the aged will be eligible for social security benefits by the end of the century.

At the end of September 1980, 35.4 million people were receiving monthly social security cash benefits (an increase from 34.9 million in September 1979). Of these beneficiaries, 19.4 million were retired workers, 3.6 million were dependents of retired workers, 96,000 were uninsured individuals receiving "special age-72" (Prouty) benefits, 4.7 million were disabled workers and their dependents, and 7.6 million were survivors of deceased workers.

The monthly rate of benefits for September 1980 was $10.6 million compared to $8.9 billion for September 1979. Of this amount, $7.2 billion was paid to retired workers and their dependents, $1.3 billion was paid to disabled workers and their dependents, $2.1 billion was paid to survivors, and $10 million was paid to special age-72 beneficiaries.

Retired workers received an average benefit for September 1980 of $340 (up from $293 in September 1979), while disabled workers received an average benefit of $370 (up from $321). Retired workers newly awarded social security benefits for September 1980 averaged $363, while disabled workers received average initial benefits of $395. During fiscal year 1980 (October 1979-September 1980), $116 billion in social security cash benefits were paid compared to $101 billion in fiscal year 1979. Of that total, retired workers and their dependents received $74.5 billion, disabled workers and their dependents received $14.9 billion, survivors received $25.6 billion, and special age-72 beneficiaries received $121 million. In addition, lump-sum death payments amounted to $381 million.

II. SUPPLEMENTAL SECURITY INCOME BENEFITS AND BENEFICIARIES

In 1980, SSI payment levels (like social security benefit amounts) were automatically adjusted to reflect a 14.3 percent increase in the CPI. Thus, beginning in July 1980, maximum monthly Federal SSI payment levels increased from $208.20 to $238 for an individual, and from $312.30 to $357 for a couple.

During fiscal year 1980, over $7.5 billion in benefits (consisting of $5.7 billion in Federal funds and $1.8 billion in federally administered State supplements) were paid. Of the 4.1 million beneficiaries on the rolls during September 1980, 1.8 million were aged, and 2.3 million receiving SSI based on blindness and disability, although 400,000 of them reached age 65 after they began to get payments. During September 1980, total payments of $695 million were made. The total payments in fiscal year 1980 represent an increase of about $0.9 billion over fiscal year 1979.

III. BLACK LUNG BENEFITS AND BENEFICIARIES

During September 1980, about 404,000 individuals received $83.8 million in black lung benefits which were administered by the Social Security Administration. These benefits are financed from general revenues. Of these individuals, 122,000 miners and their dependents received $45.1 million, while 146,000 widows and their dependents received $38.7 million. The miners and widows had 135,000 dependents. During fiscal year 1980, SSA administered black lung payments in the amount of $1.0 billion.

Black lung benefits increased by 10.1 percent in November 1980 due to an automatic general benefit increase adjustment under the law. The monthly payment to a coal miner disabled by black lung disease increased to $279.80 from $254. The monthly benefits for a miner or widow with one dependent is $419.60, and with two dependents is $489.60. The maximum monthly benefit payable when there are three or more dependents is $559.50.

IV. LOW-INCOME ENERGY ASSISTANCE

Beginning in October 1980, SSA was given Federal administrative responsibility for a program of low-income energy assistance. The purpose of the program was to help low-income individuals avoid serious health and financial crises by providing them assistance to meet the rapidly rising cost of home energy, particularly for heating. Congress appropriated $1.2 billion for the program. Of this amount, $400 million was paid in early 1980 as a special one-time energy allowance to about 3.9 million SSI recipients. (These were all December 1979 recipients except those living in medicaid institutions.) Payments varied by State based on a formula contained in the legislation, and ranged from a low of $34 to the statu-

tory maximum of $250. The remaining $800 million was distributed to the States in the form of block grants. States had flexibility to develop their own programs for distributing the aid, subject to HHS approval. These funds were available to supplement the payments to SSI recipients, and to make payments to persons on other assistance programs or with incomes below 125 percent of the poverty level.

V. OUTREACH

The SSA reorganization of 1979 established the Office of Governmental Affairs which has as one of its principal missions the planning and managing of SSA's "outreach" activities, with the goal of increasing SSA's responsiveness to public concerns about social security programs. Outreach refers to the agency's concerted effort to establish and maintain ongoing, two-way relationships with individuals and organizations inside and outside of government in order to inform them about social security as they inform SSA about their interests. Some of the key elements of the overall outreach strategy are discussed below in the "outreach symposia project" and "implementation of Executive order on consumer affairs."

VI. OUTREACH SYMPOSIA PROJECT

In the period January-June 1980 over 300 town meetings were sponsored by local social security offices throughout the country. These meetings followed a national symposium, ten regional symposia, and a symposium in Puerto Rico in the October–December 1979 period. The series of meetings was designed to help strengthen public confidence in the viability and stability of social security through enhanced public understanding of the present system and current issues. Over 16,000 persons, including significant representation of the aged, attended these meetings. SSA staff presented basic information on the value of the programs, their content and coverage, how they are financed, and the impact on the programs of changing demographic and social patterns, particularly implications of the changing roles of men and women in society. Participants contributed their views and opinions about the topics presented and social security in general, resulting in a wide variety of thoughts and suggestions to shape the programs in the years to come.

VII. IMPLEMENTATION OF EXECUTIVE ORDER ON CONSUMER AFFAIRS

On September 26, 1979, the President issued Executive Order No. 12160, "providing for the enhancement and coordinating Federal consumer programs," the purpose of which is to ensure that consumer interest is integrated into the decisionmaking processes of government. Many requirements of this order are already ongoing activities of SSA through such functions as: Review of all proposed regulatory and procedural material for adverse impact on the public; identification of problems in existing policy and practices adversely affecting the public; linking interested outside groups with policymakers to ensure consideration of their views before policy is revised; conducting and reviewing the current process for conducting public hearings on proposed regulations; production of informational materials for the public on SSA-administered programs; and the systematic handling of complaints. SSA published its draft Consumer Affairs Plan on June 9, 1980 setting forth the initiatives underway and planned to assure full implementation of the Executive order. The draft was made available to well over 200 groups and organizations for comment. The revised plan has been forwarded to HHS for review and eventual publication in the Federal Register. In the meantime, SSA is continuing to broaden its contacts with the public and is moving ahead to provide the public with greater access to SSA's decisionmaking process.

VIII. INFORMATION AND REFERRAL PROJECT

The broad mission of SSA in the area of income maintenance and social welfare as a result of the HEW reorganization of 1977, has prompted the agency to explore a change in its information and referral policies and practices to meet the needs of this greater and more varied population. In 1979, SSA began an initiative to reassess the agency's role in information and referral for related social and economic services to determine how SSA services can be improved and/or expanded to meet current needs. The effort is aimed at developing processes for referral at the local level based on other agencies' ability to deliver services. SSA is consulting with other government agencies and outside organiza-

tions regarding their needs and programs in developing its information and referral plan. This initiative resulted in various proposals to strengthen SSA's information and referral services. These proposals are currently being evaluated within the agency.

IX. IMPROVED COMMUNICATION AND SERVICES

In fiscal year 1980, the Office of Public Affairs undertook the following projects:

Improved Publications

During fiscal year 1980 the Social Security Administration's Office of Public Affairs conducted a comprehensive review of all the administration's public information pamphlets. The objective was to make sure that the information provided to the public was concise, understandable and relevant. A secondary objective was to reduce the total number of publications produced. The revised, redesigned pamphlets will be distributed during fiscal year 1981.

Service to Hispanics

In an effort to improve the overall service to the Hispanic community, the Social Security Administration has translated almost all applications, forms and notices into Spanish for people who indicate a desire to get social security information in Spanish. In addition, the Social Security Administration is now producing publications, radio and television materials specifically designed to reach the Hispanic community.

Improved Notices to Social Security Administration Beneficiaries

The Social Security Administration has redesigned its computer notice system that sends personalized notices to several million working social security beneficaries each year. Using the information from each beneficiary's annual report of earnings, the system generates a notice which explains how social security benefits are affected by the beneficiary's work and earnings. Each notice has a covering letter which summarizes the benefit changes in a few short paragraphs. Attached to the cover letter is an information sheet that gives more detailed information about how the benefit changes were figured. This notice style gives the beneficiary a simple, easily understood explanation of benefit changes (and for those beneficiaries who want more background, a breakdown of specific benefit facts and figures).

Food Stamp Service in Social Security Administration Offices

In August 1980, Social Security offices began taking food stamp applications from supplemental security income recipients and applicants who live in households where everyone either receives supplemental security income or is applying for it. The Social Security Administration began this service to make it easier for aged, blind and disabled persons to apply for food stamps.

X. SSA ADMINISTRATIVE GOALS AND ACCOMPLISHMENTS

During fiscal year 1980, SSA placed major emphasis on balancing speed and accuracy in the processing of DI, SSI, and RSI claims; improving the processing and recovery of SSI overpayments; working with the States to reduce errors in the AFDC program; and maintaining control over the processing of hearings and appeals in spite of increasing receipts of hearing requests.

These objectives were generally achieved. The gains made in improving processing times during fiscal year 1979 were maintained or improved upon, while accuracy rates were also improved. RSI claims accuracy improved from 95.9 percent at the end of 1979 to 96.3 percent; State agency processing accuracy (medical determinations) increased from 90.6 percent to 93.7 percent in the DI program and from 92.5 percent to 93.2 percent in the SSI program; the amount of unresolved SSI overpayments decreased by 19 percent during 1980; collections increased 7 percent over 1979; and the number of hearing dispositions increased by almost 10 percent over 1979.

Along with these improvements, there were some problem areas. Even though hearings dispositions were up, pending hearing requests increased because of an 11-percent increase in requests for hearing and the inability to hire sufficient

numbers of Administrative Law Judges (ALJ's). The SSI payment error rate remained at 5 percent through March 1980. As a result of SSA's concern with the AFDC error rates, a special task force has been established to determine improvements which can be made in this program. Recommendations will be made during fiscal year 1981.

SSA's major emphasis in 1981 is to maintain the processing time and accuracy gains achieved over the past 2 years while implementing the substantial provisions of the disability amendments of 1980. Special emphasis is also being given to assure a smooth move to the new computer center, to improve women and minority work force representation through the equal employment opportunity program, to begin the upgrading of our telecommunications system, to achieve socioeconomic procurement goals and improve management of grants and contracts, to upgrade field office facilities, and to improve systems security.

XI. NATIONAL COMMISSION ON SOCIAL SECURITY

The 1977 amendments established the National Commission on Social Security. Some members were appointed by the President and some by Congress. The National Commission is engaged in a broadscale, comprehensive study of the social security program, including medicare. The study also includes the status of the trust funds, coverage, adequacy of benefits, possible inequities, alternatives to the current programs and to the method of financing the system, integration of the social security system with private retirement programs, and development of a special price index for the elderly. (The Commission issued interim reports on May 11, 1979 and on January 11, 1980. The release of the final report is expected early in 1981.)

XII. PRESIDENT'S COMMISSION ON PENSION POLICY

The President's Commission on Pension Policy was established by Executive order in July 1978. The Commission is examining pension systems around the country in an effort to develop national policies for retirement, survivor, and disability programs that can serve as a guide for public and private programs.

In response to the problems that pension systems face, the President's Commission will:

—Provide an overview of all existing retirement, survivor, and disability programs.

—Assess the ability of existing programs, and systems—encompassing the Federal, State, local, and private sectors—to meet future commitments and future needs.

—Devise a national policy on retirement that can be used as a guide by all programs; and

—Propose reforms that are needed to meet national policy goals, both now and in the future.

The Commission issued interim reports in May and November, 1980; it is expected to submit its final report to the President in February.

XIII. PRECEDENT-SETTING COURT DECISIONS THAT AFFECT THE ELDERLY MADE DURING FISCAL YEAR 1980 OR STILL PENDING

Califano v. *Boles.*—Marriage Requirement—Mothers of Illegitimate Children

On June 27, 1979, the U.S. Supreme Court upheld the constitutionality of the marriage requirements of section (202g) of the Social Security Act. That statute provides for a mother's benefit for a widow or surviving divorced wife of a deceased worker if she has an entitled child of the worker in her care. The Supreme Court concluded that the mothers' benefit was designed to benefit mothers who suffer economic loss upon the death of a worker. To effectuate this, the court determined that the Congress could reasonably conclude that a woman never married to the worker was less likely to be dependent on him at his death than one who was his widow or surviving divorced wife.

Harris v. *Rosario.*—Limitation on AFDC Payments in Puerto Rico

On May 27, 1980, the U.S. Supreme Court upheld the constitutionality of sections 1108(a) and 1905(b) of the Social Security Act. These sections concern Federal medical assistance in Puerto Rico and cause a lower benefit ceiling for Federal programs in Puerto Rico than for Federal programs in the States in the

United States. The Supreme Court held that under the Territory clause of the Constitution, the Congress could treat Puerto Rico differently from the States as long as a rational basis existed. The Supreme Court found such a basis in (1) the increased program costs; (2) the fact that residents of Puerto Rico do not pay Federal income tax; and (3) the possibility of disruption to the economy of Puerto Rico because of increased benefit levels.

O'Connor v. *Harris.*—Gender-Based Classification—Surviving Divorced Father

On September 24, 1979, the U.S. District Court for the Western District of Washington found section 202(g) of the Social Security Act unconstitutional insofar as it provides benefits to a surviving divorced mother with an entitled child in her care, but precludes entitlement to benefits for a similarly situated surviving divorced father. Regulations to effectuate this decision have been promulgated.

Ambrose v. *Califano.*—Gender-Based Classification—Surviving Divorced Husband

On July 17, 1980, the U.S. District Court for the District of Oregon entered a final judgment adjudging unconstitutional the absence from the Social Security Act of provisions for benefits for "surviving divorced husbands." The district court had found application of the Social Security Act unconstitutional to the husband's income, unless this presumption is, in effect, rebutted by the wife. but provides no comparable benefit for a similarly situated male. The district court ordered payment to the plaintiff and what is essentially a nationwide class. Regulations to effectuate this decision are being drafted.

Becker v. *Harris.*—Gender-Based Classification—Allocation of Self-Employment Income in a Community Property Jurisdiction

On July 17, 1980, the U.S. District Court for the Eastern District of California found section 211(a)(5)(A) of the Social Security Act to be an unconstitutional gender-based discrimination. That section provides that self-employment income derived in a community property jurisdiction shall generally be presumed to be the husband's income, unless this presumption is, in effect, rebutted by the wife. The court determined that the statute served no valid "governmental objective" and was "patently arbitrary." Regulations to effectuate this decision are being considered.

Mertz v. *Harris.*—Gender-Based Classification—Widower's Insurance Benefits

On September 10, 1980, the U.S. District Court for the Southern District of Texas entered a judgment finding section 202(f)(1)(A) of the Social Security Act unconstitutional. Section 202(f)(1)(A) requires as a condition of entitlement that a widower "has not remarried." The comparable provisions for widow's benefits, section 202(e)(1)(A), provides a benefit if a widow "is not married." The district court found the challenged provisions to be violative of the "equal protection" clause. If no appeal is taken to the Supreme Court, this decision will be effectuated by regulations.

XIV. SUMMARY OF LEGISLATION ENACTED DURING FISCAL YEAR 1980 THAT SIGNIFICANTLY AFFECTS SSA

Public Law 96-88 (S. 210), Education Organization Act of 1979—signed on October 17, 1979

Establishes a Department of Education, with provisions to transfer to the new department vocational rehabilitation functions and offices vested in HEW. The functions of the Secretary of HEW under sections 222 and 1615 of the Social Security Act are exempted from the provisions of the Act. HEW has been renamed the Department of Health and Human Services.

Public Law 96-110 (H.R. 4955), State Department Migration and Refugee Assistance Appropriations—signed on November 13, 1979

Provides for continuation of the existing Indochinese refugee program at current funding levels from October 1, 1979 through September 30, 1981.

Public Law 96–126 (H.R. 4930), Department of the Interior Appropriations and Energy Assistance Payments to SSI and Low-Income Households—signed November 27, 1979

Includes an SSA-related amendment to fund energy assistance for fiscal year 1980 with a $1.35 billion appropropriation to the Community Services Administration. Of this amount, $1.2 billion was transferred to HHS for payment of energy grants, allowances, and related administrative costs. About $400 million was made available for payment as a special one-time energy allowance to SSI recipients. About $800 million was made available for block grant funding to States for assistance to AFDC, food stamp, or other assistance households, and households with incomes below 125 percent of the poverty level.

Public Law 96–167 (H.R. 5224), Legislation Pertaining to Independent Contractors—signed on December 29, 1979

Extends for 1 more year (from January 1, 1980 to January 1, 1981), the interim relief provided by Congress last year (i.e., forgave all FICA and income tax liability) to businesses that have been treating workers as independent contractors rather than employees.

Public Law 96–178 (H.R. 3091), Tax Treatment of State Legislators' Travel Expenses (Includes Child Support Enforcement Amendment)—signed on January 2, 1980

Continued through March 31, 1980, 75 percent Federal matching of States' costs of providing child support services to non-AFDC clients. Also extended the authority to subsidize childcare employment of welfare recipients.

Public Law 96–212 (H.R. 2816/S. 643), The Refugee Act of 1979—signed on March 17, 1980

Provides a single statutory framework governing the admission and resettlement of refugees; established an Office of Refugee Resettlement within the Department of Health and Human Services; repealed the Indochina Migration and Refugee Assistance Act of 1975; provided 100 percent Federal funding for cash and medical assistance to any refugee during the 3-year period following admission into the United States; provided reimbursement in any fiscal year for 100 percent of the non-Federal cases associated with Cuban refugees to whom SSI payments were being made as of September 30, 1978; and requires the Secretary to report to Congress by January 31 of each year on the status of the program.

Public Law 96–222 (H.R. 2797), Technical Corrections Act of 1979—signed on April 1, 1980

Makes technical corrections related to the Revenue Act of 1978, including conforming amendments concerning earned income tax credits (EITC), pension reform and the Black Lung Benefits Revenue Act. The act is of interest to SSA in that it provides for counting EITC as earned income under the AFDC and SSI programs. It further provides that in cases where an AFDC or SSI recipient receives excess EITC payments which have to be refunded to the Government, the person would receive a corresponding increase in the AFDC or SSI benefit.

Public Law 96–223 (H.R. 3919), Crude Oil Windfall Profit Tax Act of 1979—signed on April 2, 1980

For fiscal years 1981–90, the act sets aside 25 percent of the first $227 billion of windfall profits revenue and one-third of any revenue above that amount to be used for programs for energy assistance to low-income persons.

For fiscal year 1981, the act authorizes $3.115 billion to States for low-income energy assistance programs. Each State will establish and operate, subject to Federal approval, its own plan, but may request SSA to make payments to SSI recipients. Households eligible for the assistance are those receiving AFDC (except foster care); SSI (except households eligible solely on the basis of an SSI recipient who is in a title XIX institution, in the household of another, or in the household a child); food stamps; certain income-tested veterans' benefits; and households with incomes at or below the Bureau of Labor Statistics (BLS) lower living standard.

The funds will be distributed to the States based on allocation formulas in the law. The Secretary shall reserve $2.5 million to be apportioned on the basis of

need among the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, Northern Mariana Islands and the Trust Territory of the Pacific Islands and shall transfer to the Community Service Administration $100 million for energy crisis-related activities.

For fiscal years 1982–90, the programs are not specified but rather must be developed and enacted in separate legislation. Of the 25 percent of the projected $227 billion in revenues which are allocated for low-income assistance, for fiscal years 1982–90, the Act does provide a suballocation, as follows:

—50 percent allocated for programs to assist AFDC and SSI recipients under the Social Security Act.

—50 percent allocated to a program for emergency energy assistance.

Public Law 96–243 (H.J. Res. 545), Urgent Appropriation for the Food Stamp Program—signed on May 16, 1980

Made urgent appropriations for the food stamp program for the fiscal year ending September 30, 1980.

Public Law 96–249 (S. 1309), Food Stamp Act Amendments of 1980—signed on May 26, 1980

Increased the fiscal year 1979 authorization and the fiscal year 1980 and 1981 dollar limitations on appropriations for the food stamp programs. The Act also includes provisions to require the Secretary of HHS to provide SSN's and data in HHS files to the Secretary of Agriculture and State agencies for use in the administration of the food stamp program. It also contains provisions to raise the level of deductions for certain medical and dental expenses for purposes of determining food stamp eligibility for residents of households containing an SSI recipient or a member age 60 or over.

Public Law 96–265 (H.R. 3236), Social Security Disability Amendments of 1980—signed on June 9, 1980

Family benefit cap: Family benefits in disability cases are limited to the lesser of 85 percent of the AIME or 150 percent of the PIA, but no less than 100 percent of the PIA. Effective for individuals eligible for benefits after 1978 who were never entitled to disability benefits before July 1980.

Variable dropout years: Dropout years for disabled workers are:

Worker's age:	*Number of dropout years*
Under 27	0
27 to 31	1
32 to 36	2
37 to 41	3
42 to 46	4
47 and over	5

A worker will also get 1 dropout year for each year in which he had no earnings and had a child under age 3 living with him. However, if any year is dropped as a child care dropout year, the total number of dropout years—regular and child care—cannot exceed 3. Effective for individuals who were never entitled to disability benefits before July 1980, except that the child care provision will be effective for monthly benefits after June 1981.

Medicare waiting period: Provides that months in the 24-month medicare waiting period need not be consecutive. Thus, for former DI beneficiaries who become disabled again within a certain time period (60 months for disabled workers and 84 months for disabled widow(er)s and adults disabled since childhood), any months which counted toward meeting the 24-month medicare waiting period will count toward meeting that requirement in the subsequent period of disability.

Extension of entitlement for medicare: Extends medicare for DI beneficiaries (who have not medically recovered) for the proposed 15-month automatic reentitlement period following the trial work period (TWP) and for an additional 24 months.

Work expense deductions: Allows deductions in DI cases of the cost of impairment-related services and devices and attendant care costs from earnings in determining SGA if they are necessary for the beneficiary to work and if the beneficiary pays for them.

Closed evidentiary record: Forecloses the introduction of new evidence in OASDI claims after decisions are made at hearings.

Study of time limits for decisions on benefit claims: Requires the Secretary to report to the Congress by July 1, 1980, on appropriate time limits within which a decision should be made in initial, reconsideration, Hearing and Appeals Council cases under OASDI.

Payment for existing medical evidence: Provides for payment from the trust funds for medical evidence submitted by non-Federal institutions and physicians in DI claims when such evidence is requested and required by the Secretary.

Extension of the term of the National Commissioner on Social Security: Extends the appointments of members of the National Commission on Social Security to April 1, 1981.

Frequency of deposits of social security contributions from State and local governments: Requires that deposits from State and local governments be due 30 days after the end of each month.

Benefits and services for the terminally ill: Provide the Secretary with the authority to participate in a demonstration project being done by HHS on providing services to the terminally ill.

Voluntary certification of medicare supplemental health insurance policies: Establishes a voluntary program to certify medicare supplemental health insurance policies which meet certain minimum standards (so-called medi-gap policies). Issuance of seals of certification is to begin July 1, 1982.

A panel consisting of the HHS Secretary and four State insurance commissioners will be appointed to determine which States are in compliance with the National Association of Insurance Commissioners Model Regulations and have loss-ratios in effect. Effective July 1982 in those States which do not meet standards.

Benefits for people engaging in SGA and exclusion of impairment-related expenses: SSI disabled beneficiaries whose earnings equal or exceed the SGA level will be entitled to special cash benefits until their countable income reached the Federal (or State, if applicable) "breakeven" point. States will have the option of supplementing those entitled under the provision.

People who receive the special benefits will be eligible for medicaid and social services on the same basis as regular SSI recipients.

A blind or disabled person will continue to be eligible for medicaid and social services even if his or her income is at or above the "breakeven" point (and he or she is no longer getting cash benefits) if it is determined, under regulations, that the person:

—Continues to have a disabling impairment.

—Does not have income, except for earnings, which is equal to or in excess of the amount which would cause him to be ineligible for regular or special SSI benefits.

—Would be seriously inhibited in continuing employment through loss of medicaid and social services eligibility; and

—Does not have earnings high enough to allow him or her to provide a reasonable equivalent of the SSI benefits, medicaid, and social services he or she would have in the absence of earnings.

For SSI beneficiaries, impairment-related work expenses will be deductible for substantial gainful activity purposes if paid for by the beneficiary. The deduction is also allowed for benefit-computation purposes. (For purposes of initial entitlement, an individual must meet the income test and qualify for benefits without the deduction.)

Also provides for a 3-year pilot program of grants to States who may, at their option, provide medical assistance (not necessarily under a State's medicaid program) and social services to severely handicapped people engaging in SGA not eligible for SSI, special benefits or medicaid, if the State determines medical assistance and social services are necessary for the individual to keep working. ($6 million authorized for September 1981 through September 1982, with total 3-year expenditures not to exceed $18 million.)

Sheltered workshops: Treats remuneration received in sheltered workshops as earned income for SSI purposes.

Parental deeming: Terminates parental deeming for SSI at age 18. Benefits to recipients who were age 18 or over in September 1980, and who received a supplemental security income benefit for September will not be reduced as a result of this provision.

Aliens under SSI: Provides that income and resources of sponsors will be deemed to aliens for 3 years after entry and aliens will be required to obtain cooperation of sponsors in providing necessary information to SSA. (Exceptions

to the deeming provision are provided for: (1) Blind or disabled aliens whose blindness or disability commenced after entry; (2) refugees or aliens granted political asylum.) Makes aliens and sponsors jointly liable for any overpayment during the 3-year period on account of failure to provide correct information to SSA, except where good cause for failure exists.

Continuing DI or SSI benefits for persons in a VR plan: Permits DI and SSI benefits to continue after medical recovery for persons in approved VR programs if SSA determines that the continuance will increase the likelihood that the person will go off the disability rolls permanently.

Automatic reentitlement to disability benefits: Provides that a person may become automatically reentitled to DI or SSI benefits (assuming nonmedical criteria are met) if he stops performing SGA within the 15 months following the end of the trial work period.

Trial work period for disabled widows and widowers: Extends the trial work period to disabled widows and widowers.

Administration of the disability program: Gives the Secretary the authority to establish, through regulations, procedures and performance standards for the State disability determination process. In the event of unsatisfactory State performance, the Secretary could take over the administration of the State determination process. Requires the Secretary to report to Congress by July 1, 1980 on contingency plan for Federal assumption of State functions and operations. Also (1) provides for preferential hiring of State employees (except for the State DDS Administrator or his Deputy), and (2) prohibits HHS from assuming a DDS function until the Secretary of Department of Labor determines that the State has made arrangements to protect State employees not hired by HHS.

Federal review of State agency determinations: Requires the Secretary to review, on a preeffectuation basis, State agency DI allowances. The effective dates for Federal preeffectuation review of title II allowances and continuances would be: 15 percent for fiscal year 1981, 35 percent for fiscal year 1982 and 65 percent for 1983 and thereafter. Title XVI cases will also be reviewed although not mandated in the law.

Also requires the Secretary to implement a program of review of ALJ decisions and submit a report to Congress by January 1, 1982.

Detailed denial notices: Requires that social security and SSI disability denial notices be expressed in language understandable to the claimant and include a discussion of the evidence and reasons why the disability claim was denied.

Limitation on court remands: Permits OASDI cases to be remanded from courts on the Secretary's motion only for "good cause" shown, and on court's own motion only if there is new and material evidence that was not previously submitted and there is "good cause" for not having submitted the evidence. (Provision also would apply for SSI cases since the provision of title II that is amended is referenced in title XVI.)

Payment for certain travel expenses: Provides for payments from the trust funds for travel expenses (with a limit on air travel costs) incident to medical examinations required by SSA in conjunction with a disability or medicare claim and for travel expenses incurred by OASDI and SSI applicants, their representatives and witnesses in traveling to hearings and reconsideration interviews before an Administrative Law Judge. Travel expenses for SSI applicants will be paid from general revenues.

Periodic review of disability determination: Requires that, unless a finding has been made that an SSDI or SSI beneficiary's disability is permanent, the case will be reviewed by the Secretary at least once every 3 years.

Report by the Secretary: Requires the Secretary to submit to the Congress no later than January 1, 1985 a report as to the effects of OASDI and SSI provisions of the bill.

Adjustment of retroactive title II benefits on account of SSI benefits: Provides for adjusting retroactive title II social security benefits by the amount of SSI benefits already paid that would not have been paid if the social security benefits had been paid, and therefore taken into account as income, on their regularly scheduled payment dates.

Demonstration authority: Requires the Commissioner to conduct demonstration projects and experiments to test effect of substantial gainful activity (SGA) alternatives on attempts to return to work and to report the findings by January 1, 1983.

Authorizes waiver-of-benefit requirements of the disability insurance and medicare programs to permit demonstration projects to test ways to stimulate disabled people to return to work. An interim report on the project must be sent to Congress by January 1, 1983 and a final report 5 years after enactment.)

Authorizes waivers in the case of other DI demonstration projects which SSA may wish to undertake, particularly rehabilitation projects.

Also provides SSA general experimentation authority in the SSI program with the following qualifications: (1) Participation must be voluntary; (2) total income and resources of a person must not be reduced as a result of an experiment; and (3) there must be a project to ascertain the feasibility of treating drug addicts and alcoholics to prevent permanent disability.

Work incentive program: In addition to registration requirements under current law, adds a requirement that AFDC recipients not exempted by law must register for and participate in employment search activities in the WIN program as a condition of AFDC eligibility; provides to registrants additional social and supportive services necessary to find and retain employment.

Allows States to match Federal WIN funds with in-kind goods and services.

Provides for locating employment and supportive services together.

Eliminates required 60-day counseling period in termination of assistance.

Authorizes Secretaries of HHS and Labor to establish the period during which individuals will continue to be ineligible for AFDC if they refuse without good cause to participate in the WIN program.

Clarifies that earned income from public service employment (PSE) is not disregarded in computing AFDC benefits.

Provides a limitation of 8 weeks per year on employment search activity and requires reimbursement of employment search expenses.

Use of IRS to collect child support for non-AFDC families: Extends IRS child support collection authority to non-AFDC child support enforcement cases, subject to present law certification and other requirements.

Safeguarding information: Exempts any governmental agency, or component or instrumentality thereof, authorized by law to conduct audits or similar activities in connection with the administration of the AFDC program from the general prohibition against disclosure of personal information about AFDC recipients to legislative bodies. The amendment makes similar changes with regard to audits under title XX, social services.

Federal matching for child support duties performed by court personnel: Allows Federal matching for State expenditures (including compensation) for court personnel (less payment of judges' salaries and other officials making judicial decisions, e.g., magistrates) and other supportive and administrative personnel for title IV–D functions, to the extent the expenses exceed State expenses for the same activities for calendar year 1978.

Child support management information systems: Increases Federal matching to 90 percent for title IV–D costs incurred by States in developing and implementing computer information systems; requires HHS assistance and review of State systems.

AFDC management information systems: Increases the current 50 percent Federal matching to 90 percent for title IV–A costs incurred by States in developing, designing, and installing computer information systems and retains the current 50–50 matching for operational costs.

Child support reporting and matching procedures: Prohibits advance payment of the Federal share of State title IV–D administrative expenses for a calendar quarter unless the State has submitted a complete report of the child support collected and disbursed in the quarter which ended 6 months earlier; allows reduction in the payment to a State of title IV–A monies by the Federal share of title IV–D collections made but not reported by the State.

Access to wage information for child support program: Authorizes the Commissioner of Social Security to disclose wage, self-employment and retirement income records for title IV–D purposes to State and local child support agencies, with stringent safeguards. Also permits State unemployment compensation information to be released to child support agencies.

Public Law 96–272 (H.R. 3434), Adoption Assistance and Child Welfare Act of 1980—signed on June 17, 1980

Transferred the current title IV–A, AFDC foster care program to a newly created part E of title IV, "Federal Payments for Adoption Assistance and Foster

Care." States may shift AFDC foster care from title IV–A to the new title IV–E program as of October 1, 1980 and are required to have made the transition by October 1, 1982. The new law removed the limitation, with certain conditions, that children must be placed in foster care as the result of a judicial determination in order to receive foster care payments. It also authorized Federal matching for adoption assistance payments to parents who adopt children eligible for AFDC or SSI with "special needs." A ceiling of $2.7 billion for fiscal year 1980 was placed on Federal title XX funds. This amount will be increased annually thereafter.

With respect to the AFDC, SSI and CSE amendments the law provides that:

—AFDC earnings disregards will not be applied to any earned income not reported on a timely basis.

—States will be permitted to prorate the shelter and utilities portion of the AFDC benefit when the AFDC household includes ineligible, closely related relatives.

—States must file claims for Federal reimbursement under the AFDC, SSI, medicaid and other Social Security Act programs within 2 years after expenditure (with certain exceptions).

—Federal matching will be allowed for AFDC foster care children voluntarily removed from the home of a relative prior to a judicial determination when such a determination (made before October 1, 1978) subsequently found the action to be in the best interest of the child.

—The $30 million annual Federal funding for the services programs administered by States for disabled and blind children receiving SSI shall be extended to September 30, 1982.

—AFDC and SSI recipients eligible for higher VA pension benefits under the 1978 VA pension improvements legislation, and living in States which provide medicaid eligibility for AFDC and SSI recipients only on a categorical basis (i.e., States which do not have programs for the medically needy), may refuse to accept the higher VA pension in order to continue eligibility for SSI, AFDC and medicaid.

—The 75-percent Federal matching for the non-AFDC child support enforcement program that was reinstated by Public Law 96–178 was made permanent.

—The fiscal year 1979 temporary increase in the ceiling and matching rate for AFDC and aid to the aged, blind and disabled in the territories was made permanent. The new ceiling is $77.7 million with a matching rate of 75 percent.

—A 15-percent incentive payment financed entirely from the Federal share of collections shall be made to States which enforce and collect child support within the State on their own behalf.

—The imposition of the 5-percent penalty for failure by a State to have an effective child support enforcement program for the period January 1, 1977 to October 1, 1977 was delayed until October 1, 1980.

Public Law 96–321 (S. 2995), Heat Crisis Program—Signed on August 4, 1980

Permitted the Community Services Administration to reprogram $21 million from its rural developments' unspent funds under the energy crisis assistance program to help low-income individuals meet the cost of heat crisis-related energy bills.

Public Law 96–354 (S. 299), Regulatory Flexibility Act—Signed on September 19, 1980

Contains provisions concerning agency rulemaking requirements which require an agency to:

—Assess the economic and paperwork impact of a proposed rule on individuals, small businesses, organizations and governments; and also require that such assessment include possible alternatives to the proposed rule.

—In addition to current information required at the time of publication of a notice of proposed rulemaking, include: (1) A description and estimate of the number of entities to which the proposed rule would apply: (2) identification of duplicative or overlapping rules; (3) agency assurance to consider acceptable alternatives to the proposed rule; and (4) statements outlining the purpose, form and length of recordkeeping and reporting forms and skills needed to complete same, estimate of personnel required for recordkeeping purposes, and estimate of time required for compliance for the entities.

Public Law 96-364 (H.R. 3904), Multiemployer Pension Plan Amendments Act of 1976—Signed on September 26, 1980

Contains a social security-related provision to provide that the unemployment pension offset requirement of existing law (section 3304(a) 15 of the Internal Revenue Code) shall continue to apply in the case of social security and railroad retirement benefits. The law also authorizes States to limit the amount of pension offset to take account of the individual's contributions to the retirement benefit.

HEALTH CARE FINANCING ADMINISTRATION

Long-Term Care Studies and Demonstrations

The mission of the Health Care Financing Administration (HCFA) is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 45 million aged, disabled, and low-income Americans. HCFA is committed to making beneficiaries aware of the services for which they are eligible, promoting the accessibility of those services and ensuring that HCFA policies and actions promote efficiency and quality within the total health care delivery system.

HCFA's programs are the principal source of funding for long-term care services in the United States, primarily skilled nursing and intermediate care facilities, and home health care services. HCFA spent an estimated $8.2 billion in Federal and State funds for long-term care services in fiscal year 1979. The medicaid program financed the greatest part of these expenditures, with Federal and State payments of over $7 billion for skilled and intermediate care nursing facility services, and an estimated $248 million for home health care services. (The medicare program spent approximately $368 million for skilled nursing facility services and $445 million for home health services in fiscal year 1979). Since 1970, nursing home care expenditures have experienced annual increases averaging 16 percent. In addition, during that period, nursing home days of care increased from 4 to 6 percent annually. The increased utilization of institutionalized long-term care services may be attributed in part to the growing population at risk. Today, about one-fourth of the elderly population is 75 and over. However, this proportion is projected to increase by over one-third by the year 2035. The 85 and over age group will represent 1 of every 10 elderly persons by the year 2035. The data indicates that currently three-fourths of all nursing home residents are 75 and over, and more than one-third are 85 years and older.[1] However, the aged are only one segment of the long-term care population.

The adult disabled constitute a substantial element of the population with long-term care needs. Approximately 23 percent of the population over the age of 18 have at least some limitation to their physical functioning.[2] Data have also been reported which indicate that the number of adult disabled under age 65 who have severe impairments is equal to the number of impaired persons over 65.[3]

Still another segment of the long-term care population are the mentally retarded and developmentally disabled. Developmental disabilities are defined as those conditions attributable to mental retardation, cerebral palsy, epilepsy or other related conditions. Mental retardation is defined on the basis of IQ as well as adaptive behavior. Recent estimates set the number of mentally retarded persons of all ages in the United States at 6 million, of whom 670,000 are diagnosed as severely handicapped. Of the remaining developmentally disabled population, 580,000 are estimated to have cerebral palsy, 206,000 are epileptics, and 600,000 with other neurological disorders including muscular dystrophy and speech and hearing disorders.[4] Within this segment of the long-term care population alone, there are several levels of impairment—from the profoundly retarded who require total and constant care, to the moderately retarded who might be able to manage some personal tasks with supervision, to the mildly retarded, who are often able to care for themselves and hold jobs. This latter subgroup are often able to live in a sheltered environment or alone.[5]

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[1] "Some Prospects for the Future Elderly Population," Statistical Reports on Older Americans, AoA, HEW, January 1978, p. 3.

[2] Final Report, "National Long-Term Care Project," University of Chicago, Center for the Study of Welfare Society, August 1980 (unpublished), p. 11.

[3] LTC for the Elderly and Disabled, Budget Issue Paper, CBO, February 1977, p. ix.

[4] "Long-Term Care, A Challenge to Service Systems," Judith LaVor; "Long-Term Care," Praeger 1979, pp. 22 and 23.

[5] LaPorte and Rubin, "Long-Term Care," Praeger 1979, p. 1.

The adult chronically mentally ill make up another growing portion of the long-term care population. Mental disorders affect up to 15 percent of the population in the United States during any given year.[6] The President's Commission on Mental Health reports that the direct cost of mental health services in the mid-70's exceeded $17 billion per year representing 12 percent of total national health care expenditures. In addition, the mentally ill have higher than average rates of physical illness, using medical services at almost twice the rate of the nonmentally ill population.[7] Primary diagnosis data from 1976 and 1977 reveal that 800,000 mentally ill people were residents in nursing homes during that time. This accounts for upwards of two-thirds of the total nursing home population.[8]

HCFA's Office of Research, Demonstration and Statistics (ORDS) has the responsibility for conducting long-term care research and demonstrations. The Long-Term Care Division of Experimentation within ORDS has been especially interested in supporting research and demonstrations which include the following areas:

DEMONSTRATIONS

(1) Organization and delivery of long-term care services at the State or community level, including management of services by providers, new configurations of service settings and management of the service needs of individuals.

(2) The provision of service packages to determine what packages of health and social services are most appropriately funded by the patient, private insurance, welfare-based programs or social insurance at the State and Federal level.

(3) Innovative reimbursement methods which would test new ways to pay providers of services in order to promote cost-effectiveness and the development of added services in areas of identified need.

(4) Test the impact of changes in the current methods of regulating quality of care in institutional and community settings.

(5) Testing financing of services with private insurers or HMO's to determine whether a health care benefit can be designed to include sufficient support services to maintain the aged and the disabled in the least restrictive, most cost-effective setting.

RESEARCH STUDIES

(1) Economic and reimbursement analyses which would include economic analyses of the home health industry, analyses of the influences of funding patterns on the availability and use of services, and studies of the economics of the insurance industry regarding long-term care.

(2) Patient characteristics and service use of residents in long-term care settings other than nursing homes; such as domiciliary care facilities. After an analysis of the available data, it may be deemed necessary to conduct a survey of those facilities and their residents for the purpose of comparative analysis with nursing homes.

(3) Analyze the role of families in the provision of care. This area would include programs providing home-based care, and/or the relationship between family roles and publicly provided services.

Research and Demonstration Activities

GENERAL SUMMARY

Research and demonstration projects are underway to examine the effects of revising benefits and eligibility criteria which currently place restrictions on admissions to nursing homes and hospices, often producing system inefficiencies. Studies and demonstrations are being conducted to assess the impact of new reimbursement strategies to promote cost containment and foster quality of care. Efforts are also underway to identify more effective long-term care quality assurance techniques and to improve the statistics and baseline information upon which future assessment of needs, problem identification and policy decisions will be based. A number of demonstrations are aimed at the development of com-

[6] Archives of General Psychiatry, June 1978, vol. 35.
[7] Services D. No. 5, Mental Disorder and Primary Medical Care, Analytical Review of the Literature, 1974, National Institute of Mental Health.
[8] Services for the Chronically Mentally Ill. The Implications of Financing. Unpublished paper (Wallack, 1979).

munity-based and in-home delivery systems for long-term care services. These projects focus on the coordination and management of an appropriate mix of health and social services directed at individual client needs.

DEMONSTRATIONS

Individual Projects—Ongoing

Community Care Demonstrations

New York, Monroe County I

The New York State Department of Social Services is conducting a demonstration project under the authority of section 1115 of the Social Security Act, through the Monroe County Long-Term Care Program, Inc. (MCLTCP). The purpose of this project is to demonstrate alternative approaches to delivering and financing long-term care to the adult disabled and elderly medicaid population of the county.

The project has developed the assessment for community care services (ACCESS) model as a centralized unit responsible for all aspects of long-term care for Monroe County residents, 18 years of age or older, who have long-term health care needs, and who are eligible for medicaid benefits. Program responsibilities include developing and coordinating community services, administering long-term care funds, approving all public payments for institutional and community long-term care services, and collecting program data. ACCESS staff provides each client with a comprehensive needs assessment, assistance in planning and obtaining community or institutional services, and ongoing monitoring of the appropriateness of the services. All long-term care services provided under medicaid in the county must be coordinated with the ACCESS unit in order for the provider to be reimbursed. Private pay patients may voluntarily use ACCESS services.

ACCESS assessment activity varies based on client location (e.g., acute care facility or in the community). However, actual assessments are all carried out by using the preadmission form (PAF) developed by the project to improve upon previously utilized State forms which attempted to document patient condition. The principal focus of the PAF is to determine client's capacity for self-care and to determine specific service needs necessary for the patient to remain at home, if at all possible. Assessments are carried out by the community health nurse (CHN) from the county health department or the Visiting Nurse Service of Rochester (VNS).

Once a patient's need have been determined, the assessor completes an alternate care plan (ACP) form which provides a detailed home care package, including identification of service, personnel needed and equipment necessary for home care. On the basis of the ACP, ACCESS determines the cost and practicality of home care for the patient. If the patient and family agree to the service plan, steps are taken to initiate services for the client (whether it involves home care or admission to a long-term care facility). As part of its contract with the County Division of Social Services, ACCESS may only approve home services for medicaid clients who can be assisted in home care for less than 75 percent of the cost of a comparable level of care in an long term care facility. If costs exceed 75 percent, ACCESS must make a special request to the DSS to allow home services. Nonmedicaid patients (e.g., private pay voluntary participants) must arrange for payment of their services on their own, although ACCESS will assist and advise them in these arrangements.

ACCESS provides followup to its client population by a home review system. Home review visits are made three times a year for medicaid clients and where necessary and agreed to by nonmedical clients.

Utilization review forms are routinely shared with ACCESS by three church sponsored nursing homes and one public facility in the county for all required review periods (i.e., 30, 60, and 90 day review) determines whether the patient is at the appropriate level of care. If the UR form indicates a change may be necessary, the Genesee Valley Medical Foundation (that conducts the utilization reviews) transmits the form to ACCESS for review and resolution.

Section 1115 medicaid waivers permits the project to include the following services: Friendly visiting, housing improvement, home maintenance/heavy chore services, housing assistance, transportation, moving assistance, and respite care.

The project has the authority to contract with providers for the delivery of services. After bills are submitted to the project by providers, their claims based on State medicaid reimbursement schedules are forwarded by the project to the State medicaid office for payment.

Objectives.—The objectives of the project are:

—To provide long-term care services which are appropriate, cost-effective, and acceptable to the client.

—To provide coordination and continuity of case management for long-term care clients.

—To improve long-term care assessment and review procedures.

—To collect data about needs, service utilization, and appropriateness of placement of persons requiring long-term care.

—To reduce the number of county residents who are in acute hospitals and long-term care institutions.

—To reduce per person rate of increase of medicaid expenditures for individuals needing long-term care below the rate that would have occurred had the project never existed.

In the initial 24 months of ACCESS activity, 6,451 referrals were received; 3,430 from hospitals and 3,021 from community sources. The community referrals came from home health agencies (29 percent), clients and/or families (29 percent), long-term care facilities (11 percent) local human services agencies (5 percent) and physicians (5 percent). During that time a total of 4,433 clients were processed through the assessment stage and were either set up with a package of home services or admitted to a long term care facility. Of the 4,433 clients who were processed into the system, 63 percent were at home and the others admitted to a facility.

Medicaid costs for all direct, noninstitutional services for the 835 skilled level patients who were assessed at home under the ACCESS system, is estimated to be $23.38/day, or 52 percent of the comparable medicaid institutional rate (at $45/day). The medicaid cost for health related and proprietary home level service packages are also reported to be less than half of the comparable institutional rate.

Preliminary data show that home care costs for long-term care patients under the demonstration are from 30 to 50 percent of the county's comparable institutional costs. Skilled nursing services provided in the home through the project were estimated to be $20.01 per day compared to $45 per day for equivalent institutional care. For health-related services (equivalent to ICF care), the costs were $9.08 for home care as compared to $27 for institutional care. At the domiciliary care level, the costs were $4.21 compared to $16 at the institutional level.

New York, Monroe County II

The delivery model used for the section 1115 Monroe County long-term care medicaid project (Monroe County I) will be expanded under the authority of section 222 of the Social Security Act to include case management and patient assessment services for the county's *medicare* population in need of long-term care. This demonstration shares the purpose and goals of the section 1115 *medicaid* project. The addition of this project to the Monroe County program will enable the county to work toward an integration of medicare and medicaid long-term care services in the county and to simplify administration.

In addition to the ACCESS process described for the Monroe County I project, section 222 medicare waivers will enable this project, approved in July 1980, to implement a utilization review component whereby once a client has entered a facility or has been approved for home care, a set review schedule will be used. Medicare entitled clients will be reviewed in a skilled nursing facility every 14 days by a utilization review nurse from the Genesee Valley Medical Foundation. Medicare entitled clients at home will be reviewed by a nurse from a certified home health agency every 28 days. In addition, the section 222 medicare waivers will permit ACCESS to certify a client's need for skilled nursing services for up to 14 consecutive days in a skilled nursing facility, and up to 28 days for the provision of home care services, if approved by the client's private physician.

The waivered medicare services under this demonstration include: client intake and assessment; noninstitutional skilled nursing facility services; financial counseling; in-home architectural review; and transportation services. Extended care services will be furnished to participating skilled nursing facilities (SNF's) if the patient requires daily skilled nursing or other skilled rehabilitation serv-

ices which can only be provided in a SNF on an inpatient basis. The "post-hospital" medicare requirements for SNF care and part A home health care are also waived in order to implement this project.

This project is scheduled to begin operations in May 1981.

New York State, Long-Term Home Health Care Program—Nursing Home Without Walls

The New York State long-term home health care program (LTHHCP), also known as the "nursing home without walls" program, was established by the State legislature to become effective April 1, 1978. The program provides for a voluntary alternative to institutionalization for medicaid clients who meet the medical criteria for skilled nursing facilities (SNF's) or intermediate care facilities (ICF's). A maximum expenditure for home care has been set at 75 percent of the going rate in a locale for SNF or ICF levels of care for which the client is eligible.

The New York State Department of Social Services received medicaid waivers in September 1978 under section 1115 of the Social Security Act to assist in a 3-year demonstration of the gradual implementation of the program.

The purpose of the program is to reduce fragmentation in the provision of home care services to the aged and disabled through a single entry system which coordinates and provides these services in nine sites throughout the State. The sites are based on a single entry system which coordinates and provides all of the services. The objectives of the project include: (1) Maximizing the use of available resources; (2) determining whether various types of providers are differentially successful in providing these services; (3) comparing the effectiveness of long-term care programs in different geographical areas; (4) comparing the program with traditional home health care provided by certified agencies; and (5) promoting cost containment.

As illustrated below, each of the nine sites show a different pattern in development of their respective patient caseloads.

Sites	Operational date	Current caseload[1]	Capacity
Bronx, Montefiore Hospital	August 1979	32	100
New York City, St. Vincent's Hospital	September 1979	30	80
Queens, Visiting Nurse Service	May 1980	45	75
Brooklyn, Metropolitan Jewish Geriatric Center	May 1979	133	155
Buffalo, 24 Rhode Island St. Nursing Home Co., Inc. N.Y.C.	November 1978	35	50
Buffalo, Erie County Department of Health	September 1979	32	105
Syracuse, Visiting Nurse Association of Central New York	March 1979	40	100
Syracuse, Onondaga County Department of Health	March 1979	72	120
Olean, Cattaraugus County Department of Health	April 1979	23	20

[1] As of the end of November 1980.

Under the LTHHCP, all patients must be medicaid eligible in need of either SNF or ICF levels of care. For all potential program users, a medical assessment abstract must be completed which produces a prediction score, referred to as the DMS–1 score. The DMS–1 assessment instrument is used in New York State as a tool to determine the appropriate placement of patients in long-term care facilities. When patients are determined to be eligible for the LTHHCP program a joint in-home assessment is completed by an LTHHCP nurse and a caseworker from the local (State) social service district. Following completion of the assessment, a plan of care is developed and a budget review is initiated by the caseworker. This budget review determines whether the total projected costs are within 75 percent of the monthly average medicaid costs of the going rate for SNF or ICF levels of care for which the client is eligible. A reassessment is conducted every 120 days and a physician review of patient care needs is renewed every 60 days.

The coordination of the services and the case management functions are shared by the LTHHCP coordinator and caseworker. Professional support must be available to patients through an emergency on-call system 24 hours a day.

In the initial startup phases, the State Department of Social Services and Health Systems Management together with Senator Lombardi (the author of the LTHHCP legislation), met with local commissioners in each district site to

familiarize them with the program and facilitate programs implementation. In addition, the State met with hospital discharge planners to make them aware of the program and worked with the local social service districts to train staff and provide technical assistance to the LTHHCP staffs. However, the project experienced some difficulties in becoming fully operational. Startup was delayed as a result of staff turnover, problems in coordination and site difficulties in obtaining referrals. There was also a delay in the enactment of State legislation authorizing financial participation for reimbursement of the seven waivered services under the section 1115 demonstration authority. The implementation and payment mechanism for these services is currently under development by the State and will be released shortly. The waivered services are: home maintenance, nutrition counseling/educational services, respiratory therapy, respite care, social day care, transportation, congregate meal services, moving assistance, housing improvement services, and medical-social services. For evaluation purposes, the project will also conduct primary data collection on a comparison population for analysis by Abt Associates, Inc. (the HCFA evaluator).

The project has acted to resolve some of its problems with three additional State monitoring staff positions to provide site assistance and is working with the evaluator in coordinating and developing the data collection strategy. Because there have been delays in the joint assessment process to determine patient eligibility, an "alternative entry procedure" was established, which allows the provider to begin service to the patient immediately based on their own initial assessment of the patient. A joint assessment is then conducted with the local social service district.

In the New York City area, where there are four sites, a long-term care task force has been established with participation from the sites and the New York City Human Resources Administration to facilitate communication and coordination of efforts in program implementation.

In addition, it is anticipated that the following legislative modifications passed by the State legislature in June 1980, will enhance project operations:

(1) Reallocation of patient slots among the nine approved sites through a change in the State hospital code and legislation authorizing the commissioner of health to stipulate the maximum number of persons that an LTHHCP may serve.

(2) Passage of a Senate bill will annualize the 75 percent cap so that if it is reasonably anticipated that average expenditures for a year's time will not exceed the cap, the patient can be admitted to the program.

(3) Legislation that amends the eligibility requirement in the LTHHCP program. This will require that the patient be "medically eligible" for placement in a residential health care facility.

Oregon, FIG Waiver Continuum of Care Project for the Elderly

The Oregon Department of Human Resources was awarded a grant in September 1979, to test the provision of alternate community-based services to the elderly in a five-county area in the southwestern part of the State. This demonstration was funded for the first year of a 3-year project under the authority of section 1115 of the Social Security Act. The project has also received a grant from the Administration on Aging to support administration costs and an evaluation component for the project.

The two components of the project—FIG (flexible intergovernmental grant) and section 1115 waivers share the same objective: to serve the elderly more appropriately and contain medicare costs. The FIG component most directly addresses service delivery deficiencies due to uncoordinated, unintegrated service delivery by diverse agencies serving the elderly. The waiver component addresses fiscal imbalance in the service system due to Federal funding patterns which encourage maximum utilization of medicaid institutionalization. Each component utilized separately will impact both problems to some extent; however, use of both of the components together in one of the five counties should maximize the impact on deficiencies in the current system.

The five sites and their respective research conditions are: Jackson County (FIG and waiver), Josephine County (FIG only), Coos/Curry counties (waiver only), and Douglas County (comparison).

In carrying out this demonstration, a cost containment model was developed to address the problems involved with a statewide multiple entry service delivery system without changing any of the State agency's internal structure. Unique features of the project are: (1) Accountability and decision making assigned to

a county policy committee; (2) a profile of all provider agencies serving the elderly to be distributed to each participating provider; (3) the use of a common functional assessment tool to standardize placement choices. Each site is conducting assessment and reassessment; care planning, and case management with followup by currently employed county personnel.

The State project is targeted to individuals 65 years or older who are eligible for medicaid and title XX benefits and have been assessed as eligible for in-home services instead of nursing home placement.

Certain health-related and social services which are not otherwise provided under title XIX are provided under waiver authority in the waivered counties. These include: Homemaking and housekeeping services, chore services, home delivered meals, adult foster home services, adult residential services, and limited transportation services.

The specific objectives of FIG are:

—To overcome fiscal imbalance and service delivery deficiencies in current title XIX program.

—To achieve cost containment.

—To provide alternative community based service to elderly persons to delay or prevent institutional placement.

—To provide more appropriate in-home health services without increasing current fiscal resources allotted to institutional and in-home titles XIX and XX program components.

The basic patient assessment instrument utilized by the project is known as the placement information base (PIB), which was developed by the State prior to the current demonstration. Although shorter than most instruments currently being used in demonstration projects, the PIB contains the important items that provide information on which a decision to maintain a person in his own home can be made. The items are organized to obtain pertinent information regarding an individual's ability to communicate, to ambulate, to manage his living environment, to perform both activities of daily living (ADL) and instrumental activities (IADL), and to handle financial affairs. The instrument has undergone a number of revisions and has been expanded and is currently being used statewide for adult services. This instrument is used by county agency personnel, by providers (for referrals made to the project) and by project staff. A training program has been developed for all project staff to assure uniform application of the expanded assessment instrument in the five-county area. The project became operational in January 1980.

As of September 1980, the caseload in the five-county area was 1,002. The project results to date in the FIG only and the FIG/waiver counties are similar. Both counties have shown consistent reductions in expenditures of medicaid funds for nursing home care. It appears that the FIG component continues to have significant impact on the long-term care system in both counties. Results in the waiver only and the comparison counties tend to reinforce the tentative conclusion that local agency cooperation and planning toward the goal of preventing or delaying nursing home placement is vital to impacting nursing home utilization.

The provision of additional financial resources (e.g., waivers) without other intervention (e.g., FIG component) has not significantly impacted nursing home growth in the four counties involved in the project.

A report on the first operational year of the project will be available in the spring of 1981.

San Diego, North San Diego County, Long-Term Care Project

The purpose of this demonstration is to compare client benefits and costs of care between existing long-term care services and those provided under the project. The project will provide a comprehensive, coordinated system of long-term care for medicare beneficiaries aged 65 and over. The hypothesis to be tested is that a coordinated system of long-term care service delivery for medicare beneficiaries 65 and over, providing continuity of care with a wide array of in-home, community-based, and institutional resources, stressing client education for self-care and client participation in care plan development, will result in clients achieving and maintaining optimal health status and functional independnce and will assist in containing the overall costs of health care.

In designing the demonstration, the project established broad goals: (1) To demonstrate that a medicare-certified provider of home health services with a range of supplementary in-home supportive services, and an established system of

communitywide linkages, is an appropriate and cost effective resource for the administration of a long-term care system; (2) to assist the frail elderly, chronically ill, and disabled persons 65 and over to achieve and maintain an optimum level of health, self-care and functional independence in their own homes and cultural environment; (3) to assure appropriate and acceptable out-of-home placement only after a thorough exploration of personal and community resources demonstrates that needs cannot be met at home.

The project builds upon the existing scope of medicare covered home health services provided by the Allied Home Health Association and the Visiting Nurse Association. Through this delivery model the project links an existing information and referral network with a centralized single entry system. The project services include: professional assessment of client needs, client participation in care plan formulation, and case management. The project contracts with providers for delivery of services.

The project will provide the following services under the Section 222 waiver authority: Adult day health care, home delivered meals, homemaker services, escorted transportation, patient educational services to enable the patient to follow the physician's instruction for self-care, and professional staff visits to monitor the patient's functional status.

Approximately 500 experimental and 250 control participants are expected to be enrolled in the project.

During this first developmental year; a patient assessment instrument which has been used by the Allied Home Health Association since 1977, was revised for use by this project to include items of broader scope. The instrument provides four levels of information regarding patterns of service utilization: (1) Patient assessment; (2) services of existing community providers; (3) services provided by the patient's informal support system; and (4) medicare-waivered services specific to the long-term care project.

The project has trained the initial assessment teams, who include staff of the San Diego Visiting Nurse Association as well as project staff. In addition, special training has been provided for project nurses and social workers in the area of care planning and case management.

The project has obtained commitment of local service providers and referral sources. It is estimated that the project will be fully operational by February 1981.

Connecticut, Triage

The Triage model is based upon a single entry access point to the health delivery system for elderly persons. The demonstration project tests the feasibility and effectiveness of service coordination for elderly and disabled individuals living in a seven-town area in central Connecticut. The project is designed to build an appropriate interface between client and multiple service agencies, whereby care is organized around the client and the available resources.

Triage was initiated by the State of Connecticut in 1974, with State funding and a grant from the Administration on Aging and in 1975 received section 222 medicare waivers together with funding from the National Center for Health Services Research, Public Health Service, for the research component of the project. These initial years of the project are referred to as Triage I.

On April 1, 1979, HCFA approved a 2-year project utilizing the same demonstration and research design in order to obtain needed longitudinal data regarding the utilization and cost of services provided to this group of patients from the inception of the project. This 2-year project is known as Triage II.

The project serves an eligible population of 19,526 people, 65 years and over who are entitled to medicare parts A and B and who has developed its service delivery system around individual needs, rather than tailoring the care to existing reimbursable sources. The delivery model includes the following features: patient assessment and individualized plans of care, coordination of all available health related services, creation of new services in the demonstration area, monitoring of the plans of care, and evaluation of pertinent data in accordance with a research design so that patient outcomes and costs of services can be available for study by health care planners.

The project serves 1,500 participants; 300 of which are experimentals and 195 are controls for research purposes.

The objectives of the project are: To increase effectiveness of health services, and to develop necessary preventive and supportive services and demonstrate their value to target population.

To provide single entry assessment mechanism to coordinate delivery of institutional, ambulatory, and in-home services which will result in cost containment.

To demonstrate the effectiveness of coordinated care, including: (a) Care to prevent illness, compensate for disability and support independent living at home; (b) care prescribed appropriate to need rather than according to third-party payor service restrictions; and (c) use of professional nurse-clinician/social service coordinator teams to assess needs of individuals, arrange for appropriate services and provide case management services.

To reduce expenditures for health care delivered to target population.

The Triage model operates through a clinical process of care developed and monitored by interdisciplinary teams, each of which consists of a nurse-clinician and a social service coordinator (social worker). The clinical process of care includes the following four stages:

(a) *Referral.*—Most frequent sources of referral have been self-referral, family, friends, visiting nurses, hospital discharge planners, physicians and social workers.

(b) *Assessment.*—The nurse-clinician/social service coordinator team jointly visit the client's home to fully assess client needs, using a comprehensive assessment form. This form was developed and refined by project clinical staff, the project research team, and a geriatric physician consultant. The assessment consists of a modified physical examination, and an extensive interview. The interview includes a complete health history, information on client functional status, nutrition, physical environment and living expenditures. Functional status is assessed by the use of three standardized instruments—the Activities of Daily Living (Katz, et al.), the Instrumental Activities of Daily Living (Lawton and Brody) and the Mental Status Questionnaire (Goldfarb, Kahn, et al.). This process provides the data base upon which the plan of care is developed for each client.

(c) *Coordinating the care plan.*—Based on the assessment data, a plan of care is developed. The Triage team works with the client and his or her family to select services appropriate to the client's needs and the providers that will be asked to deliver the services.

(d) *Monitoring.*—After service delivery commences, the Triage team maintains ongoing contact with the client to assure that services continue to be consistent with the care plan, in terms of quality and quantity. In addition, the team consults frequently with providers and meets on a monthly basis with home health agencies in the region and other providers as needed. A medical-dental advisory committee is available to Triage staff for consultation and review of client status. The committee consists of five physicians (with different specialties) two dentists, a podiatrist and a pharmacist.

The section 222 medicare waivers have made it possible for Triage to authorize payment for many ancillary and supportive services not traditionally covered by medicare; and to waive specific medicare requirements such as coinsurance and deductibles and restrictions on home health care.

The following table describes the services available to Triage clients, including waivered services and traditional medicare services.[1]

Service category	Traditional medicare services	Waivered services
Institutional	Hospital, skilled nursing facility	Intermediate care facility, home for the aged, day care.
Home care	Visiting nurse, home health aide	Homemaker, chore, companion, meals and meal delivery.
Ambulatory	Physician, outpatient service, diagnostics (X-ray and laboratory), therapy (speech, physical, occupational). Dentist (selected medical conditions). Podiatrist (selected medical conditions).	Optometrist, dentist (routine and preventive), podiatrist (routine and preventive), mental health counselor.
Products	Medical equipment, supplies	Pharmaceuticals, hearing aids, glasses.
Transportation	Ambulance	Chair, car, taxi.

Traditional medicare services are reimbursed according to the procedures and rates of that program. For other services not normally included under medicare, the method of reimbursement varies according to service type. Homemaker and

[1] Triage I final report, December 1979.

ICF's for example, are reimbursed on a cost reporting basis; pharmaceuticals and optical care are reimbursed using medicaid rates established by the State Department of Social Services. For other services, Triage obtained schedules from government and industry sources (e.g., Connecticut Public Utilities Commission rates used for transportation). Rates were negotiated with each provider for services such as meals and meal delivery, companions and chore service.

Triage has also provided training opportunities for providers and students in health professions programs throughout the life of the project.

Data from Triage I are currently being analyzed by NCHSR. Findings from the initial years of the project funded under the auspices of PHS, should be available in fiscal year 1981. Preliminary data from Triage I indicate that: 72 percent of participants improved or maintained their ADL (activity of daily living) and MSQ (mental status) scores. However, the overall performance of the participant group on assessment scores decreases with advancing age. The total cost per participant for 1978 was $3,620 or an average per diem cost of $12.63 per day. Data collection for Triage II is not available, as the project will not terminate until the end of fiscal year 1981.

South Carolina, Community Long-Term Care Project

The South Carolina Department of Social Services is conducting a 3-year demonstration under section 1115 of the Social Security Act to test community-based client assessment, services coordination, and provision of alternative services; and to develop proposals for permanent modification of the State medicaid program. The project has also received funds from the Appalachian Regional Commission to pay part of the administration costs of the project. A major goal of this project is to establish a community network of services that support the efforts of disabled and elderly individuals to remain in their communities. The network will have a self-sustaining community structure without a separate coordinating agency, thereby developing an integrated model for long-term care services.

Key operational components of the project include: community-based client assessment; reassessment; and service coordination toward provision of services which are alternatives to institutionalization. The population to be served are medicaid eligible elderly individuals with functional disability who are at risk of nursing home placement; 2,000 individuals are expected to participate in the project over the 3-year demonstration period, 1,000 of which will be experimentals (55 percent from the community; 45 percent from nursing homes). The control group will be randomized.

The project will provide certain waivered health-related and social services which are not otherwise covered under medicaid. These include: homemaker, chore, respite care, alternative housing, home delivered and congregate meals, and adaptive equipment in the home.

The project includes three project sites, located in three different counties. Each county site is establishing an advisory committee. The advisory committees will assist the sites in identifying service needs and priorities for new service development.

A major objective of this project is to facilitate cooperation among service providers at the community level. The existing medicaid, medicare and title XX services will be coordinated for project participants.

The assessment instrument designed to be used by the project (all sites) was based closely on the instrument developed by the Monroe County, N.Y., ACCESS project. The South Carolina instrument has undergone a number of revisions to meet the unique needs of this primarily rural project. Training has been provided to project staff in the areas of assessment, care planning and case management.

The project became operational in July 1980 in each of the three counties. Strong support has been provided by the South Carolina State Long-Term Care Council. A legislative advisory committee is providing active liaison between the project and the State legislature. In addition, the State appropriation for the project has been increased by $225,000.

The project anticipates that 1,800 medicaid eligible individuals will be referred for screening during the first full operational year.

Texas, "Modification of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged"

The Texas Department of Human Resources (DHR), is conducting a 3-year "waiver-only" demonstration project under section 1115 of the Social Security

Act to develop and test a comprehensive continuum of care for the aged that is appropriate in terms of quality of care, preferences of recipients, and costs.

This demonstration was initiated as a result of a State legislative mandate to eliminate unnecessary and inappropriate utilization of nursing home services. The mandate requires DHR to eliminate one of the two medicaid ICF levels of care (ICF II and ICF III) and to provide community-based services to patients who can be deinstitutionalized. A State appropriation was voted to carry out the intent of the legislation.

As of February 1980 the distinction between ICF II and ICF III was eliminated so that only a single ICF program (in conformity with Federal regulations) now exists below the SNF level. Some of the individuals who were receiving benefits in ICF II are being institutionalized to community-based settings and provided with alternative health-related services. The remaining individuals will be "grandfathered" into the single ICF program.

Under this project a 5-percent sample of the 18,000 institutionalized patients in level II ICF's will be assessed to determine their discharge potential. For those who are deinstitutionalized a care plan will be developed and arrangement for in-home services through community service providers will be made. In addition, the project will conduct case management, monitoring, and followup activities for project participants.

The following services will be provided: Medicaid home care benefits, medicaid personal care benefits, title XX adult in-home services, and section 1115 waivered community based in-home supportive services.

The objectives of the project are: To create a single ICF level of care (by eliminating level II), to increase the availability of alternative care services in communities, to develop a new State assessment instrument that is appropriate for institutional discharge planning, and to assure appropriate continuing care for current level II ICF patients.

As of March 1980, the State had terminated all new admissions to level II ICF. Standards for SNF's and ICF nursing homes have been revised and new criteria for ICF's have been established. In addition, a plan for monitoring long-term care facility admissions has been developed.

The project will become fully operational in the spring of 1981.

San Francisco, Mount Zion Hospital Long-Term Care Demonstration Design and Development

The Mount Zion Hospital and Medical Center is conducting a 3-year medicare demonstration under section 222 of the Social Security Act to implement a hospital-based long-term care services delivery system in a designated service area. This model builds upon components of Mount Zion's existing geriatric services, including acute care, emergency health services, outpatient services, home care and information and referral. A consortium of five service providers under the direction of Mount Zion will cooperate to provide a range of health and social services to the frail elderly in the designated catchment area.

The project is providing centralized intake and case management, including assessment, care planning and case monitoring. It is designed to test the ability of a consortium of service providers to provide more accessible, appropriate, and cost effective care.

The project has received waivers to provide certain health-related and social services which are not otherwise provided under medicare. These include: Day care services; homemaker services; chore services; home delivered meals; interpreter services; respite care; discharge assistance; drugs and biologicals, including immunizations and those which can be self-administered; audiology services, including hearing aids; optometry services, including eyeglasses and contact lenses; podiatry services, including orthopedic footwear and other supportive devices; dental care, including prosthodontics; adaptive and assistive equipment; transportation of patients by specialty vehicles, cabs, and other private and public means; case management services; mental health counseling, including services by psychologists, psychiatric nurses, psychiatric social workers, and pastoral counselors; and prosthetic and orthotic appliances.

The basic assessment instrument used by the project is the patient status assessment instrument, which was used for the Public Health Services section 222 experiments on adult day health care and homemaker services. This instrument has been expanded to include items which are necessary for care planning and determination of appropriate patient placement. Material from the Monroe County, N.Y. (ACCESS) instrument was used in the revisions. The resulting instrument has been field-tested extensively, further revised, and validated.

The project developed a formal training program for project staff in assessment, care planning and case management functions. In addition, Mount Zion has established a seminar program to provide project staff as well as consortium members and other hospital personnel an opportunity to increase knowledge regarding long-term care. Knowledgeable individuals from the Mount Zion Medical Center and the community are leading the seminars.

In August 1980, the project became operational. The project will ultimately have a caseload of 200 experimentals and 100 controls.

Florida, Ancillary Community Care Services

The Florida Department of Health and Rehabilitative Services is conducting a 3-year "waiver only" demonstration project under section 1115 of the Social Security Act, to develop and test ancillary community care services for the chronically impaired elderly.

The purpose of the project is to establish in five Florida counties (Broward, Dade, Duval, Pinellas, and Polk) a model of preventive, maintenance and restorative health care systems for medicaid eligibles, noninstitutionalized, functionally impaired persons aged 60 and over. The project's goals include the following: (a) To assist persons 60 years of age and older identified as "at risk" of institutionalization to remain in the community by helping them maintain a level of self-sufficiency through provision of health and related services not provided under the State's medicaid program; (b) to conduct a study of individuals receiving ancillary community care services to determine the effectiveness of community based socio-medical services; (c) to evaluate the organizational structures and costs related to each site, including but not limited to: client impact, staffing, annual budgets, urban/rural orientation, service cost, referral networks, and incidence of undetected health problems.

Each of the five county agencies will be responsible for the deve'opment of individual care plans, case management, and contracting for services with local providers. The demonstration project consists of three major components:

(1) A comprehensive medical-social assessment (CMA) designed to: (a) Provide a comprehensive health examination and a functional assessment to select aged Floridians; and (b) to collect information about the general health, mental health, physical impairments, availability of social resources, unmet needs, and living conditions of older persons.

(2) A case management system; and

(3) Six ancillary community care services, including: personal care services; specialized home management services; medical therapeutic services; respite services; day treatment services; and medical transportation services.

During the first developmental year of the project, the following tasks were completed:

(1) Key staff including the project director, deputy director and data specialist have been recruited and oriented.

(2) A protocol manual for project implementation has been developed.

(3) A training program for the (five) sites has been developed, with plans to use the first site to train and orient site personnel from other sites.

(4) Contractural arrangements have been established with physicians and a management firm to help with training and administrative protocol manuals.

(5) The project has initiated working relationships with the State medicaid program.

(6) The existing State MIS has been modified to track all project expenditures, and the project has arranged with Blue Cross to perform a similar service in relation to medicare services and costs.

The project will begin in Duval County—Jacksonville, and will build incrementally on the experiences at that site to develop the other four sites. The first site is expected to be fully operational as of January 1, 1981. The project plans to recruit 50 potential participants and field test all intake and assessment procedures during the first operational month in order to refine protocols. During the first 12-month operational period, at the first site the project estimates developing a caseload of about 266 participants.

California, Multipurpose Senior Services Project (MSSP)

In September 1977 the State enacted AB998, which required the State health and welfare agency to establish MSSP across the State that would test single entry access to the health and social services system through case management, care planning and needs assessment. In October 1979, the State health and wel-

fare agency received a "waiver-only" grant under section 1115 of the Social Security Act to implement the State mandated MSSP demonstration over a 4-year period.

The demonstration is being implemented in eight sites across the State. Some of the sites provide services directly while others are limited to case management and purchase of service functions. All sites have the authority to contract for services with local providers.

The target population for this project is persons aged 65+ who are considered at risk of institutionalization and who meet the State eligibility requirements for Medi-Cal (medicaid). There will be 1,900 participants in the MSSP; 960 will comprise the comparison group sample. The sample is being drawn from Medi-Cal eligibles from the community; acute care hospitals; and from skilled nursing facilities (SNF).

The project has medicaid received waivers to provide certain health-related and social services which are not otherwise provided under medicaid. These include: (1) Adult social care, (2) housing assistance, (3) in-home supportive services, (4) legal services, (5) nonmedical respite care, (6) nonmedical transportation, (7) meal services, (8) protective services, (9) specialized communication, and (10) preventive health care.

Other services are being provided from existing State funds under title XIX and XX of the Social Security Act and title III of the Older Americans Act, as well as the State general fund.

The demonstration has both comparative and operational objectives. The comparative objectives are: To reduce client's number of hospital days, to reduce client's number of SNF days, to reduce total expenditures of social and health services for clients, and to improve/maintain client functional abilities.

The operational objectives are: To estimate effectiveness of existing services; to estimate and compare among sites, more effective mix of LTC services; to estimate optimal expenditure for client care while reducing SNF and hospital patient days; and to estimate optimal expenditure for client care while improving or maintaining client's functional abilities.

Individual MSSP sites were required to meet specific State MSSP prescribed criteria before becoming operational. As of September 1, all eight sites were operational. (The State project became operational in March 1979.) The sites are phasing in caseloads and staffing at a MSSP prescribed pace that calls for full caseload by January 1, 1981. The eight sites are: Jewish Family Services, Los Angeles; East Los Angeles Health Task Force: Senior Care Action Network, Long Beach; Mount Zion Hospital and Medical Center, San Francisco; city of Oakland; Greater Ukiah Senior Citizens Center; County of Santa Cruz; and San Diego County Area Agency on Aging.

During the first developments, and preoperational year several major tasks were carried out. A public relations campaign was launched to inform key State and local officials and agencies about MSSP. Comprehensive planning was conducted at the site level with State MSSP involvement. Staff for the State and each site were hired, and during the months of March, June, and August all sites were trained by the State on all aspects of local MSSP operations. A comprehensive training protocol was prepared for this activity.

In addition, a patient assessment instrument was developed, pretested, and refined. This extensive comprehensive assessment instrument is conducted in two parts: social assessment and medical assessment. It is administered by a nurse practitioner and a social case worker, respectively.

MSSP has developed the data collection procedure for the participant's information, designed a system to analyze the effectiveness of the program, and designed a computerized management information system.

It is expected that all sites will have reached their full case loads, (which range from 100 to 350) by spring of 1981.

During the second year of the project, along with ongoing implementation activities, MSSP plans to initiate and implement the comparison group research activities and implement the computerized MIS system and data processing activities. In addition, it is anticipated that preliminary reports of Medi-Cal utilization trends, unit costs of services and the impact of case management hours on client outcomes will be available during the second project year.

Improving New York State's Nursing Home Quality Assurance Program

The New York State Department of Health was awarded a section 1115 waiver-only grant, effective September 2, 1980. This 3-year demonstration is part of an

overall effort by the State to improve the quality of care provided in residential health care facilities (RHCF) which include both skilled nursing facilities (SNF's) and intermediate care facilities (ICF's).

DESCRIPTION

The objectives of this project are to simplify and streamline the medical review (MR) and independent professional review (IPR) and medicare review process for all RHCF's in New York State. The current system is described as very cumbersome, particularly when 8,000 reviews are processed per week. The new system will use a screening survey (based upon the screening survey developed for the Wisconsin quality of care project). It will combine a self-reported form to be filled out by the facility with a relatively brief form to be filled out by the reviewers when they visit the facility. This latter form would reduce the number of items for the SNF survey from 1,285 to 241 and the ICF requirement from 780 to 223. PMR and IPR will be combined into a single process. The first stage will be an outcome-oriented system which will look at sentinel health events (SHE's). These are defined as untoward events whose presence represents a potential failure in the care system. Examples include the presence of decubitus ulcers, urinary tract infections, and contractures. If the number of these events exceeds a threshold (to be established on the basis of the patient mix and the facility), then the second stage of the proposal will be initiated. In the second stage, a more detailed investigation of the process of care for a sample of patients having the untoward events will be undertaken using specifically designed protocols for each SHE.

The research design calls for an assessment of the extent to which the review efforts are focused on the 20 percent of facilities anticipated to be sufficiently deficient to require intensive surveys, the validity of the outcome-based screening and the process-based followup, and the relationship between deficiencies in the new process and underlying causes. Finally, various statistical measures will be applied to test the increased efficiency of the new system over the old one.

Hypotheses to be tested include:

(1) The survey emphasis on the structural measures of quality of care will complement the outcomes/process measures of the PMR/IPR to more clearly define the root causes of lack of facility compliance with State and Federal regulations. Corollaries of this hypothesis are: (a) The deficiencies noted in the new process will be directed to underlying causes rather than symptoms to a greater extent in the new system when compared with the old; (b) the plan of correction filed by the facilities will be directed to underlying causes rather than to the symptoms to a greater extent in the new system when compared to the old.

(2) Each SHE is a reliable measure.

(3) The SHE's will point to areas of poor quality care.

(4) Different reviewers will reach the same decision as to whether a stage II review is needed.

(5) Stage II review efficiently documents poor quality care when compared to the present system.

(6) Stage II reliably documents poor quality care.

(7) The new system will document more problems associated with direct patient care rather than with documentation of patient care or other indirect factors related to patient care than the current system.

The demonstration will be implemented following HCFA approval of several conditions that accompanied the grant award.

CONCLUDED PROJECTS

UNIVERSITY OF CHICAGO, NATIONAL LONG-TERM CARE PLANNING PROJECT

The University of Chicago Center for the Study of Welfare Policy, in conjunction with a consortium of universities and State and local governments received a 1-year planning grant to develop a planning framework for a coordinated approach to the design and development of long-term demonstration projects during 1979. The consortium was comprised of a core group of planners, researchers, and State and local government representatives around the country who collaborated in the design and development of demonstration projects which were to focus on developing a conceptual and operational planning framework within which alternative models of financing, organizing and delivering long-term care services can be assessed. The overall objective of this coordinated

approach was to enable careful analysis of systemwide implications, to present alternative models for long-term care services, and to understand better the process through which States and localities can develop comprehensive long-term care service systems.

The universities involved in the consortium included the University of Chicago, which directed and coordinated the project through its Center for the Study of Welfare Policy in Washington, D.C.; the Center for Health Services Research at the University of Minnesota; the Health Policy Consortium, comprised of Brandeis University, Massachusetts Institute of Technology, and Boston University; and the health policy program of the University of California at San Francisco.

In addition to the development of two research demonstration projects (Illinois long-term care voucher experiment and Brandeis social HMO experiments), the consortium produced several useful analytical papers on key issues in long-term care. These papers, along with the project's final report, are available from the University of Chicago Center for Social Policy, Washington, D.C.

Wisconsin, Community Care Organization (CCO)

The Wisconsin Community Care Organization sponsored by the Wisconsin Department of Health and Social Services was awarded a research and demonstration grant under section 1115 of the Social Security Act in October 1974 and concluded its fifth and final project year in December 1979. The project submitted a five-part final report in June 1980: a State overview, the final evaluation report prepared by the Faye McBeath Institute on Aging and Adult Life of the University of Wisconsin and the three site reports. The purpose of the project was to demonstrate that a substantial segment of the elderly and disabled population can be maintained in their own homes or in community settings through the provision of a packaged continuum of health and social services.

Community care organizations (CCO's) were established in counties in three different geographical areas of the State; urban, Milwaukee; urban-rural, La-Crosse; in Barron County to provide a centralized system of coordination for all services provided to participants. The CCO's performed patient assessments, case management functions and arranged for services to medicaid eligibles through a community coordinated structure. These organizations assumed responsibility for providing health-related services to eligible patients and subcontracted with other community agencies for specific services. For a price negotiated in advance, the CCO assumed responsibility for maintaining disabled and elderly persons in their homes or in the community at an appropriate level of care. Medicated waivers granted for the project permitted reimbursement for community services that would not otherwise have been available (e.g., advocacy, adult day care, chore services, companions, counseling, home delivered meals, housing search, nutrition education and transportation).

The project had a service population of 943 clients. At two project sites impact was compared to matched control groups in other counties. At the third site, clients were compared to a control group determined by random assignment. Several different assessment instruments were administered by each site to both project and control clients to measure changes over time. The assessment instruments included: the geriatric functional rating scale (GFRS), a mechanism which measured the risk of institutionalization and also evolved as a screening device for eligibility in the program; the older Americans resources and services instrument (OARS), an extensive multidimensional needs assessment tool; the areas of care evaluation (ACE), a research-only tool used to measure client disability; and quality of life, a tool which attempted to measure client's behavior and life satisfaction.

Since the project included three sites each with distinct demographic features, variation in the organization and management structure and different approaches to client assessment, the final evaluation report analyzes experimental and organizational project findings by site.

In the organizational ana'ysis, the evaluators focused on planning, development and implementation of the CCO project from its inception through establishment of the sites.

Overall, the data from the project findings show that for CCO clients there was a significant reduction in acute hospital days and SNF days, when compared to the control and comparison groups. At the LaCrosse and Milwaukee sites the experimental patients had lower death rates than the control groups.

Major organizational findings included: A consistent theme of turf defense and domain protection among providers who saw CCO as potentially threatening to their vested interests. The complexity of service delivery relationships among agencies was underestimated, resulting in less than optimal strategic decision-making. CCO was able to change service system behavior in LaCrosse and Milwaukee, but only minimally.

Following are highlights from each of the sites:

CCO Milwaukee

Randomly assigned experimental and control groups did not seem to differ in important ways.

Experimental group members had, on the average, more difficulty with activities of daily living, were at less risk of institutionalization and were more disabled than the total CCO Milwaukee client population.

Almost half of the experimental clients received no more than two services funded by CCO Milwaukee.

Transportation, nutrition, home maintenance and personal care were the most frequently utilized services.

Medical assistance cost analysis indicated that, for the normal medicaid program, experimentals cost $197.87 per client per month while controls cost $325.42.

CCO Milwaukee experimentals showed savings in outpatient medical services, hospital costs, nursing home costs, costs for home health care and drug costs.

Total medical assistance costs, including CCO costs, were determined to be $330.04 for CCO clients, or $4.62 per client per month more than the regular program without CCO. Taking the assigned Milwaukee clients out of this analysis, the costs rose to $362.64. CCO costs are slightly over-estimated owing to the inclusion of research costs.

CCO Milwaukee did not appear to have an effect on the rate of institutionalization in nursing homes. However, CCO Milwaukee had fewer total days in nursing homes and fewer total hospital days than controls.

Quality of life deteriorated in both experimental groups, suggesting no experimental effect.

CCO LaCrosse

Clients living with relatives had higher service costs than those living alone.

196 clients were "case management only" clients. On the average, these clients were older than other clients, in slightly greater risk of institutionalization than medium cost clients and about the same level of disability as high cost clients.

The mean monthly medical assistance cost for LaCrosse clients was $189.45 as compared with $150.19 for Eau Claire controls.

LaCrosse clients experienced fewer hospital days and fewer nursing home days than Eau Claire controls, but higher medical assistance costs.

LaCrosse clients showed increasing risk of institutionalization over time while Eau Claire controls showed less risk.

LaCrosse clients showed less institutionalization and lower death rate than Eau Claire controls when matched on disability and risk levels.

LaCrosse County showed substantial increases in institutional utilization when compared with Eau Claire County. Only a minor change was noted in the number of licensed beds.

In terms of quality of life, LaCrosse clients showed only three positive comparisons and 17 negative ones over time. This was compared with Eau Claire's eight improvement comparisons with no regression.

CCO Barron

The mean monthly cost to the medical assistance program for Barron clients was $164.41, including evaluation costs.

Barron's clients showed gains in GFRS and areas of care evaluation (ACE) functioning at 6 months, but these gains seemed to disappear over time.

148 clients were active at the conclusion of the data collection period, compared with 22 who had died and 18 who had been institutionalized.

Barron County experienced decreasing institutionalization when compared with Clark County.

Barron's aged were significantly more expensive to provide service for than were the disabled.

There were no significant differences among the service costs for Barron's developmentally disabled, mentally ill and physically disabled.

Married client service costs were about the same as for single individuals; there were no differences between those living alone and those living with others.

Recently, in an effort to phase out the project's waivered services and the CCO activities, the State wrote into the 1980 medical assistance administrative rule that eligible CCO clients who were receiving benefits or services from the local project sites as of April 1976, would be allowed to continue to receive these CCO services. The three CCO sites have been certified as providers under the medical assistance plan. Under the plan, the sites are able to provide both the regular medicaid services and the services formerly provided under waiver. The nonmedicaid services are now paid out of a State appropriation. Following is the current status of the three sites:

—The Milwaukee site had enrolled 768 clients as of December 31, 1979 and will continue to serve those "grandfathered" clients.

—In Barron County a limited staff will remain to continue providing services to clients who had been served under the demonstration.

—In LaCrosse County, a newly created aging unit will continue to serve the current CCO client population, and continue the system of services and case management.

Special Initiatives

National long-term care demonstration program

In fiscal year 1980, Congress appropriated $20 million to support the national long-term care demonstration program. This intradepartmental effort was launched in an attempt to test the ability of community-based long-term care projects to address many of the inefficiencies in the existing long-term care system and assess the factors which influence their structure. $10.5 million was appropriated to HCFA and $10 million was appropriated to the Administration on Aging (AoA) for this initiative.

The program is an intradepartmental effort which includes the close cooperation of HCFA, AoA, the Public Health Service, and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) which was designated the lead agency in the effort. A steering committee of senior policy officials in these agencies has been established under the chairmanship of ASPE to set broad goals and provide policy guidance regarding the program. An intraagency management team has also been established, composed of senior staff in each participating agency, which has responsibility for providing technical direction and management on all aspects of the program.

On September 30, 1980, the Department announced implementation of the program, which includes the following four components:

1. Channeling Demonstrations

Twelve States were awarded contracts to conduct channeling demonstrations. The term "channeling" refers to the organizational structures and operating systems required in a community to make sure a client receives needed long-term services. The primary elements of this concept are: (1) case finding, (2) comprehensive client assessment, (3) case management, and (4) monitoring and reassessment.

Of the 12 channeling demonstrations, 6 are being monitored by HCFA (Maryland, Maine, Pennsylvania, Kentucky, Texas and Hawaii) and 6 are being monitored by the Administration on Aging (Florida, Massachusetts, Missouri, New Jersey, New York and Ohio).

2. Evaluation Contract

Each project will collect data in a uniform manner for use in the Department's national evaluation of the program. The evaluation will collect uniform data on client characteristics, outcomes and costs. The evaluation contractor is Mathematica, Inc.

3. Technical Assistance Contract

A Technical Assistance contract has been let to provide support to the 12 demonstration projects in developing uniform assessment and data collection procedures. The technical assistance contractor is Temple University Institute of Gerontology.

4. State System Development Grants

Fifteen States have received 1-year system development grants. This grant program, which is intended to help States build their capacity to plan, coordinate and manage the allocation of long-term care resources, will terminate at the end of fiscal year 1981. The system development program parallels task I of the State long-term care channeling demonstration contracts.

The system development grants are being monitored by AoA. The evaluation and technical assistance contracts will be jointly monitored by teams comprised of representatives from ASPE, HCFA and AoA.

A portion of funds from this initiative will also be used to gather baseline data necessary to evaluate the sites and to derive national estimates from the demonstration experience. In this regard the following new surveys and modifications of existing surveys is planned:

(1) A new inventory of community long-term care (LTC) providers to obtain information on the supply of these providers and to provide a sampling frame for a study of the clients of such providers.

(2) A new household panel survey which will provide information on a nationally representative sample of impaired individuals internally linking data on degree of impairment, services received, cost of care, informal supports received, household income, etc. It is recommended this survey be piggybacked on the Department's survey of income and program participation (SIPP) in 1984 with supplementation of the SIPP sample of severely impaired individuals.

(3) A new survey of individuals in LTC institutions which together with the household survey will provide a complete picture of the population in need of LTC. The recommended option for this study would cover a broadened definition of LTC institution (e.g. institutions serving the mentally ill would be included) and would reinterview clients over the course of a year to gain more accurate data on charges and financing and information on change in client status unavailable from past cross-sectional nursing home surveys.

(4) A study of State government programs to provide information by program on expenditures, reimbursement practices, management techniques, etc. Major programs include medicaid, title XX, and title III of the Older Americans Act, but information will also be obtained on other Federal programs and on State programs.

(5) An analysis of exisiting data sets containing policy relevant information bearing on LTC policy questions and implementing the recommendations of the Interagency Statistical Committee on Long-Term Care for the Elderly and analysis of data of the new surveys.

HUD/HHS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill

The Departments of Housing and Urban Development (HUD) and HHS are jointly funding this demonstration with the goals of: (1) Integrating the chronically mentally ill into the community and improving the quality of their lives by providing housing arrangements linked to supportive and rehabilitative services; (2) providing an environment that protects the privacy and personal dignity of the chronically mentally ill and at the same time offers incentives and encouragement for them in assuming increasing responsibility and control over their own lives; and (3) encouraging and assisting States in providing housing and comprehensive health/social services for the chronically mentally ill.

The demonstration is one part of the initial response of the two agencies to the recommendations of the General Accounting Office and the President's Commission on Mental Health that relate to deinstitutionalization, housing, and service provision for the chronically mentally ill. For this demonstration, the chronically mentally ill are defined as "any adult, age 18 or older, with a severe and persistent mental or emotional disorder that seriously limits his or her functional capacities relative to primary aspects of daily living such as personal relations, living arrangements, work, recreation, etc., and whose disability could be improved by more suitable housing conditions." (Alcoholism and drug abuse are not included in this definition.)

The following three categories of individuals may be served:

—Chronically mentally ill individuals currently residing in institutions but capable of more independent living;

—Chronically mentally ill individuals at risk of being reinstitutionalized;

—Chronically mentally ill individuals with no prior institutionalization who are at risk, but for whom housing linked to services would provide an alternative to institutionalization.

Under this demonstration, provision of the following services is required: Case management and program planning, house and milieu management, life skill development, medical and physical health care, and crisis stabilization.

Additional services that are recommended but not required: Vocational development, education development, family relations planning, recreational/avocational activity planning, psychotherapy, and advocacy/legal assistance.

Under the authority of section 202 of the Housing Act of 1959, as amended by Public Law 86–372, HUD is providing 40-year direct Federal loans to assist private, nonprofit corporations in the development of new or substantially rehabilitated housing. Over a 3-year period, HUD has set aside approximately $69 million in loan reservations for 229 sites in 39 States, including the District of Columbia and Puerto Rico. These sites will house from 3,500 to 4,000 residents. In addition, HUD will provide section 8 rental assistance for 100 percent of the units constructed or rehabilitated.

This community based residential housing (group homes and independent living complexes) will allow chronically mentally ill persons to live more independently in the community. A group home is defined as a small living arrangement for not more than 12 persons with a home-like environment for those who require a planned program of continual supportive services and/or supervision, but do not require continual nursing, medical or pyschiatric care. An independent living complex is defined as an arrangement of six to 10 individual apartment units that are supervised by professional or paraprofessional staff living in a separate or adjacent apartment or living off the grounds of the facility. The complex may house no more than 20 individuals with a maximum of two persons per bedroom.

Through a cooperative arrangement with HUD, HHS (HCFA, NIMH, and ASPE) will assure that the residents of the demonstration will receive an appropriate service package and reimbursement for selected services. A steering committee comprised of staff from each agency provides review and input into each phase of the program. ASPE has had the HHS coordination role, NIMH provides the guidance, direction, and review of the service component, and HCFA is committed to the approval of section 1115 waivers to provide medicaid reimbursement for services that the States are unable to pay for under current funding programs. This reimbursement mechanism is considered to be transitional in that it allows a State time to secure funding for these services and thus fulfill its commitment to HUD. Each site within a State is to be covered by waivers to be approved for 3 years.

Up to 26 States are expected to submit section 1115 waiver-only grant applications to HCFA. In addition to waiving specific sections of the statutory requirements for the medicaid State plan, the grant will authorize Federal matching funds for such services as case management, supervision, training in life skills and transportation. The Minnesota Department of Public Welfare now has an approved grant and has one site providing services. Georgia, Vermont, Oregon, and New Jersey have also submitted applications and expect to have sites ready to provide services early in 1981.

HHS will conduct a 4-year cost-benefit evaluation of the demonstration with HCFA as the lead agency in this endeavor. Funding for the evaluation has been committed by NIMH and ASPE. It is expected that the evaluation design, developed under contract with Urban Systems Research and Engineering, Inc., will be pilot tested in 1981. The schedule of events relating to the evaluation will be determined by the date on which a sufficient number of sites become operational.

RESEARCH ACTIVITIES

ON-GOING PROJECTS

Dallas, Tex., University of Texas Health Science Center—Public Programs' Impact on Long-Term Care Facility Utilization by the Elderly

The major objective of this project is the exploration of the relationship between nursing home utilization and the levels of social services and income maintenance programs available outside the institution. The project specifically

will attempt to determine whether or not the amount of public income maintenance and social service support available to residents of the community is related to extent of nursing home utilization.

There are three primary objectives of the proposed research:

(1) To identify the critical socioeconomic and demographic determinants of substitutability between alternative long-term care (LTC) settings.

(2) To investigate the magnitude of social service expenditures and income support programs on nursing home and personal care utilization, with emphasis on rates at which existing capacity is utilized, rates of utilization of the aged segment of the population, and the duration of illness.

(3) To predict future capacity requirements based on plausible public expenditure levels.

The research design proposed involves analyzing the determinants of three different measures of long-term care utilization (mean LTC duration of stay, mean LTC occupancy rates, and number of residents per thousand of aged population) for two alternative institutional arrangements (nursing home care and personal care with or without nursing). The project will use a log-linear model specification to investigate the impacts on these LTC measures of various socioeconomic and demographic variables (e.g., poverty, educational attainment, health status, prices of home nursing care and for general LTC services), social service and income maintenance variables (e.g., social security benefits, medicare and medicaid home health care expenditures, average medicaid payment rate, and other social service expenditures targeted primarily for the elderly), and the long-run adjustment to the optimum stock of LTC beds.

The final report from this project is due early in 1981.

New York City, Community Research Applications—Information About and Attitudes Toward the Use of Long-Term Care and Community-Based Alternatives Among Blacks, Hispanics, and Whites

This 1-year project, which began in September 1979 will examine consumer information about, and attitudes toward, the use of long-term care and community-based alternatives, particularly those alternatives which may act so as to prevent or postpone long-term institutional placement in intermediate care or skilled nursing facilities.

The objectives of this project are as follows:

(1) To identify the extent of minority information about long-term care and about community-based alternatives in communities in which actual availability and characteristics of services are known and have been quantified.

(2) To identify what service characteristics, e.g., service location in a minority neighborhood, minority staffing, minority-white client ratio, affect minority willingness to use long-term care and alternate services.

(3) To identify the personal characteristics and functional limitations which affect minority willingness to use long-term care alternative services.

(4) To examine the decisionmaking process as regards the selection and use of different health care modalities.

The final report for this project is due in December 1980.

University of Michigan—Forecasting Geriatric Home Health Outcomes from Personal, Familial, and Systemic Variables

In this 1-year project, which began in November 1980, a multivariate analyses will be conducted to identify the effects of referral source and service utilization on the outcomes of geratrics home care. The source of the data are cases served by the San Francisco Home Health Service Agency from 1957 to 1975.

By expansion and/or refinement of variables and confidence intervals, the project will attempt to establish multiple indices of causality. The findings will facilitate the refinement of criteria for decisionmaking for geriatric long-term care. The analysis will examine the relationships of service input to the outcome of the patient at discharge or after a period of care, and the relationship of the variables at entry to utilization patterns and outcome status. Variance in care outcome will be related to numerous personal variables, familial/residential variables and contextual or institutional variables.

The final report for this project is due in early 1981.

Washington, D.C., American Association of Homes for the Aged—Factors Influencing the Provision of Noninstitutional Long-Term Care by Homes for the Aging: A Study of Long-Term Care Center Feasibility

This project will analyze data on outreach services from members of the American Association of Homes for the Aged. Among the issues to be explored are:

—The type, frequency, and level of noninstitutional care services provided by homes.
—Type and mix of funding sources used to finance outreach services.
—Groups of services provided (those services most frequently provided in association with other services).
—Characteristics of homes with the largest and most extensive outreach programs, as well as those with few or no programs.
—Percentage of minorities served as residents in the home versus recipients of outreach services.
—Expansion rate of homes providing outreach services.
—Participating or nonparticipating medicare/medicaid homes which most typically provide outreach services.
—Outreach activities of homes drawing large numbers of residents from outside their health services area (HSA).
—Characteristics of homes providing senior center activities in the homes for nonresidents (inreach versus outreach).
—Activity of congregate care (life care) homes in the provision of outreach services.
—Characteristics of homes which provide more medical care versus those providing nutritional or social services.
—Level of outreach provided through charitable contributions.
—Level and area of administrator education compared to level of outreach program activities.
—Sponsorship of homes (public, religious, fraternal) and level of outreach activity.

Approximately 200 of the homes, with various levels of outreach programs, will be included in another survey to be supported by this grant. In-depth data will be gathered on (1) community characteristics of the homes, (2) recipient characteristics, (3) outreach program description, and (4) funding characteristics.

Final results from this 1-year project will be available in mid-1981.

Duke University—Bioactuarial Estimates and Forecasts of Health Care Needs and Disability

The objective of this project which began in June 1980, is to study the health status of the U.S. population using a model of the natural history of important chronic diseases for the individual, adjusted for the effects of population dynamics. This model, which integrates evidence from several sources (vital statistics, epidemiological studies, clinical findings, and physiological models), will be used to produce distributions of chronic diseases (differentiated by stage of disease and associated conditions) in the U.S. population, stratified by age, race, sex and geographic area.

A major rationale for the study is the derivation of more accurate estimates of the prevalence and incidence of chronic diseases so that better estimates of health care costs can be derived. Current estimates of medical needs are inextricably confounded with demand (which is strongly related to the level and availability of health care services). Adequate information presently seems to exist on the unit cost of medical services and various economic theories have been promulgated for the health care sector of the national economy. However, before this information and theory can be successfully applied to projecting, monitoring and controlling health care expenditures, it is necessary to produce better and more detailed estimates of the level of medical need. Such improved estimates could then be used as inputs to the efforts at economic forecasting.

The methodology for deriving national population-specific estimates of chronic health problems centers on new analytic strategies (e.g., stochastic process modelling) which permit one to infer chronic disease incidence and prevalence patterns from national cause-specific mortality data. The morbidity and disability distributions are inferred from the morality data by extrapolation from age and

cause of death, backwards through the "health history" of the individual as implied from biomedical and epidemiological evidence about the behavior of chronic diseases. Once the "health histories" for individuals are assembled into the morbidity distributions for the population it will be possible to generate measures of health care need and long-term disability. The estimates of chronic disease incidence and prevalence generated by the proposed methods will be much less subject to confounding with the psychological and market factors determining health care demand than are estimates of health needs available from other sources. Data for these analyses are from various sources, but primarily the national vital statistics files. Such vital statistics represent near total coverage of all deaths in the United States (hence, they are divorced from selection for health providers, are gathered continuously over time, are large in number, contain a listing of specific medical conditions at death, and represent a specific and crucial point in the natural history of chronic disease processes.

This project is expected to conclude in mid-1981.

University of Washington—Cost Containment by Nursing Home Administrators

The primary objective of this project is to analyze the impact of cost containment efforts by nursing home administrators on the cost of services and quality of care in long-term care facilities.

This project will research in detail the variety and efficacy of cost control (containment) methods currently being utilized by nursing home administrators to aid in the improvement of methods for administratively controlling costs.

A second objective of this project is to study the impact of contextual variables (specifically: facility size and external pressures) on administrators' programs to contain costs.

This project will utilize a pretest-posttest control group design. Half of the randomly selected homes will be assigned to the control group; half to the experimental group. Data will be gathered by interviewing personnel within each facility (including the nursing home administrator, nursing director, dietary supervisor, two registered nurses or licensed practical nurses, two nurse's aides and two dietary aides), and from on-site visitations. Baseline information will be gathered on (1) the presence and use of cost control methods, (e.g., budgets, cash flow reports, revenue and expense statements, employee turnover reports, comparative cost models, and so forth), (2) the efficiency (cost of services) and effectiveness (quality of care) of nursing home performance, and (3) the presence and intensity of external contextual pressures on nursing home administrators.

Afterwards, the nursing home administrators in the experimental group will receive training in the variety of methods and efficacy of implementing cost controls. Then both experimental and control groups will be retested.

This 2-year project will conclude late in 1981.

New York City, Hunter College and the Research Foundation of City University of New York—The Role of Families in Providing Long-Term Care to the Frail and Chronically Ill Elderly in the Community

The overall goal of this study is to examine the family care-giving systems of the frail elderly. Two hundred persons will be selected for the sample and will be from three major ethnic groups: white, black and Hispanic. They will be family members of older persons who have requested and/or received services from the social and health care system in New York City and will be interviewed to provide data relevant to the study objectives listed below:

(1) Examine family care-giving systems of frail elderly.

(2) Document types of services and extent of commitment.

(3) Assess economic value of services.

(4) Determine impact of care on family unit in both psychological and financial terms.

(5) Determine knowledge, utilization and satisfaction with publicly financed social and health care service.

(6) Identify factors that strengthen or weaken family homes in providing care to an elderly relative.

(7) Estimate costs and benefits of current hypothetical home care plans, which include family support services.

(8) Recommend methods of enhancing the family care-giving system which would result in the most efficient use of public service dollars.

The findings from the study will result in:

(1) A descriptive picture of the characteristics of family care-givers, the tasks they perform, and the social and economic impacts they experience in doing so.

(2) Identification of the medical and social characteristics of the patient/care-giver dyad which predict the extent to which supportive home care services will be needed.

(3) Recommendations regarding the types, quantity, and providers of home care necessary to sustain the elderly in the community and to avoid more costly alternatives.

The final report from this project is due late in 1981.

University of Colorado—Long-Term Care Reimbursement and Regulations

The University of Colorado, under this grant, which began in March 1979, is studying the empirical interrelationships of patient mix (case mix), quality of care and costs in nursing homes in Colorado, and assessing the practical implications of the findings for reimbursement and regulation policies. This project is in the second of a 3-year study to explore ways to improve the long-term care system so that quality of life of populations served can be improved at a reasonable cost to both government and private parties. The products of this study will be useful in assisting public programs to develop procedures designed to measure patients' need for services, to monitor that quality of care provided so that these needs are met, and to insure that the cost is commensurate with the level of care provided.

The objectives for the second year study remain unchanged from those originally proposed:

(1) To analyze case mix, quality and cost at the facility level.

(2) To analyze case mix and quality at the resident level, and to design an approach for analyzing cost at the resident level.

(3) To build a data base for longitudinal analysis at the facility level by collecting data for 1979 and 1980.

(4) To analyze reimbursement and regulatory systems and to assess the implications of study results for such systems.

(5) To refine methodology for sampling residents within nursing homes to obtain accurate assessments of both case mix and quality.

The project will conclude early in 1982.

Boston, Mass., Peter Bent Brigham Hospital—Innovative Methods of Pricing Ambulatory Care Treatment for Patients With Hypertension

The overall goals of this project are to devise for the medicare and medicaid program reimbursement techniques that encourage the most economical, efficient, and effective long-term management of hypertension. By reducing excess mortality and morbidity from cardiovascular disease, these measures should improve health outcomes for participants, and reduce health care costs.

In order to develop these techniques, this project proposes to study the experience of the 14 clinical centers throughout the United States that participated in the recently completed 5-year hypertension detection and followup program (HDFP) of the National Heart and Lung Institutes.

The hypertension detection and followup program (HDFP) is one of the largest randomized controlled trials ever undertaken. This program was instituted by the National Heart, Lung, and Blood Institute of the National Institutes of Health in 1971. The primary goal of the program was to determine whether systematic antihypertensive therapy, compared to customary medical care, can effectively reduce morbidity and mortality in a wide spectrum of persons aged 30 to 69 years who had an elevated blood pressure.

The initial goals for this project include:

(1) To ascertain how much care, on the average, was rendered for the treatment of hypertension under the HDFP protocols for stepped care established in the participating 14 clinical centers.

(2) To investigate how this average quantity of care varied with the characteristics of patients, the stages of their disease, and the differences among the 14 clinical centers in the manner in which care was provided.

(3) To review the findings with the directors and staff of the clinical centers in order to segregate that portion of the care that would be considered essential for the optimal treatment of different types of patients at different stages of the disease from that portion of the care that was in fact rendered to implement the research component of the HDFP program.

(4) With the aid of the findings from the Delphi interview methods to be applied in (3) above, to construct profiles of the estimated care required for the effective treatment of hypertension, stratified by age, race, sex, and stage of the disease.

(5) To estimate the cost of providing such services under the medicare and medicaid programs under various assumptions concerning the prevalence of hypertension and the reimbursement mechanisms that might be used.

The long-term goals, which are to be approached from the foregoing background are:

(1) To propose innovative methods of pricing ambulatory care treatment (IMPACT) for hypertension that will encourage the efficient and economical provision of effective care under the medicare and medicaid programs.

(2) To plan an appropriate demonstration project in which price schedules developed under the IMPACT program would be tested.

Final results from this project are due in mid-1982.

University of Minnesota—Collection and Dissemination of Data on Long-Term Care Residential Facilities for Physically Disabled Individuals

The purpose of this project is to collect and disseminate data and disseminate data on U.S. long-term residential institutions for physically disabled individuals.

This project has several specific objectives:

(1) To gather information on the characteristics of U.S. long-term care public residential facilities for physically disabled individuals (e.g., geographic location, number, size, expenditures, rates of admission, sponsorship, etc.).

(2) To gather information on the demographic characteristics of persons who reside in these facilities.

(3) To gather information on the nature and characteristics of services provided to physically handicapped individuals, both within and outside of residential facilities.

(4) To write a report on the policy implications of the data collected for the use of (a) policymakers and planners at local, State, regional, and national government levels, and (b) for consumers of such services.

(5) To gather information which is necessary for effective planning, improvement, and evaluation of long-term care public residential facilities, and the services they provide.

(6) To evaluate the progress being made by various levels of governmental agencies in the implementation of national goals concerning the integration of physically handicapped people into the "mainstream" of communities, including cost and financial data.

(7) To collect nationwide information on the licensing practices of states, the development of instruments, and methods of data collection (including the development of a registry of all long-term care residential facilities primarily serving physically handicapped individuals). Efforts will result in a prototype information system useful for the design, planning, and organization of services for physically handicapped individuals.

The expected completion date for this project is mid-1982.

Washington, D.C., The Urban Institute—Implications of Medicare and Medicaid Policies for the Nursing Home Market

The Urban Institute was awarded a 3-year grant to study the impact on the nursing home market of selected medicare and medicaid policies. The study will be a comprehensive analysis of the effects of medicaid reimbursement policies on nursing home cost inflation. The study will also assess the impact of reimbursement policies on the quality of care, access and changes in industry characteristics.

The importance of the study results from the major role of medicaid in financing nursing home care and the rapid rate of increase in nursing home costs. Nursing home costs per day rose faster than hospital costs per day between 1967 and 1977.

Data from cost reports of 250–300 nursing homes in each of 4 years (1977–80) in eight States will be analyzed. States will be selected for both their importance in terms of the size of the industry and for their thoughtful approach to reimbursement policy. The inflation analysis will examine various cost components, as well as total costs. Disaggregation by types of homes will examine the behavior of different ownership types, of high and low cost homes, and of homes with high and low proportions of medicaid patients.

A second part of this project will consist of an investigation of factors affecting participation in medicare by skilled nursing facilities. The role medicare policies and the interaction of medicare and medicaid policies will be examined. The analyses will be based on both case studies and quantitative models.

The final report will be due in 1983.

New York City, Community Service Society—Impact of Home Services for Functionally Disabled Adults

In this project, which began in June 1980, functionally disabled low-income adults will be followed for 12 months after acute hospitalization to determine the impact of substantial, ongoing home service programs which are largely medicaid-financed.

The purpose of the research is to test four major hypotheses.

(1) Among functionally disabled adults of modest financial means, those eligible for publicly financed home services will tend to make greater use of home services and, in turn, experience better solutions to problems of daily living.

(2) Greater availability of publicly funded home services will lead to diminished use of inpatient hospital services and long-term care institutions.

(3) Use of organized home services is greatest among those with the weakest family resources. Where family resources are present, introduction of home services will reduce, but not eliminate, family participation in care. Home services will tend to diminish the burden experienced by family members who participate in long term care.

(4) At various levels of functional disability, persons living independently who receive publicly funded home services will tend to experience solutions to problems of daily living which compare favorably to those experienced by institutionalized persons.

In addition to these hypotheses, the applicant intends to address other questions which are listed under seven substantive areas. These areas are: (1) accessibility of home services; (2) service delivery questions; (3) personal survival and durability of care arrangements; (4) rehabilitation; (5) cost containment; (6) quality of circumstances of the functionally disabled; and (7) family contributions to care.

The completion date for this project is mid-1983.

University of California, San Francisco—Long-Term Care: Impact of State Discretionary Policies

This 3-year research project, which was initiated in March 1980, will study (1) currently available State data on long-term care (LTC), and (2) State discretion in the major programs affecting availability, scope, and cost of long-term care services for the aged.

This project has seven objectives:

(1) To assess existing data reporting systems with respect to their content and comparability, including expenditure and utilization data, for long-term care services for the aged.

(2) To provide an inventory of current State policies affecting long-term care for the aged in three major programs: Title XVI (supplemental security income), title XIX (medicaid), and title XX (social services) of the Social Security Act.

(3) To assess the relation of preconditioning variables (e.g., perceived fiscal crisis in the State and policy responses, economic conditions, etc.) to State discretionary long-term care policies and outcomes (e.g., expenditures, utilization).

(4) To assess how State discretionary policy choices affect the availability and utilization of long-term care services for the aged.

(5) To assess how State discretionary policy choices affect the total cost and distribution of Federal, State, and local expenditures for long-term care services for the aged.

(6) To assess how State discretionary policy choices affect payment systems for LTC, especially in the private sector, and to assess the effects of these systems on the utilization of and expenditures for LTC services for the elderly; and

(7) To assess the implications for Federal and State policy, particularly with respect to effectiveness of cost containment strategies, and to examine alternative Federal and State policies based on these analyses.

This project will conclude in mid-1983.

University of Colorado—Comparison of the Cost and Quality of Home Health and Nursing Home Care

The center for Health Services Research at the University of Colorado Health Sciences Center was awarded a grant to evaluate nursing home and home health care provided in both free-standing and hospital-based settings.

The purpose of the project is to assess both the cost and quality of care provided under four organizational arrangements: free-standing nursing homes, hospital-based nursing homes, free-standing home health agencies, and hospital-based home health agencies. Policy issues addressed will include the following: Do the higher costs of hospital-based facilities justify different treatment from free-standing units for reimbursement and regulatory purposes? Is home health care a cost effective substitute for nursing home care for certain types of patients?

The study will utilize a stratified sample of 16 providers from each modality. Two samples of patients will be drawn from each provider, one random and one stratified in terms of case mix. Forty patients from each provider will be selected for a total of 2,560 patients.

The project will first compare the case mix of patients served by the four modalities using the random samples of patients. Second, costs, quality and cost effectiveness of the four modalities will be analyzed using the stratified patient samples to control for case mix and other factors.

The study will be conducted over a 4-year period, and final results will be available in 1984.

New York City—Delivery of Medical and Social Services to the Homebound Elderly

The New York City Department for the Aging is conducting a 3-year medicare demonstration of the delivery of medical and social services to the homebound elderly, under section 222 of the Social Security Act. A separate grant from the Administration on Aging is supporting certain administrative activities and supplemental service delivery costs for the project.

The purpose of the demonstration is to test a community-based methodology which will provide a spectrum of medical and social services, directly and by linkage and coordination, to a home-bound chronically ill population. Specifically, the project is targeted to persons aged 65 and over entitled to medicare part B who suffer from chronic illness, functional or mental impairment and who are unable to visit a physician without assistance or have no access to medical care.

Four sites will be developed, each serving 100 individuals (totaling 400 participants for the project) with a comparison group of 200 for research purposes. The project's major objectives are threefold:

(1) Identify characteristics of this population, needed levels of care, cost of delivering such care, and the effect of care delivery.

(2) Demonstrate the process of coordination, and identify mechanisms and strategies effective in achieving coordination; and

(3) Develop a cost-effective model of coordinated service delivery to be incorporated into the city's system.

A coordinating model has been established to carry out the project, composed of separate organizational components, each with specific responsibilities related to coordination and service delivery. These components include a project advisory committee which is comprised of relevant city departments and four neighborhood-based service delivery sites. The project advisory committee reviews policy, selects sites, and establishes criteria for clients and services. The committee is

also responsible for facilitating agreements between service providers. The neighborhood based sites will conduct centralized intake, assessment, care planning, reassessment and monitoring, conducted by an interdisciplinary team (e.g., nurse and social worker).

Each site will have a physician consultant whose responsibilities will include:

(1) Participation in selected care planning conferences.

(2) Serving as a consultant to the nurse and social worker on medical management problems of clients.

(3) Making specialized assessment visits to clients who have no physician in the community, signing off on the care plans developed by the case management team for such clients (wherever a client has a personal physician, he or she will approve the client's care plan); and

(4) On behalf of the assessment team, intervening in client situations where current medical care is no longer adequate.

The project is developing the four sites incrementally; two became operational in December 1980, and two more will be operational by March 1981. The first two sites are: Sunset Park Family Health Center (Brooklyn) which is part of Lutheran Medical Center (but functions as a freestanding clinic). Community Agency for Senior Citizens, which is sponsored by the Staten Island Home Care Integration Service Coalition and funded under Older Americans Act, title III–B.

The next two sites are: Jamaica Service Program for Older Adults (Queens) which is a voluntary social service agency providing a broad range of services to the elderly in this borough, including services funded under title III–B of the Older Americans Act. The Comprehensive Family Care Center (Bronx) which is sponsored by the Albert Einstein College of Medicine.

The four sites may provide services directly, contract for, or arrange for other services in their respective catchment areas.

Services to be provided through the medicare waivers are the core around which other community services will be obtained for project clients. These services are: Homemaker, personal care services, transportation and escort services, and drugs and biologicals.

The assessment instrument is based for the most part on the Georgia Alternative Health Services "client assessment interview," together with the New York State DMS–1 medicaid preadmission instrument.

Reimbursement

THE FLEXIBLE LEVELS OF CARE EXPERIMENT

The Connecticut Department of Income Maintenance was awarded a 1-year planning grant for a 3-year demonstration on September 30, 1979. The State plans to demonstrate an innovative approach to levels of nursing home care: a separate level of skilled nursing patients, a level of "total care" patients, and a number dually licensed/certified beds; to coordinate these new levels of care with the reimbursement system; and to develop profiles for patients who will be classified and reimbursed as total care patients.

The proposal includes two components: a service or administrative phase and an evaluation or research phase.

A. Administrative or Service Phase

(1) A project director, planning analyst, and secretary will be assigned to the Department on aging.

(2) Twenty-two chronic and convalescent nursing homes will volunteer to participate in the project. One-half will be randomly assigned to the experimental group and one-half to the control group.

(3) In experimental homes (an average of 102 patients in nursing homes in Connecticut), 30 beds will be set aside as the skilled/swing unit and the remaining beds (70–75 beds) reserved for total care patients. Total care patients make up 80–85 percent of the patients in chronic and convalescent nursing homes (CCNH) in Connecticut. Connecticut PSRO's estimate that fewer than 10 percent of patients in Connecticut's CCNH meet the Federal definition of skilled care, yet all CCNH patients are being reimbursed at the skilled level.

(4) Patients will be assigned to levels of care in the 11 experimental homes as determined by PSRO reviews.

(5) Patients designated by PSRO as rest home with nursing supervision level of care will be transferred to those facilities.

(6) Nurse staffing in the skilled/swing units and total care units in the experimental CCNH will be increased from the present minimum State staffing requirement to provide a higher level of care. Costs of additional staffing will be paid from grant funds.

(7) It is planned that there will be linkages with other State based projects; i.e., Triage, sail, find, adult day care, and others, although the method of linkage was not clarified.

(8) Five 1115 waivers have been requested; Statewideness, levels of care, differential in rates, differential in staffing, and dually licensed beds.

B. Evaluation or Research Phase

(1) A part-time project director, research analyst, systems analyst, key punch operator, secretary and four data collectors will gather data, analyze the findings, share results with central administrative staff, and make recommendations for State and nationwide applications.

(2) The evaluation team will evaluate the process and systemic effects of the demonstration, gather client profiles, and determine outcomes and costs of flexible levels of care. A number of hypotheses have been stated.

(3) It is planned that the demonstration will be evaluated by an outside agency; therefore, hypotheses, data collection instruments, method of analysis, reports, etc. have not been spelled out in detail.

Work accomplished to date include:

(A) Memorandum of agreement between departments of income maintenance and aging.

(B) Employment of qualified principal investigator and support staff.

(C) Selection of sample nursing homes and development of a letter requesting participation in demonstration.

(D) Work initiated with PSRO's to coordinate demonstration with PSRO survey of nursing homes involved.

(E) Meeting with community leaders and representatives of proprietary and nonprofit homes to describe the study and solicit cooperation.

(F) Continuation proposal to be submitted before October 6 for November review.

WAIVER OF PRIOR HOSPITALIZATION REQUIREMENTS FOR MEDICARE SNF COVERAGE

HCFA provided medicare waivers and entered into contract with Blue Cross of Oregon and Blue Cross of Massachusetts in 1977 to conduct demonstrations in eliminating the 3-day prior hospitalization requirement for SNF coverage to determine whether a waiver of the 3-day requirement would result in lower overall costs for both the patient and the medicare program. In addition, an attempt will be made to determine if the 3-day requirement ordinarily imposes a burden on medicare patients who may need SNF care but not hospital care.

The SNF benefit included in medicare part A to provide a lower-cost alternative to extended hospitalization. The requirement, of a 3-day hospitalization prior to admission to an SNF, imposed by the statute to limit SNF benefits to persons who need continuing care after hospital treatment. The requirement also ensured that medical conditions and needs of medicare patients admitted to SNF's have been given adequate medical appraisal prior to admission. The Senate Finance Committee recommended that the Secretary of HHS conduct experiments to determine the effects of eliminating or reducing the requirement.

The experimental phase of the projects, which began in the spring of 1978, will continue through 1980. It was hypothesized that the 3-day prior hospitalization requirement has resulted in unnecessary hospital stays for medicare beneficiaries who could effectively use less costly SNF care without hospitalization. Nursing home utilization and quality of care also will be studied. Under the project approximately 28 facilities in each State have participated in the experimental part of the demonstrations admitting a total of 970 patients during the first 2 years of the project. During the experiment all other criteria involved in the medicare SNF level of care decisions remained unchanged. The utilization of the waiver option in Massachusetts and Oregon was low compared to the HCFA

Office of the Actuary's national estimate of a 25-percent increment in SNF utilization. The Oregon waiver project accounted for 7.2 percent of the Medicare SNF utilization in the demonstration period; for Massachusetts it was 11.5 percent. Since some patients involved would have gone to the hospital and then transferred to SNF care afterward, the actual increment in nursing home utilization due to the waiver is somewhat less than these figures. The utilization rates for the two States were 0.38 and 0.23 waiver admissions per bed in Oregon and Massachusetts, respectively; the number of waiver admissions per 1,000 medicare enrollees with 1.3 in Oregon and 0.7 in Massachusetts. Both States had similar experience with respect to the length of stay. In Oregon, 79 percent of medicare covered stays were below 31 days in length; in Massachusetts, 69 percent were below 31 days. The average covered days under the demonstration varied between the two States: 26.6 days for Massachusetts and 20.5 days in Oregon.

The two States differed with regard to source of admission and patient diagnosis characteristics. In Massachusetts, 70 percent of all waiver admissions were internal transfers from a lower level within the institutions. Direct admissions from home represented another 22 percent, transfers from other nursing homes were 6 percent, and hospital transfers were 2 percent. The composition of admissions differed in Oregon; only transfers from other nursing homes (8 percent) were close to the percentage found in Massachusetts. Home admissions represented 40 percent of all admissions (Almost twice that experienced in Massachusetts), 39 percent of admissions were internal transfers (approximately half the rate for Massachusetts), and hospitals were involved in 13 percent of waiver admissions.

Patient diagnosis categories differed for the two States. While fractures and amputations accounted for 27 percent of all admissions in Massachusetts, Oregon patients accounted for only 5 percent of admissions in these categories. The reason for this difference can be explained partly by the presence of three chronic rehabilitation hospitals in the Massachusetts demonstration, two of which were entirely rehabilitative in their orientation; there were no facilities of this type in Oregon, which is more typical of the Nation.[1] The home admissions in Massachusetts occurred primarily in these rehabilitative facilities (73 percent of all home admissions), and the remaining home admissions were dispersed throughout the free-standing SNF's. Excluding the rehabilitation hospital cases, home admissions accounted for only 6 percent. This difference in home admissions between the two States was largely attributed to the better awareness of the demonstration by Oregon physicians and their more favorable attitude toward nursing homes.

The most important aspect of these data is that the numbers of demonstration admissions over the 2-year experimental period are small in both States, 545 in Massachusetts and 425 in Oregon—11.5 percent and 7.2 percent of Medicare SNF utilization in each State, respectively. These utilization rates raises a key issue for evaluation: Can the same moderate level of utilization be expected if the program is expanded nationally, or is it an artifact of either the peculiar environment of each State or the way in which the demonstration was implemented.

Each demonstration has been explored preliminarily in terms of its environment and special characteristics with the intent of identifying specific factors that differentiate the two demonstrations and account for the utilization experience that was lower than expected. The low overall utilization can be attributed to the medicare SNF admission criteria, the physician's practice patterns and bed shortages. The major factor that would lead to increased utilization of the medicare SNF benefit in a nondemonstration setting would be a reduction in the stingency of the medicare SNF criteria themselves, or in their enforcement by intermediaries or PSRO's; however, this reduction would affect direct entry and prior hospital stay entry equally. The degree to which this and other factors change or are not present nationwide will alter the utilization in a nondemonstration setting.

Finally, not all increases in medicare SNF utilization led to reductions in hospital utilization. Evaluation interviews suggested that between 35 and 67 percent of the waiver patients probably would have entered a hospital if the waiver option had not been available. Thus, it appears that the waiver option will result in some increases in medicare SNF costs, but the degree to which these will be

[1] Of the 68 chronic rehabilitation hospitals in the Nation, six are in Massachusetts.

offset by saved hospital stays is not clear and needs further analysis. The cost analyses will assess the cost of the waiver with respect to medicare reimbursement for SNF care and will estimate the potential hospital savings to assess the net cost of the waiver of the 3-day hospitalization stay prior to SNF admission requirement.

The evaluation contract was awarded to Abt Associates in September of 1979. Final reports from the demonstrations will be available in late 1981.

ON LOK COMMUNITY CARE ORGANIZATION FOR DEPENDENT ADULTS

HCFA has granted medicare waivers to the On Lok Senior Health Services to provide reimbursement for the delivery of a comprehensive health and social service package to an elderly population in the Chinatown-Northbeach area of San Francisco. This project will demonstrate the feasibility of a capitation system of reimbursement for the elderly in an HMO-type organization. The Office of Direct Reimbursement (ODR) is the fiscal intermediary for the demonstration. In addition, funding for the development and study of On Lok's CCODA is provided by a grant from the Administration on Aging.

The objectives of this demonstration are: To develop and operate a centrally funded and administered community care system; to measure the impact of capitated, decategorized funding on utilization, quality and cost of services; to contrast the management efficiencies of the model with those of other systems; and to develop actuarily sound budgeting methods for medical and social needs.

The demonstration is now in its second of 4 years. On February 1, 1980, inpatient services (hospital and skilled nursing facility) provided under contract were added to the package of outpatient services that was provided the first year of operation. These latter services include in-home services, portable meals and transportation, as well as a full array of health and social services provided in On Lok's two day health centers and one social center by physicians, nurse practitioners, registered nurses, social workers, and physical, recreational and occupational therapists. An intake and assessment team comprised of representatives of each discipline together with the participant, develops a plan of care based on the participant's needs. These needs are identified by a physical examination and an assessment that includes functional and mental status, as well as environmental and financial elements. The plan is carried out by the staff and is updated as the need arises and after quarterly reassessments. Specialized services such as dental care, eye examinations, surgery, etc., are provided by the specialists under contract to On Lok.

All participants who are admitted to the CCODA are judged by the intake and assessment team to meet ICF and SNF admission criteria. This judgment is verified through an independent certification by a medicaid field representative from the California Department of Health Services.

Funding for all services for participants is provided on a cost basis under medicare waivers. With increased cost experience, a more accurate prediction model will be developed to estimate inpatient utilization and total medical expenditures. This model will ultimately provide the capitation rate of reimbursement. Currently the per capita cost is $27.95 per day ($20.47 outpatient, $7.48 inpatient).

The role of the research team, funded under the AoA grant, includes the development and testing, in conjunction with the On Lok service staff, of the numerous computerized systems required to manage the CCODA and its diverse functions. Through On Lok's information management system, as each system becomes functional its management is transferred to the CCODA staff to replace a manual system. The intricacies of scheduling for all services, transportation, meals, etc., is one example of this role. Others include data collection and analysis activities.

A comparison group study is underway to assess the impact of the CCODA program on the quality and cost of long-term care, as compared to a matched control group of community cohorts who are receiving services through the traditional long-term health care system. The research design for assessing participant cost impacts of the CCODA program is a pre/post comparison group region. For each sample participant admitted to the CCODA, a matched individual from outside of the On Lok catchment area is selected. The total sample size will be 200 (100 CCODA participants and 100 matched controls). To date, approximately one-quarter of the sample has been selected. Analysis of the selection strategy and equivalency of the groups is being carried out.

HCFA is evaluating the On Lok CCODA through the cross-cutting evaluation of its long-term care demonstrations. This evaluation contract was awarded to Berkeley Planning Associates in September 1980.

SKILLED NURSING PHARMACY SERVICES—CAPITATED REIMBURSEMENT

A grant was awarded in 1979 to the California Department of Health Services to conduct a pilot project on capitated reimbursements of drugs for medicaid patients in SNF's, under the authority of section 1115 of the Social Security Act. The objective is to improve the drug regimen received by medicaid SNF patients which should improve the overall quality of care and reduce costs.

The California State Department of Health Services (DHS) currently administers a program of medical assistance under title XIX of the Social Security Act. The program provides a broad range of medical services to a beneficiary population that is predominantly categorically linked. By and large, medicaid pays for these services on a fee-for-service basis. Approximately 2.5 percent or 67,500 of the nearly 3 million beneficiaries receive their care in skilled nursing facilities (SNF's). Medicaid payment for health care for these beneficiaries is made to the individual provider of service, e.g., skilled nursing facility, physician, dentist, physical therapist, pharmacist. To control utilization of pharmacy services, medicaid employs a closed formulary, that is, a specified list of covered drugs, with prior authorization required for nonlisted therapeutic agents. In addition, both minimum quantities per prescription and minimum days supply per prescription are required for certain medications unless the prescription represents the initial order or has been prior authorized for a smaller quantity or duration of therapy. Minimum quantities commonly are required of drugs used for chronic medical conditions, and the minimum days supply requirement commonly apply to certain drugs dispensed to patients in SNF's. Current costs of pharmacy services for SNF inpatient average approximately $26 per patient per month. To determine if there are ways that the current expenditures for drugs for SNF patients in the medicaid program can be reduced, the California State Legislature enacted Assembly Bill 1395. The legislation authorized a pilot project wherein pharamacists would be reimbursed on a capitated basis for pharmacy services provided in SNF's.

The project proposes to establish capitation rates for 30 selected SNF's based on 30 pharmacies' experiences with those facilities. The monthly capitation rate will be calculated for each facility and will be paid to the pharmacy in advance for each medicaid patient served by that pharmacy in the following month. In addition, pharmacists who participate will be granted the authority to approve nonformulary drugs necessary for the treatment of the patients.

Participants will be selected to reflect the geographic and bed size distribution of nursing homes in the State. Contracts will be prepared to establish project requirements with the participating pharmacies. A group of pharmacies and skilled nursing facilities will be selected for comparison purposes. The project will be a 3-year effort with a 1-year precapitation period for selection of participants, baseline data collection, rate determination, and the development of the evaluation methodology. A 1-year period of capitation will then commence, followed by analysis and reporting of the results.

Capitation rates will be determined by dividing the prior year's medicaid expenditures for drugs in the facility by the number of patient months for which the facility was paid by medicaid. This figure will then be increased by an inflation factor for the year of the demonstration to account for increases in ingredient costs and to achieve parity with pharmacies serving Medicaid beneficiaries costs and to achieve parity with pharmacies serving Medicaid beneficiaries on a fee-for-service basis. In order to protect the participating pharmacies against excessive prescribing practices, the project will incorporate an upper limitation on risk. While the final figure will be related to the actual utilization levels of the pharmacy/facility, Department of Health Services staff anticipate that this risk amount will be in the vicinity of an average of two prescriptions per patient per month or an equivalent dollar amount. Any expenditures above this limit will be reimbursed by the Department on a fee-for-service basis to the participating pharmacies.

Pharmacists will be required to submit an invoice monthly, in advance, listing the names and medicaid ID numbers of those patients for whom the capitation rates are being claimed. In those cases where beneficiaries are reported to the

department and are ultimately determined to be ineligible, reconciliation will be made by offsets to future capitation payments. Submittal of a current label or copy of the ID card for the month in question will satisfy eligibility questions. Participating pharmacists will be required to submit claim forms for data collection but not payment.

The project will allow the pharmacist to bypass the usual utilization controls of the medicaid program and to exert his professional judgment to a maximum degree, consistent with a high quality of care. Minimum quantity, minimum days' supply, 4/75 audits, and diagnosis restrictions will all be waived for the patients served under this project.

The pharmacist will be authorized to approve nonformulary drugs. However, in those instances when the pharmacist does not feel that the drug is necessary, the service can only be denied by the medicaid consultant. The department and the pharmacy association both feel that the professional arguments that may be raised against use of any particular medication will probably provide adequate justification for the consultant to support the pharmacist's position. This feature is built in, however, to insure against obvious underutilization on the part of the pharmacy and to enhance the professional relationship between prescribing physicians and pharmacists.

A two-part evaluation of the results of this project will be made. The department will conduct an evaluation of the changes in costs and utilization of services which result, if any. A second evaluation will be performed by outside consultants under contract, utilizing a multidisciplinary team of physicians, pharmacists, pharmacologists and nurses to evaluate the professional decisions involved in the TAR approval process as well as the overall quality of care received by the patients.

THE SOCIAL/HEALTH MAINTENANCE ORGANIZATION CONCEPT

A 3-year planning grant was awarded to the University Health Policy Consortium at Brandeis University in spring of 1980 to develop the concept of a social/health maintenance organization for long-term care. The social/health maintenance organization is a capitation financed delivery approach to meet the needs of the disabled and/or elderly. It is designed to address two of the most pressing problems in long-term care: (1) The fragmentation of services, and (2) the fragmentation of funding sources. The concept promises to integrate health and social services as well as acute care services.

The objectives of the planning grant are multifaceted and include the following: (1) Provide technical assistance to several possible demonstration sites; (2) develop the methodology for estimating utilization rates and for calculating costs and capitation rates; (3) coordinate development of the data system and evaluation plans to insure maximum test results; (4) develop criteria for selection of the demonstration sites; and (5) link the evaluation of social/health maintenance organizations to other long-term care demonstrations.

A social/health maintenance organization (S/HMO) is an approach to the organization of health and social services in which an elderly population, including those at high risk of institutionalization, is voluntarily enrolled by a managing provider entity into an integrated service system. All basic acute hospital, nursing home, ambulatory medical care services and personal care support services, including homemaker, home health, and chore services would be provided by or through the S/HMO at a fixed annual prepaid capitation sum. Other offered services would include emergency psychiatric, meals (home delivered and/or congregate), counseling, transportation, information and referral. The provider either may employ staff or establish contracts with other providers for the services. In the S/HMO model, financial, programmatic, case decision-making and management responsibility rests with the provider entity. The S/HMO provider will share risk for service expenditures and will be responsible for brokering other needed services not covered but which are available from other community providers. Financial risk is defined as absorption of agreed-upon costs which exceed a capitation agreement.

In comparison with other models, the S/HMO integrates health and social services under the direct financial management control of the provider at the point of services delivery. The success of conventional HMO's with medicare contracts and of other managed systems of care (e.g., Triage and Monroe County models) have suggested the possibility of expansion to an S/HMO system model.

In the proposed demonstration, the S/HMO will be geared to serve persons from a targeted elderly population ranging from the ambulatory nonimpaired aged to those who are extremely impaired. Inclusion of the well-ambulatory permits preventive activities for a population which feeds both hospital and nursing home utilization. Early management is expected to result in a delay or reduction in nursing home care. For such a population survey data indicate that approximately 55 percent are ambulatory and well, 25 percent are ambulatory with modest home care needs, 15 percent are living at home with severe impairments, and 5 percent are very impaired whether housebound or in nursing homes. While the S/HMO is expected to have all four groups represented, the proportion enrolled will depend upon the attractiveness of the program to different groups and the intake procedures established by the S/HMO.

Financing of the S/HMO will flow from some combination of public funds (e.g., medicare, medicaid, and title XX), as well as from private payments, deductibles and potential private third party payors. Reimbursement would be on the basis of prepaid capitation.

The S/HMO offers incentives to all involved parties. Incentives to the provider organization, for example, include improved cash flow, reduction in the cost of administering third-party billing mechanisms, flexibility in program innovation, financial incentives through negotiated rate ceilings and flexible savings arrangements, greater organizational stability, and growth potential in the long-term care marketplace. Public authorities gain by harnessing HMO control methodologies to long-term care. The uncontrolled, or diffuse long-term care costs can be addressed systematically through an integrated financing plan with provider risk-sharing and reduced administrative complexity. Consumers will benefit by having a single-entry access to a wider range of services. These services will be provided in an integrated manner, thus reducing the need and costs of shopping around. Paperwork usually associated with medicare (e.g., assignments) will be eliminated.

It is hypothesized that the S/HMO will reduce the number of expensive institutional days for enrollees as well as encourage significant changes in utilization patterns.

Three S/HMO demonstration sites, to be selected, will provide a strong comparative evaluation of different S/HMO modes of organization. They will all use common assessment instruments, comparable experiment populations, compatible management information systems and a common evaluation strategy. The demonstrations will provide answers to questions about cost/benefit effects of a S/HMO; the effects of integrated care on the elderly and on service costs; the administrative feasibility of the S/HMO model compared with the fee-for-services model; and the effects on quality of care.

This grant is in the preliminary planning stage at this time.

Quality Assurance

SURVEY-BY-EXCEPTION (SBE)

In July 1980, a section 1115 waiver-only quality assurance grant was awarded to the Massachusetts Department of Public Welfare. The purposes of this 18 month project are to: reallocate surveyor time so that facilities with the greatest certification compliance problems can receive additional consultation and technical assistance by the surveyors; and improve the quality of care in skilled nursing facilities (SNF's) and intermediate care facilities (ICF's).

This project will test an experimental facility survey process in medicaid and medicare facilities. The medical review (MR) and independent professional review (IPR) patient survey process will be performed as usual. A facility screening instrument has been developed by Massachusetts and will be pretested for reliability and validity before use in the demonstration.

Methodology

The facility survey is a modification of the screening survey developed by the Wisconsin quality assurance project. The design for the demonstration involves classifying facilities into three groups, based upon the performance of facilities on annual surveys for the preceding 3 years.

The Massachusetts long-term care information system (LTCIS), a management information system containing the results of all facility surveys since 1976,

allows the aggregation of survey results at the facility level, so that survey results can be compared across facilities. The criteria for facility classification are as follows:

(a) Screening survey group.—Compliance scores of 95 or above on annual inspections for 3 calendar years prior to the inspection date (classified as outstanding).

(b) Abbreviated survey group.—Compliance scores of 85 or above for the past 3 calendar years (classified as acceptable).

(c) Full survey group.—Compliance scores below 85 for the past 3 calendar years (classified as unacceptable).

The demonstration is planned as a 2X2 experimental design with test facilities in outstanding (95 score and above) and acceptable (scores between 85 and 95) groups assigned randomly to the traditional method of survey and the SBE method.

The design calls for 120 of the 160 facilities in two geographic areas, the northwest and southeast sections of the State, to be assigned to the four cells of the design—60 will be eligible for SBE and 60 will receive the traditional survey.

Hypotheses to be tested include:

(1) Quality of care in the screening and abbreviated survey facilities in the experimental groups will increase or remain constant relative to screening survey and abbreviated survey facilities in the control group.

(2) Quality of care will improve in the full survey facilities.

(3) Time spent on certification visits will decrease in facilities in the abbreviated and screening survey visits.

(4) Time spent on certification visits will increase or remain constant in the poor performance group.

(5) The number of interim visits, followup visits, and consultation visits, and the time spent on such visits, will increase in each of the three groups.

(6) Provider attitudes toward the State survey agency will be more favorable in facilities participating in SBE.

The demonstration will be initiated October 1, 1980, following completion of pretesting and compliance with conditions attached with the notice of grant award.

This demonstration will be evaluated by an independent evaluator chosen by HCFA to evaluate all of the survey/certification related demonstrations.

NURSING HOME QUALITY ASSURANCE PROJECT (QAP)

The Wisconsin Department of Health and Social Services is in the third of a four year 1115 waiver-only project that proposes to improve the quality of care in nursing homes using an experimental survey and certification methodology. This demonstration is based on the premise that the State should reallocate surveyor time so that more time is spent in nursing homes that are cited as having deficiencies and less time in nursing homes providing good care.

Project Objectives

The primary goal of the project is to improve the quality of care in nursing homes in the demonstration areas using cost-effective techniques which reallocate the State's resources.

1. To increase the efficiency and effectiveness of the facility review process, QAP:

(a) Uses a screening technique which allows teams to separate homes into three categories: homes performing well; homes with minor problems likely to be resolved with consultation; and homes with one or more serious problems requiring detailed analysis for possible negative action.

(b) Omits the full facility survey except where indicated by a history of problems or after using the new facility screening technique.

(c) Involves nursing home administrators and rehabilitation specialists in the facility survey to provide a broader base of knowledge for the evaluation.

(d) Trains survey staff to collect court-worthy data when negative action is indicated; and

(e) Schedules survey visits at less predictable and more frequent intervals to allow for collection of more accurate data.

2. To increase the efficiency and effectiveness of the Medical Review (MR) and Independent Professional Review (IPR) of patient care, QAP:

(a) Uses a statistical quality control methodology to choose a stratified sample of patients for *intensive* review, rather than performing a cursory review of all patients currently in the home.

(b) Reallocates staff time and focus to an in-depth evaluation of the home's *system* for identifying and meeting patient needs.

(c) Omits the full MR and IPR survey except where indicated by a history of patient care problems or after using the new patient sampling technique; and

(d) Provides feedback to the facility survey process by citing deficiencies and by documenting cases of poor patient care for court use.

3. To improve the quality of nursing home care by matching the most appropriate actions for resolution with the problems discovered through the facility survey and patient review, QAP:

(a) Has developed criteria for quickly choosing corrective actions from a list ranked by severity.

(b) Has added new options to the list of correction/enforcement actions, including consultation with survey team members and contracted technical assistance; and

(c) Has provided more immediate feedback to homes detailing deficient areas of patient or institutional management discovered through the evaluation process, especially for homes evaluated as needing enforcement action.

Since these last three elements are considered essential in any quality assurance system, they are used in both control and experimental sites. The experimental design separates the effect of these changes from those caused by the experimental facility and patient review processes.

Methodology

The Bureau of Quality Compliance, Wisconsin Division of Health, is demonstrating two new approaches to the control of quality in nursing homes. These approaches deviate from traditional State and Federal requirements. The first requirement is that a nursing home be evaluated for compliance with applicable State and Federal regulations at least annually. The second requirement is that every medical assistance nursing home resident be evaluated at least annually for appropriateness of placement and level of care.

Facility screening.—In place of existing requirements for annual surveys of nursing homes, a screening survey designed to quickly identify problems in critical areas affecting quality of care is being tested. Based on problems found during screening, decisions for further action are made ranging from informal consultation to decertification. The time saved through this screening process is allocated to consult with homes where appropriate and to more rigorously pursue enforcement in homes that are endangering the health of their residents.

Sampling patient review.—In place of existing requirements for review of medical assistance recipients in nursing homes, a scientifically chosen 10 percent sampling of all patients in the home are intensively reviewed. As in the facility screening process, decisions for further action are based on problems found during the careful review of the sample of patients. State surveyor time saved by not examining all patients is devoted to more extensive consultation and enforcement.

In July 1978, during the first phase of the demonstration, 122 facilities (SNF's and ICF's) in a rural area were studied. A 2 x 2 factorial design of the treatments, facility survey and patient evaluation, was employed in the rural site. The two options for facility "treatment" are the old full survey and the new screening survey; the two options for the patient "treatment" are the old 100 percent medical review and the new patient sampling technique.

In the second phase of the project, an additional 40 homes in a large urban area were added to the demonstration. In half of these nursing homes (20), the screening survey and patient sampling techniques were used and in the remaining 20, the old full survey and 100 percent medical review were carried out. In addition, another group of 20 homes were selected as control homes in the urban area.

Two additional changes were made in the second year which impacted on the demonstration methodology, they were:

(1) HCFA approved a waiver of the Life Safety Code so that a screening survey instrument could be used by the engineer/architect.

(2) Health Standards and Quality Bureau approved receiving less than the full report for title XVIII certified facilities which resulted in the inclusion of these facilities in the demonstration.

In the last phase of the demonstration, 40 additional facilities were added to the sample. These facilities are located in a mixed rural/urban area of the State. The methodology has been slightly changed in the last phase to further eliminate the possibility of surveyor bias. In these areas, separate survey teams have been assigned to each treatment cell. One team utilizes the screening survey and patient sampling methodology and the other, the full survey and 100 percent patient sampling.

With this last expansion, the demonstration project includes 31,000 resident/patients and 281 (59 percent) of the State's nursing homes.

Findings to Date

(1) The total time for survey and certification visits using the screening survey and 10 percent sampling of patients for MR/IPR is 2 days in homes 100 beds or less, while the traditional methods in homes of the same size require 15 working days.

(2) The State survey staff and nursing home administrators and staff have positive attitudes about the screening survey and sampling technique.

(3) The number of nursing home administrators serving on the screening surveys has increased but has not yet reached 100 percent.

(4) Surveyors are making increased use of the option to switch from the screening survey to the traditional method. The most common reasons cited are a poor survey record, new administrator, or director of nursing.

(5) Surveyors in the rural districts make more frequent use of the surprise visit than those in the urban areas.

(6) Surveyors using the new methods are spending proportionately more time on facility assessment than when using the traditional method: somewhat less time on resident assessment; and only a slightly greater proportion of time on followup.

(7) When the new methods of survey and certification are used, slightly more class A violations (probability of death or injury to a patient) and slightly less class B (direct threat to health and safety) and class C (does not threaten health and safety) violations were found.

(8) Surveyors using the new methods make more frequent use of a variety of State followup actions, i.e., consultation, special advisor, and return to followup.

(9) There is a lower percentage of patients observed to be at an incorrect level of care using the sampling methodology. However, after reviewing the history of facilities in the study, the QAP findings reflect preexisting differences in these homes.

A grant for an independent evaluation of the demonstration was awarded in July 1980, and should reflect a more precise analysis of the data.

HOSPICE

MEDICARE/MEDICAID HOSPICE DEMONSTRATION

Background

The growth of hospice care in the United States is a relatively recent phenomenon aimed at helping terminally ill patients live with maximum comfort and minimal disruption to routine activity. Hospice emphasize palliative care for the control of pain and other symptoms of terminal illness. In addition, the hospice concept of care views the patient and family as a single unit of care. Many hospice patients are able to remain at home with their families while continuing to receive services. Hospices use a multidisciplinary approach to deliver social, psychological, medical, and spiritual services, employing a broad spectrum of professional and voluntary care givers.

The medicare and medicaid programs do not currently recognize hospices as a separate provider category, although some hospice organizations are participating in Federal programs within existing provider classifications (e.g., hospital, skilled nursing facility, and home health agency). Some hospice services, such as drugs used in the home and bereavement visits to the patient's family, are not reimbursable under medicare. State medicaid programs have differing coverage of

hospital, nursing home, and home health services, and many States do not cover certain services integral to hospice care.

Project Description

Because this concept of care is relatively new in this country, HCFA has implemented a hospice demonstration project which permits the waiver of certain statutory and regulatory requirements in order to allow coverage of hospice services provided to medicare beneficiaries and medicaid recipients. No discretionary grant funds have been awarded for this project.

The demonstration includes a 24-month experimental phase during which hospice services will be reimbursed, and a 6 month, wind-down period. It is likely to provide a basis for considering more flexible approaches to medicare and medicaid reimbursement of hospice services. The operational phase of the demonstration began on October 1, 1980.

Twenty-six sites have been selected for participation in the HCFA hospice demonstration program. The decision to choose these 26 was based on the need for evaluation data that would reflect urban and rural differences and variations in hospice provider types. Of the demonstration hospices, 11 are hospital-based, 11 are home health agency-based, and 4 are freestanding. All 26 hospice organizations are either certified home health agencies (HHA's) or have contractual arrangements with certified HHA's to provide home health services. Some also have the capability of providing inpatient hospice services. There is at least one demonstration site in each of the 10 Health and Human Services regions.

For 24 of these hospices, medicaid State agencies have also agreed to participate in the project and will reimburse for services to medicaid recipients.

Under the demonstration, the hospices will serve patients who have (1) a life expectancy of 6 months or less, (2) a primary care giver, such as a relative or friend, who is available to provide simple personal care and emotional support on an around-the-clock basis, and (3) entitlement to hospital insurance benefits (medicare part A) and supplementary medical insurance benefits (medicare part B) and/or eligibility under medicaid.

Participating hospices may be reimbursed under the demonstration for a number of items and services not currently covered by medicare. Examples include: outpatient prescription drugs, institutional respite and home respite services (primary care giver relief), visits by dieticians and homemakers, supportive and counseling visits to hospice patients during occasional hospital stays, continuous care (by nurses, home health aides, or homemakers) on a shift basis in the home, certain self-help devices such as safety grab bars, inpatient hospice care, and bereavement services to family members.

The project evaluation is being jointly supported by HCFA, the Robert Wood Johnson Foundation, and the John A. Hartford Foundation. HCFA and the Foundations have selected Brown University, Division of Biology and Medicine, to conduct an independent study of the project in terms of cost, use, and quality of care provided to hospice patients and their families. To more clearly understand the effects of hospice care and of reimbursement for hospice care, HCFA and Brown University will also gather information on other groups of terminally ill patients, including one selected comparison group of patients served by hospices outside the demonstration and another selected comparison group of patients served by hospitals and cancer centers which provide conventional medical care.

The evaluation will focus on: (1) Identification of the types of hospice services provided to terminally ill medicare and medicaid beneficiaries and a determination of the cost of providing those services; (2) identification of the types of services provided to terminally ill patients by conventional modes of care and a determination of the cost of providing those services; (3) comparison and analysis of the cost of services provided in-home and in inpatient settings by the demonstration hospices and conventional modes; and (4) assessment of the adequacy of the care received.

The Office of Direct Reimbursement (ODR), Bureau of Support Services, HCFA, serves as the fiscal intermediary to process all medicare claims submitted by participating hospices. Medicaid hospice claims from the participating States will either be processed by their own fiscal intermediaries or by ODR. For demonstration services provided to medicare beneficiaries, ODR will reimburse the hospices on the basis of reasonable cost subject to retrospective cost reimbursement.

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Relations with PSRO's

Impatient hospice care may be necessary to closely monitor a patient's pain and symptoms. This type of care may also be recommended for a short period of time when there is no one in the patient's home to assist the patient, or the family needs a rest from the routine of caring for the patient (respite care). This nonmedical hospitalization presents the possibility of conflict with PSRO review. To avoid a denial of payment for these hospice patients, HCFA's Health Standards and Quality Bureau (HSQB), which is responsible for coordinating PSRO activities, has suggested two options to ensure compatibility between the demonstration goals and the PSRO program. The first option encourages the PSRO to continue its concurrent review by developing criteria consistent with the project goals. In recognition of time and budgetary constraints, however, the PSRO has been given the flexibility to focus out on these patients. Under this second option, the PSRO would only maintain a monitoring function. HSQB issued a transmittal to PSRO's which outlined these options.

INDIVIDUAL PROJECTS—NEW

COMMUNITY CARE ORGANIZATIONS

Illinois, Long-Term Care Voucher Experiment for the Elderly

The Illinois Department of Public Aid received a grant from HCFA in September of 1980 under section 1115 of the Social Security Act to test a voucher system of financing the personal care and maintenance services believed essential for elderly individuals with moderate to severe functional impairment, in conjunction with the State Department on Aging.

Clients participating in this project will be able to purchase services necessary to maintain themselves in their own homes from any provider agency including voluntary agencies, "for-profit" agencies, project case management aides, informal providers, families (excepting the spouse), and neighbors. The amount of each client's voucher will be based on his/her degree of functional impairment.

The project will establish a centralized case management system for identifying resources, assisting in service planning, advising clients in the use of the voucher and monitoring the receipt and quality of care. Case managers will work with clients and their families on developing care plans but final decisions about what services to purchase and which provider to use will be left to the client, preserving a strong emphasis on client freedom of choice. For services that cannot be purchased through the voucher, the case manager will refer to appropriate resources, arrange for and monitor services.

Services to be provided by the project under waiver which are not otherwise covered by medicaid are: homemaker services, chore services, meal services, and adult day care.

The projects will operate in one site: Joliet Township.

A major research objective of this project is to determine the impact of the voucher on informal supports. The research design calls for the investigation of costs, utilization and client outcomes through an experimental design, and analysis of case management and program administration through a nonexperimental design. In addition the project will investigate the effectiveness of using a predetermined client cost ceiling through the voucher as a way of controlling long-term care costs.

Other overall project objectives are:

—To improve the coordination of and client access to community long-term care services by establishing a centralized case management system.

—To improve the match between identified clients needs of functionally impaired elderly and the use of community services.

—To investigate the costs, benefits and administrative feasibility of providing long-term care benefits under this system.

—To investigate the impact of expanded publicly financed long-term care benefits on informal systems of care.

The project is currently carrying out planning and preoperational tasks.

Georgia, Alternative Health Services

In July 1976, under the authority of section 1115 of the Social Security Act, the Georgia Department of Medical Assistance embarked on a demonstration

project in two of the State's human resources districts (covering 17 counties). The project offers alternative services to nursing home care for persons who would otherwise be placed in institutions. The model is built on a centralized single point of entry into all service systems. In addition to regular medicaid financed health services, the demonstration offers three alternative services; adult day rehabilitation, home delivered services and alternative living services (e.g., personal care, adult foster care, boarding services and congregate living arrangements). Currently, the program serves 1,385 clients, approximately 1,040 have been referred to the experimental group and 345 to the control group for research purposes.

All potential alternative health services (AHS) clients receive a health and social needs assessment prior to enrollment. Along with self-referrals, the project receives referrals from hospitals, the county department of family and children services and the Georgia Medical Care Foundation, the project's independent utilization review contractor. Clients who appear to be eligible for services are interviewed by designated caseworkers from the county who administer the client assessment interview which collects health and social information on the client. Following the interview, the caseworker obtains the relevant medical data from clients physicians and additionally significant social information on family and support systems. The information gathered by the caseworker is reviewed at a team conference consisting of an AHS nurse and social worker and designated caseworker. The team uses the State maximum units of service guidelines to identify patients who require more intensive care than the project can provide. After the conference, the caseworker notifies the client of service recommendation or control assignments. (Three out of every four clients determined appropriate for the project are randomly assigned to AHS service groups with the fourth assigned to a control group. Clients in both groups are tracked for the duration of the project.)

Once a patient is accepted to participate in the project he or she is referred to appropriate providers. A face-to-face interview is conducted by the provider who notifies the team within 5 days whether or not the services recommended are adequate for the client. The provider then indicates the services to be offered, the frequency of services and provides a justification for not providing services recommended by the assessment team. Any changes in the client's care plan must be approved by the team.

Standard contracts have been negotiated with a large number of alternatives services providers which include: (1) prior agreement on specific expenditures and cost allocations; (2) a line item budget which the provider cannot exceed; and (3) a system which allows a provider to retain unexpended funds for use in program expansion.

An evaluation of the project is being undertaken by Medicus Systems Corporation under contract to the grantee. Medicus has participated and reviewed all aspects of the project including the technical research aspects and the management system. In particular, the evaluation will focus on costs, utilization, health impact and effectiveness.

Preliminary analysis of the effectiveness of project services indicates that project services can reduce the rate of client mortality, particularly among those at higher risks of entering a nursing home. For clients judged to be at high risk of entering a nursing home, 18 percent of the service group died, compared to 45 percent of the control group, within 12 months of enrollment in the project. Additional preliminary findings indicate that 42.6 percent of the clients have received home delivered services, 14.7 percent have received adult day rehabilitation and 2.8 percent have received alternative living services.

The final project report is expected in the spring of 1981.

The Georgia State Legislature has appropriated funding for the expansion of the AHS program so that it may be adopted statewide (over a 3-year period) as part of the State medicaid plan. Efforts to phase in AHS statewide began in August 1980. The program is currently working on the transition from a demonstration project to a statewide program and establishing ongoing linkages with providers and agencies. In addition, the project is conducting audits of providers. Together with the evaluator, AHS is working on developing a methodology to convert the current financial data base which is in a charge-based format suitable to a demonstration, to a cost-based format, more suitable to the State medicaid program.

CAPITAL INVESTMENT IN NURSING HOMES

In August of 1980 the West Virginia Department of Welfare was awarded a section 1115 grant. This allowed waiver of the current methodology for determining capital costs included in the medicaid reimbursement of skilled nursing facilities and intermediate care facilities. The basic objectives of this demonstration are as follows:

To determine whether the proposed reimbursement system results in the production of satisfactory patient care within the operating cost standards.

To determine whether the proposed system results in lower reimbursement rates when compared with a system of reimbursement based on historical costs for all service factors (for example, a medicare formula).

There is reason to believe that operating cost control by cost center is preferable to an aggregate operating cost cap, but the data required to evaluate this hypothesis are not currently available. This project will, therefore, focus upon the investment component and the total reimbursement rate under the following operational assumptions. Functional and physical variances from the model facility standard result in operational and nursing services deficiencies, inefficiencies, and diseconomies. Quality of care is assured and verified through review of the monthly long-term care services invoices and quarterly nursing services audits. Both the rates of reimbursement and the manner in which they are determined impact significantly upon investor confidence in the industry and upon the quality of services provided.

Since the advent of the medicare and medicaid programs, the requirement for a suitable, feasible, and acceptable means of determining the rates at which health services providers should be compensated has been at issue. Current Federal law (Public Law 92–603, section 247) provides ". . . for payment of the skilled nursing facility and intermediate care facility services provided under the plan (State medicaid plan) on a reasonable cost-related basis, as determined in accordance with the methods and standards which shall be developed by the State on the basis of cost finding methods approved and verified by the Secretary." In moving toward passage of section 249 of Public Law 92–603, the Congress indicated a concern about the effects of both underpayment and overpayment for medical care and services in long-term care facilities on the quality of care for patients. Furthermore, the strain on State welfare budgets imposed by rising prices for medical care and services in skilled nursing facilities has harshly focused realities underlying such concerns to bear upon the State programs. On the one hand, State programs realize that long-term care facilities which are not compensated for the real costs of providing services to medicaid patients will be under pressure to reduce the scope, quantity, or quality of care; to make their nonmedicaid patients absorb some of the costs of medicaid patients' care; or at worst, to refuse to accept medicaid patients. Furthermore, in areas which are not now adequately served by skilled nursing facilities and intermediate care facilities, underpayment may discourage investments in needed service capacities. On the other hand, overpayment provides little or no incentive for providers to employ the most efficient and economical methods for meeting the service requirements of their patients, resulting in reduced effectiveness for State medicaid long-term care budgets. Excessive institutional costs effectively constrict limited resources, thereby reducing the amount and quality of additionally needed goods and services.

The problem is, therefore, to develop and use approved cost-finding methods to establish the reasonable costs of skilled nursing facility and intermediate care facility services, and, on the basis of such cost-finding methods, to develop and use methods and procedures for payments on a reasonable cost-related basis. These methods and procedures must set payment rates which assure that all participating providers' reimbursement will be reasonably cost-related rates. Similarly, they must set payment rates which are derived and monitored through tractable and manageable administrative procedures; and set payment rates in a way which can be validated and acceptable to both the Secretary and the State.

Within this context, West Virginia will implement a three-component reimbursement system. The nursing services component will be compensated on the basis of actual nursing services required by and delivered to individual patients. The operating costs component will be compensated by cost center and facility

class. Caps on operating costs will be derived from industry experience within the State. Incentives for efficiency and economy will be introduced through the operating cost component by encouraging costs less than the cost caps, with quality of care assured and verified. As a management incentive, the State will share with the facility any cost avoidance from efficient management which results in costs below established caps. That incentive will consist of allowing in the facility rate a percentage of the difference between actual facility cost and the established cost caps, provided such facilities meet all certification and quality patient care standards. The investment component of the new reimbursement system should allow for the reasonable costs of investments in long-term care facilities, including a reasonable return on the investment. A unique aspect of this system is the method for determining the allowance for value of the investment component (land, building, and equipment) of the reimbursement rate.

The standard appraised value (SAV) method establishes the value of the fixed assets *as a long-term care center*, thereby discouraging features which detract from or do not contribute to that function and encouraging functional utility. The model facility standard is drawn from Federal and State regulations and guidelines, and from accepted industry practice, and offsets the fundamental difficulty of the reproduction cost approach by providing a stable base for deriving consistent appraisals of long-term care properties.

The work to be undertaken in the first year includes the design and implementation of uniform accounting and reporting procedures, definition of the model facility standards, initial appraisals of all facilities, the evaluation of the appraisals and the establishment of a rate of return. This project has just begun, therefore, no findings are available at this time. It is hoped that this different method of reimbursing capital costs will discourage rapid turnover in facility ownership and encourage greater stability.

PUBLIC HEALTH SERVICE

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

National Institute of Mental Health

INTRODUCTION

Five percent of the Nation's aged live in institutions. Of these about 12 percent are in mental hospitals with the remainder in nursing and other types of homes for the aged and chronically ill. The elderly comprise 6 percent of additions to State and county mental hospitals and 29 percent of the resident patients. Approximately 80 percent of those aged 65 and older who live in nursing and personal care homes have some degree of mental impairment. Only 3.8 percent of outpatient psychiatric service admissions are aged 65 and over. An estimated 10–25 percent of the aged in the community have some degree of mental impairment. The death rate for suicide among the elderly is highest at age 55 and over (19.9 per 100,000 as compared with 12.7 per 100,000 for all ages). Approximately 44 percent of all male additions aged 55 and over to inpatient services of State and county mental hospitals had a primary diagnosis of alcohol disorder.

THE MENTAL HEALTH SYSTEMS ACT OF 1980 (PUBLIC LAW 96–398)

A focus on the specialized needs of the elderly in the mental health service system was established in law in the amendments to the Community Mental Health Centers Act (Public Law 94–63). This focus was broadened and extended in the Mental Health Systems Act (Public Law 96–398) in which grants for mental health services to elderly individuals were authorized in section 204(a).

In passing the Mental Health Systems Act, the Congress found that despite the significant progress that has been made in making community mental health services available and in improving residential mental health facilities since the original community mental health centers legislation was enacted in 1963, unserved and underserved populations remain and there are certain groups in the population, such as chronically mentally ill individuals, children and youth, elderly individuals, racial and ethnic minorities, women, poor persons, and persons in rural areas, which often lack access to adequate private and public mental health services and support services.

Nearly all sections of the act have some relevance to the elderly, with key provisions contained in four of the sections.

Community Mental Health Center (Section 201)

Grants may be made to any public or nonprofit private community mental health center to meet the costs of operating such a center. A community mental health center (CMHC) may receive these grants for operation for up to 8 years. The definition of the program and services of a community mental health center is included in the law (section 101) and is similar in most respects to that defined by the CMHC Act. Section 101 does call for CMHC's to give special attention to chronically mentally ill.

Initially, a community mental health center must provide: Inpatient services, emergency services, outpatient services, assistance to courts and public agencies in screening persons being referred to State mental health facilities, followup care to the deinstitutionalized, and consultation and education services.

Within 3 years a community mental health center must provide: Day care and partial hospitalization services, specialized services for children, specialized services for the elderly, transitional halfway house services, and unless otherwise being provided in the mental health service area, alcoholism and drug abuse services.

The community mental health center is expected to obtain State, local, and other funds, fees, premiums, and third-party reimbursements. The amount of the Federal grant will not exceed the amount by which the aforementioned resources do not cover the total cost of operation of the community mental health center up to a certain maximum percentage of the cost of operation as follows:

Poverty area: first year, 90 percent; second year. 90 percent; third year, 80 percent; fourth year, 70 percent; fifth year, 60 percent; sixth year, 50 percent; seventh year, 40 percent; and eighth year, 30 percent. Nonpoverty area: first year, 80 percent; second year, 65 percent; third year, 50 percent; fourth year, 35 percent; fifth year, 30 percent; sixth year, 30 percent; seventh year, 25 percent; and eighth year, 25 percent.

The declining percentage and limit of 8 years for CMHC grants reaffirms the philosophy that the Federal role is to initiate services and for the community mental health center to obtain State and local funding, and third-party reimbursements to become financially independent.

Chronically Mentally Ill (Section 202)

Grants may be made to State mental health authorities, community mental health centers or other public or nonprofit private entities to provide mental health and related support services for chronically mentally ill individuals. No State, CMHC, public or nonprofit entity may receive more than eight grants under this section. A grant for a project in a mental health service area (formerly a catchment area) served by a CMHC, may be made only to the CMHC or the State mental health authority, unless the Secretary finds exceptional circumstances to indicate that the chronically mentally ill would be better served by another public or private nonprofit entity.

A project under this section must provide for at least the following:

—Identification of the chronically mentally ill in the area to be served.

—Assistance to individuals to obtain mental health services, medical and dental care, rehabilitation services, employment and housing and other services, enabling the individual to function independently of an inpatient facility.

—A case manager to assure that the individual receives such services.

—Coordination of mental health and related support services.

Grants may be made to State mental health authorities to:

—Improve the skills of personnel providing services to the chronically mentally ill.

—Coordinate State agencies responsible for mental health and related support services.

The amount of the Federal grant will not exceed a specific maximum percentage of the total cost of the program, as follows:

First year, 90 percent; second year, 90 percent; third year, 80 percent; fourth year, 70 percent; fifth year. 60 percent; sixth year, 50 percent; seventh year, 40 percent; and eighth year, 30 percent.

Elderly Individuals and Other Priority Populations (Section 204)

Elderly Individuals (Section 204 (a))

Grants may be made to any public or nonprofit private entity for services to elderly individuals. No entity may receive more than eight grants for the provision of services to the elderly. Each grant shall provide at least the following:

—Location of elderly individuals in need of mental health services.

—Provision of or arrangement for the provision of medical differential diagnoses to distinguish between the need for mental health services or other care.

—Specification of the need for mental health and related support services by the elderly.

—Provision of mental health and support services in the community including those individuals in nursing homes and intermediate care facilities and training for personnel in these facilities.

To the extent that a public or private nonprofit entity is already providing the aforementioned services grants may be made to it for any of the following:

—Assurance of the availability of personnel to provide or arrange for the provision of services to the elderly.

—Coordination of the provision of mental health and support services with the area agency on aging (as defined by the Older Americans Act) and other community agencies providing services to elderly individuals.

The amount of the Federal grant shall not exceed a specific maximum percentage of the total cost of the program as follows:

First year, 90 percent; second year, 90 percent; third year, 80 percent; fourth year, 70 percent; fifth year, 60 percent; sixth year, 50 percent; seventh year, 40 percent; and eighth year, 30 percent.

At least 40 percent of the funds appropriated for section 204 are to be used for projects to serve the elderly.

Mental Health Services in Health Care Agencies (Section 206)

Grants may be made to health care centers to provide mental health services to their patients. Two types of public or private nonprofit entities are eligible for grants.

(1) An entity which provides mental health services which includes at least 24-hour emergency, outpatient, and consultation, and education service and which has an affiliation agreement for the provision of health and mental health services.

(2) A health care center which has in effect an affiliation agreement with a mental health services entity as defined above. Section 203 says, "the term "health care center" includes an outpatient facility operated in connection with a hospital, a primary care center, a community health center, a migrant health center, a clinic of the Indian Health Service, a skilled nursing home, an intermediate care facility, and an outpatient health care facility of a medical group practice, a public health department, or a health maintenance organization."

An affiliation agreement includes the following:

—Description of the geographical area to receive mental health services.

—Provisions for at least one mental health professional to serve as liaison between the two parties.

—Provision of satisfactory assurances that patients referred will receive mental health services.

—Provisions for transportation.

A grant may be made to provide any one or more of the following:

—The costs of liaison or other professionals providing mental health services in the health care center.

—Mental health services provided by other personnel of the center.

—Consultation and inservice training on mental health services provided to personnel of the health care center.

—Establishing liaison between center and other providers of mental health services.

An entity may not receive more than eight grants under this section. The amount of the Federal grant will not exceed a specific maximum percentage of the total cost of operation as follows:

First year, 90 percent; second year, 90 percent; third year, 80 percent; fourth year, 70 percent; fifth year, 60 percent; sixth year, 50 percent; seventh year, 40 percent; and eighth year, 30 percent.

The National Institute of Mental Health

Aging, though long a program area of the National Institute of Mental Health (NIMH), has only received limited support. This has been changed in recent years to where the NIMH program has grown to assume major national and international leadership roles.

Recent events of significance in the development of the NIMH program include:

(1) August 1975. Establish the Center for Studies of the Mental Health of the Aging to *coordinate* Institute activities in aging.

(2) 1975–76. National planning conferences, one each in research, in training, and in services in mental health and aging were held to help establish the agenda for the Center.

(3) 1977. $2 million in the supplemental appropriation for fiscal year 1977 was provided to support research in mental health and aging.

(4) 1978. Report of the HEW Secretary's Committee on the Mental Health and Illness of the Elderly (mandated in Public Law 94–63), transmitted to the Congress.

(5) 1978. Report of the President's Commission on Mental Health, highlighting the elderly as a major underserved population published and implementation of recommendations begun.

(6) 1978. Center for Studies of the Mental Health of the Aging elevated from a coordinating unit to full operational status with responsibility for administering grants in research and training.

(7) 1979. Aging identified as a priority target population for clinical training initiatives, in line with recommendations of the President's Commission on Mental Health.

The Center for Studies of the Mental Health of the Aging (CSMHA) is the focal point in NIMH for aging programs. The major role of CSMHA is to stimulate, coordinate, and support research, training, and technical assistance efforts relating to aging and mental health. The Center staff contains eight professionals, four support staff, and one visiting scientist.

The formal establishment of a Center is indicative of substantial programmatic and administrative priority in a particular area. Consequently, this is not a step which is taken quickly. It involves, at a minimum, complete assessment of the Institute's program activities, evaluation of the knowledge base and state of a field, and active staff stimulation of the development of programs in research, training, and service. This report contains the documentation of the progress made by the Center for Studies of the Mental Health of the Aging in the development of its program.

Program Activities

Activities of the Center fall into four categories: Research, research training, clinical/services training, and technical assistance. Each is discussed in turn.

A. Research Program

The Center supports those studies which have a primary focus on the mental health and illness implications of the aging process and of old age. It supports a wide-ranging, multidisciplinary set of studies which have both theoretical and policy or applied implications. These include:

1. Etiology, Diagnosis, and Course

Studies of the psychological, social, and biomedical factors (and their interplay) that affect mental health and mental illness in later life; clinical and diagnostic studies of the nature and types of mental disorders in later life; studies to assess and measure the extent of cognitive, affective, and social function impairment in later life; studies of the onset, course, and natural history of mental illness in later life.

Illustrative of the projects in this area is one being carried out by Dr. Leonard Berg of Washington University:

The objectives of this study are to analyze the value of various behavioral and biomedical factors in predicting the development and course of severe senile

dementia, and to study the interrelationships of behavioral and biomedical data derived from serial testing of the aged.

Subjects are persons, ages 65 to 75, who exhibit early signs of intellectual decline and controls of similar age, sex, race, and socioeconomic status who are well preserved intellectually. The results of clinical assessment, psychometric tests, the visual evoked response, and computerized tomography are analyzed to determine which measures, either singly or in combination, might be predictive of the severe intellectual decline of senile dementia, or of a much slower decline or stability consistent with what is usually considered normal aging. In addition, the results are compared with the findings at autopsy. The final results of the research are expected to provide information concerning behavioral and physiologic predictors of dementia, behavioral and physiologic changes which predict the progress of the syndrome, as well as indicators of the severity of the disease.

2. Treatment and Delivery of Mental Health Services

Treating mental disorders in later life; coordinating mental health and other services to the aging in the broader health and community services systems; providing services to special populations; structuring of services; and researching new and more effective services.

Illustrative of the projects in this area is one being carried out by Dr. Joseph Barbaccia of the University of California, San Francisco:

Analysis is made of ways in which elderly patients and their families are assisted to prepare for the patients' convalescence and readjustment at home after a period of acute hospitalization. Subjects are 600 geriatric patients treated and discharged from three San Francisco area acute care hospitals, 200 from each hospital. Primarily, diagnoses are arteriosclerotic heart disease and fracture or severe arthritis of the hip. Data are collected on: Ways in which post-hospital services are obtained by elderly patients; the conversion of assessment of need into a service plan; and the effect of the services on mental health and functioning of the patient after discharge. The results of this study are expected to be used as part of inservice training for hospital staff and will form the base of needed laterations in planning for discharge for elderly hospital patients.

3. Program Development, Social Policy, and Social Problems Research in Mental Health and Aging

Institutional program development and alternatives to institutionalization; formal and informal community support systems; financing/reimbursement mechanisms; policy and legal or administrative dimensions in technical assistance and program design; models for research utilization; and models of technical assistance for research development; and studies or developmental life crises, stress, adaptation, and morale in later life with special attention to the prevention of mental disorders.

Illustrative of the projects in this area is one being carried out by Dr. Adrian Ostfeld of Yale University:

The health, psychological, and behavioral effects of severe illness, or death of one spouse upon the other spouse are studied. Three groups of nonhospitalized spouses (categorized as high, intermediate, or low stress according to the severity of the illness of their hospitalized spouse) are followed for 25 months after the death or illness of the hospitalized spouse. Subjects are approximately 1,000 families in which the hospitalized spouse is 56 years of age or older. The relationship between the gradient of stress and the social, psychological, and health characteristics of the nonhospitalized spouses are investigated. Other behavioral and psychological factors by which death or illness in one spouse affects the health and survival of the other are studied. The findings of this research are expected to form the basis of recommendations for clinical interventions with the bereaved. An additional use of the findings is expected to be in curriculum development for mental health professionals.

A list of research grants funded by the Center is included as appendix A of this report. These grants are organized according to the four categories presented. In addition, a fifth category of grants is listed. These grants will be transferred to the administration of the Center in the near future.

B. Research Training

National research service awards, including individual fellowships and institutional awards at the predoctoral or postdoctoral levels, are given to provide

support for the training of research scientists in the area of mental health and aging. Research training is just beginning as a Center program. As the research program of the Center gains strength and visibility, however, additional research training programs will likely be initiated.

C. Clinical/Services Training

The Center's program in mental health services manpower development and training focuses on training efforts designed to improve mental health and related services to the aging within both the established mental health service delivery system (e.g., State mental hospitals, community mental health centers, etc.) and the mental health-related support systems (e.g., senior centers, long-term care facilities, etc.). Grants are available in three major categories: Mental health services manpower education/training, mental health services manpower research and demonstration, and faculty development awards in geriatric mental health.

1. Mental Health Services Manpower Education/Training: Short-Term Training Grants

These grants are for the purpose of providing training of a short-term nature and with a view toward upgrading the mental health knowledge and skills of human services and other professional and paraprofessional personnel concerned with aging. Trainees are primarily nonmental health specialists, although mental health specialists may be included where appropriate to facilitate mutual exchange of knowledge, concepts, and practices.

Illustrative of projects in this category is one being carried out in New Mexico to provide short-term training to persons who work in a rural setting with the minority elderly, particularly those of Hispanic descent. The trainees are community service agency workers not traditionally viewed as mental health specialists, but whose work requires skills for dealing with their clients' mental health problems. The course will include segments dealing with general health problems, psychosocial aspects of aging, family problems, mental health of aging, and counseling techniques. There will also be an intensive supervised internship involving field work with community agencies, particularly those serving rural and minority elderly.

2. Mental Health Services Manpower Research and Demonstration Grants

Projects in this category are for the purpose of either generating needed knowledge, curriculum, and technology that can assist in the development of improved education/training approaches and/or demonstrating innovative education/training approaches for professional and paraprofessional personnel in the field of mental health of aging. In order to be eligible for support from the Center, projects must focus on development, testing, refinement, and evaluation of innovative training models that can be of benefit to wide ranges of institutions or services. Priority is given under both research and demonstration grants curriculum and trainer/educator development. These projects are to assess the feasibility of innovative approaches or methodologies prior to incorporating them into ongoing training efforts and to contribute to the "state-of-the-art" of mental health gerontologic/geriatric education and training.

A project which was funded in fiscal year 1980 illustrates this category of grant: The Department of Psychiatry of the University of Texas at Houston was awarded a grant to develop and disseminate model curricula in mental health of the aging which are suitable for introduction into the educational programs of key professional groups serving the elderly population. The professional groups include medicine, nursing, dentistry, occupational therapy, physical therapy, nutrition, social work, chaplaincy, and psychology. These professional areas were selected to provide a multidisciplinary perspective of what is needed in the curricula regarding mental health of aging; also, members of these groups would be the most likely to be in professional contact with the older population.

A list of the clinical training grants funded and administered by the Center in fiscal year 1981 is included in appendix B of this report. Additional applications will be reviewed by the National Advisory Mental Health Council in February and May for funding in fiscal year 1981.

3. Special Projects

Special projects are supported under both of the preceding clinical/services training categories and are for the purpose of supporting conferences, seminars

or workshops that promote discussion, sharing of information, and exploration of issues and approaches for addressing training needs in mental health of aging. Topics may include such concerns as identifying special mental health service needs of the elderly and training efforts required to meet them. Projects in this category may also be used to promote dissemination and utilization of important findings from manpower training research and demonstrations in mental health of aging.

4. Faculty Development Awards in Geriatric Mental Health

This is a new category of grant which is being implemented in fiscal year 1981. The first applications were submitted on October 1, 1980. The general purpose of the faculty development award is to support, on a pilot basis, the advanced training of an experienced faculty member in psychiatry or psychiatric nursing who will become responsible for the promotion and coordination of the education of the professional schools' students and faculty in geriatric mental health. The objectives of the program are to test the effectiveness of this approach to educator development in mental health of aging and to stimulate an increased awareness of and attention to the mental health needs of the aging within the teaching programs of the professional schools.

D. Nursing Home Improvement Program

For several years, the NIMH has addressed the problems of the quality of long-term care through its nursing home improvement program (NHIP). Following a statement of Presidential support on nursing homes in August 1971, NIMH staff began development of approaches to the creation of short-term training programs in mental health for staff of the Nation's nursing homes. The program was developed through the mechanism of contracts with appropriate educational institutions, professional organizations, and service agencies. This represented the first time that nursing homes per se were made the focus of a specific mental health training program. Because of limited resources, the immediate concern was to develop a program that could have maximum impact in a relatively short period of time, and on as large a segment of the population as possible. At the same time, the program was intended to assure a sound basis on which long-term planning could be built. It was decided that the concern should not be as much with development of training materials or curricula, as with the development of mechanisms for transmitting knowledge of principles and methods of practice which would promote the mental health of patients (and personnel) in nursing homes, and minimize impairment of function caused by mental disorder. For maximum efficiency and impact, it was necessary to call upon existing resources rather than attempt to develop new ones. As a result, the program drew on existing organizations and established "models" of collaboration which could be tested, modified, and then put into operation around the country.

During this past year, the NHIP was assigned to the Center for Studies of the Mental Health of the Aging. This provided an opportunity for closer coordination of research and training activities in mental health of aging with the NHIP and greater participation of NHIP in the Mental Health Systems Act implementation activities. Regional NHIP staff were closely involved in the grant to the American College of Nursing Home Administrators. The ACNHA, in collaboration with the National Council of Community Mental Health Centers, will develop, using a continuing education model, cooperative programs between community mental health centers and nursing homes for the provision of mental health services, case consultation, inservice training of nursing home personnel and program development. This project is national in scope, with training being conducted on a regional basis.

ACCOMPLISHMENTS

A. Cofunding With Other NIMH, PHS, DHHS or Programs Outside DHHS

Not all research in mental health and aging can or should be supported or administered by the Aging Center. In fields with strong and well-established technologies, such as psychopharmacology and epidemiology, specialized expertise already exists in other programs. Similarly, certain research issues are best conceptualized as lifecourse or adulthood issues in which the elderly fit only

as part of the study. In these types of circumstances, the Aging Center has established mechanisms for joint funding while still maintaining fiscal control of the funds. Projects have been cofunded with other programs of the Institute, with the National Institute on Aging, the National Institute of Neurological and Communicative Disorders and Stroke, with the Administration on Aging, and with the National Institute of Handicapped Research of the Department of Education. In this way the total aging effort of the Institute is expanded and multiplied.

As with research, not all clinical training in mental health and aging can or should be supported or administered by the Aging Center. In prior years, Center funds have been transferred to the Manpower and Training Division to support aging-related training. In line with recommendations of the President's Commission on Mental Health, aging is among the priority areas toward which 1981 funds will be directed in addition to the funds administered by the Center for short-term training and training/education research and demonstration projects.

B. Technical Assistance

The Center for Studies of the Mental Health of the Aging has conducted a technical assistance project in four DHHS regions during the past 2 years. This project has been supported through 2 percent technical assistance (TA) funds available through the Community Mental Health Centers Act. The projects have been jointly administered by the individual alcohol, drug abuse, and mental health units in the 10 Public Health Service regional offices and the Center on Aging. The focus of the technical assistance is community mental health centers (CMHC's) and the objective is to assist the CMHC's in developing their capabilities to deliver mental health service to the elderly. The Center collaborates with regional office staff in selection, orientation, and evaluation of the technical assistance program.

The technical assistance is provided by consultants, from the project regions, who have demonstrated expertise in program development and geriatric mental health. The consultants work with the CMHC director and the program staff in analyzing needs and available resources and in the development of a program plan specifying goals and objectives for the proposed service.

A total of 39 CMHC's have directely participated, at a total expenditure of $60,000 in the program during the past 2 fiscal years. In fiscal year 1980 two additional regions will participate on this TA project at a proposed cost of $15,000. The total number of target CMHC's is 14. Based on what is learned from these 53, the Aging Center expects to export this knowledge to all 726 CMHC's through publications, workshops, and consultation.

In addition, the Center provides technical assistance through consultation for the development and stimulation of research and training applications focused on the mental health of aging persons. Researchers and directors of training programs are encouraged to contact the Center for discussion of ideas for new research or training projects. Concept papers, preliminary proposals, and later drafts can be submitted for staff review and comment prior to formal submission of the proposal.

Major technical assistance efforts are available to public and private agencies at regional, State, and local levels with the objective of improving programs affecting the mental health of aging persons and especially the delivery of services to aged persons by community mental health centers. For this latter effort, Center staff works with regional offices, States, and individual community mental health centers.

Technical assistance is carried out through consultation, active participation at national, regional, and local meetings and conferences, and development and distribution of publications and other written materials. Particular emphasis is placed on dissemination of information about NIMH-funded research and training projects concerning the mental health of the aged.

As the focal point for activities on mental health of the aging at the National Institute of Mental Health, CSMHA responds to inquiries from professionals and public alike and provides information and referral to other appropriate organizations when indicated.

C. Interagency Collaboration

There are many Federal agencies with programmatic responsibility for dealing with the aged. Consequently, many approaches, both formal and informal, have been established for coordination and joint program development. Examples of these are as follows:

Intergovernmental Science, Engineering, and Technology Advisory Panel. Long-Term Care Task Force. Information and Referral Work Group. Senile dementis initiative. Retirement age of airline pilots. Rural Services Task Force.

Among the many specific examples of collaborative projects, two are especially notable. First, in the area of senile dementia, the NIMH Aging Center, in collaboration with two NIH Institutes (National Institute on Aging and National Institute of Neurological and Communicative Disorders and Stroke), sponsored two international conferences on Alzheimer's disease/senile dementia. These conferences, the first ever held, helped establish the state of the art in research, treatment, services, and policy in this disease. Second, in the area of service delivery, a regional training conference cosponsored by the Administration on Aging and the NIMH was held as the first formal step toward local-level collaboration of aging and mental health services. This approach will be repeated two more times in fiscal year 1981 so as to gain coverage of the entire Nation.

1. Relationships With the National Institute on Aging

The mandate given to the NIMH by the Congress is to conduct a program of research, training, and services for the prevention and treatment of mental illness and for the maintenance and improvement of the mental health of the Nation. Since persons 65 years of age and older now constitute approximately 10 percent of the population and display the highest incidence of new cases of psychopathology, it follows that a significant portion of the NIMH effort should be directed toward the mental health problems and needs of this age group. The basic focus of NIMH efforts must be on mental health. When applied to this age group the essential considerations are the manner in which aging affects mental health and influence of mental health upon aging.

In this context, NIA's interest starts with the aging process itself, whereas NIMH's approach begins from the perspective of the mental health and illness of older people. From another vantage point, while NIA looks at biomedical, social, and behavioral aspects of aging with regard to development, NIMH studies adaptive and aberrant psychosocial functioning of the elderly with attention to etiology, prevention, treatment, and service delivery as they relate to mental disorders in later life. The two institutes also differ in a fundamental structural sense. NIA's focus is restricted to research and research training while NIMH's aging center program encompasses services and clinical training in addition to research and research training efforts.

Since 1974, staff of the NIMH Center for Studies of the Mental Health of the Aging have served on the Interagency Committee on Research in Aging. This Committee, chaired by the Director, NIA, and in conjunction with the National Advisory Council on Aging helped define the research goals of the NIA, and now meets regularly for purposes of coordination and consultation.

In addition, staff of the Center together with NIA staff also serve on the Interdepartment Committee on Aging conducted under the auspices of the AoA, which is advisory to the Commissioner on Aging.

Finally, considerable array of formal and informal relationships exists between the NIMH Center for Studies of the Mental Health of the Aging and the National Institute on Aging. Research applications of interest to both organizations are dually assigned. On occasion, projects with dual assignments, approved by the primary institute but for which sufficient funds are not available, have been transferred to the secondary institute for funding consideration.

D. Publications

Results of research and training projects are usually published in the technical literature of a field by the investigator. In addition, the Center devotes considerable resources to the translation of research findings into materials for practice or training, and to the transmission of this information to interested individuals and groups. Materials for the public and for the stimulation of researchers are also developed by the Center.

Grant No.	P.I.	Title	Totals, fiscal year 1980	Direct costs, fiscal year 1981
	A—Epidemiology:			
[1] 32794	Gurland	Epidemiology of depression in two urban populations	$61,344	
[1] 32885	Vaillant	Effect of mental health upon aging	49,107	$36,000
[1] 33870	Kramer	Epidemiological catchment area	100,000	100,000
	B—Clinical:			
33688	Prinz	Sleep/waking patterns in dementia	123,095	90,332
30664	Niederehe	Memory impairment in affective disorders of aged	51,022	
31054	Berg	Mental health in the aged: Biomedical factors	11,500	
32740	Feinberg	Personality, sleep and MH in the aged	81,475	6,900
32668	Larson	Dementia and MH in the aged	63,123	53,700
31054	Berg	Mental health in the aged: Biomedical factors	160,895	137,000
32612	Hardt	Anx. and aging-intervention with EEG alpha feedback	88,117	65,766
33704	Palmore	Mental illness and soc. support amg. very old	184,720	115,000
32172	Riege	Nonverbal memory in aged mentally healthy or ill	35,322	
32577	Ferris	Neurometric assessment of MH in aging	209,498	129,923
32750	Jacobs	Psychosocial and endocrine aspects of grief in men	122,593	68,263
33181	Vrtunski	Psychomotor slowing and age: Microbehavioral analysis	32,320	27,309
33282	Kripke	Home sleep diagnosis for the aged	24,108	
27281	Nathan	Aging: Brain structure and sociobehavioral variables	167,204	111,727
29535	Persky	Sexual adjustment and aging	115,467	
30626	Yamamura	Neuropsychiatric disorders: Transmitters and receptors	82,725	59,745
34889	Haug	Depression in elderly: Causes, consequences, care	19,066	
28460	Weitzman	Psychoneuroendocrine rhythms, and sleep disorders	149,614	125,000
	C—Treatment:			
[1] 28393	Granick	Improving congitive and adaptive abilities of aged	82,806	
33677	Jarvik	Psychotherapy in geriatric depression	72,005	58,850
[1] 30099	Alexander	Corticosteroid effects on learning and memory	7,250	
[1] 33699	Cole	Lecithin in senile dementia	65,000	
[1] 29819	Melinger	Natl. trends in psychotherapeutic drug use	51,745	
[1] 34223	Shader	Clin. applications of pharmacokinetics in psychiat	95,805	
[1] 31357	Jarvik	Drug treatment of depressed outpatients	118,285	33,000
[1] 29590	Ferris	Psychopharm of neurotransmitter systems in aging	31,000	31,000
[1] 32724	Corkin	Lecithin precursor treatment in Alzheimer's dis		70,276
[1] 34042	McNair	Tricyclic antidepressants and congitive toxicity	53,000	13,902
	D—Services:			
27361	Brody	Mental & physical health practices of older people	143,736	
25373	Cohen	Family agency team for noninstitutional care of aged	163,871	
34426	Koh	Adaptive capabilities of newly immigrated Asian elderly	94,654	62,334
32731	Barbaccia	Adjustment of older persons after acute hospitalization	205,162	150,038
	E—Psychosocial:			
32668	Carp	Testing a congruence model of aging and MH	122,852	20,000
35312	Lawton	Old and alone: Gender, marital status and MH	148,485	120,075
31095	Scheidt	MH and environmental adaptation of rural elderly	139,951	99,978
35360	Poulshock	Care for elders and MH of family members	123,357	100,000
34334	Kiefer	MH of Korean-American elderly	48,594	36,789
29687	Kahana	Voluntary relocation and MH of the aged	58,086	
33645	Masuda	MH of aging Japanese-Americans	89,164	67,230
31907	Johnson	Interdependence and aging in ethnic families	69,493	
33779	Becker	Stress vulnerability in Alzheimer patients' families	101,256	76,259
32155	Kivnick	Grandparenthood—meaning and mental health	5,767	
34098	Pearce	Skills for interpreting and coping with retirement	15,660	
27894	Faulkner	Maintenance and change of MH of poor, urban, black elderly.	175,295	
35252	Brody	Women, work and care of the aged—MH effects	131,867	138,000
26121	Atchley	Impact of retirement on aging and adaptation	48,967	54,568
31743	Cohen	Networks of the aging living in midtown SRO hotels	52,569	
32652	Kroeger	Retired women—career commitment and MH	170,711	110,342
32999	Ward	Aged residential segregation: MH impact	150,732	
29657	Nydegger	Timing of fatherhood: Adult child's perspective	95,455	102,559
32260	Ostfeld	Effect of spousal illness and death in older families	280,668	149,948
33141	Lee	Fear of victimization among the elderly	46,320	28,659
32305	Chiraboga	Mental illness and divorce: A lifespan study	37,000	
33713	Fiske	MH—a longitudinal study of adaptation	67,031	67,000
	RA	Administration on Aging (mini-White House conference)	9,500	
	RA	Natl. Inst. for Handicapped Rsch	50,000	100,000
	RA	Administration on Aging—(housing)		20,000
	RA	Heart, lung, and blood		210,000

[1] Cofunded.

CLINICAL/SERVICES TRAINING GRANTS FUNDED BY CSMHA

Grant Number	Program director-institution	Title	Award[1] Fiscal year 1980	Fiscal year 1981	Fiscal year 1982
5-T01 MH15538-03	Kahana, Boaz, Wayne State University.	Interdisc. trng. program in MH and aging.	$75,000	$75,000	$75,000
5 T41 MH15716-02[2]	Santos, John, Notre Dame	Outreach trng. to assist rural and minority elderly (N. Mexico).	58,665	89,519	56,919
5 T15 MH15686-02[2]	Hands, Donald, Pittsburgh Pastoral Institute.	Clergy for the aged	21,764	22,930	
5 T31 MH15696-02[2]	Gaitz, Charles, TRIMS, Houston, Tex.	Trng. in geriatric phychiatry and psychology.	168,000	176,404	
5 T15 MH15711-02[2]	Scott, Judith, Gay Community Service, Minn.	Aging and the affectional preference minority.	35,250	38,301	
5 T15 MH15544-03	Gottesman, Leonard, Temple University.	Gerontology for MH educators and adm.	136,432		
5 T15 MH14947-03	Eastman, Pauline, Lakeshore MH Institute, Tenn.	Aging, NH and cont. ed	54,581		
5 T15 MH14785-03	Connelly, Richard, University of Utah.	Focus on MH aging	75,008		
5 T24 MH15438-03	Waters, Elinor, Oakland University, Mich.	Counseling and gerontology for aging services providers.	96,791		
5 T21 MH14435-05	Edinberg, Mark A., University Bridgeport, Conn.	Programs on aging/gerontology interdisciplinary.	34,636		
1 T01 MH16133-01[2]	Levenson, Alvin, University Texas, Houston.	Model curricula in MH of aged	56,315	98,866	50,026
1 T15 MH16237-01[2]	Cyr, Bruce A. ACNHA/ Washington.	New model training for CMHC Nursing home staff.	52,762	49,901	

[1] Direct costs only.
[2] Reviewed and approved by aging panel—all others transferred to CSMHA from Division of Manpower and Training, NIMH.

National Institute on Alcohol Abuse and Alcoholism

INTRODUCTION

Alcoholism is a serious health problem among the elderly. A recent NIAAA report, "Alcohol and Health," indicates that a significant number of people 60 years old and over have problems with alcohol. Loneliness, loss of spouse, physical or emotional separation from children, ill health, or lack of purposeful employment can precipitate alcohol problems in the elderly. Estimates of the number of elderly alcoholics range from 1 to 2.7 million.

An analysis of national surveys on alcoholism among the elderly indicates that the significance of this problem has only recently been appreciated. The majority of the problem drinkers aged 65 and over are unidentified, overlooked, and untreated. It has been estimated that about 85 percent of all elderly problem drinkers are not receiving any type of service related to their alcohol problems. One of the major barriers to treatment of alcoholic senior citizens is the failure to consider alcoholism as a possible diagnosis. What is perceived as frailty, senility, or simply the unsteadiness of old age may in fact be alcoholism. Relatives, friends, and service professionals working with the elderly may be reluctant to acknowledge the need for alcoholism treatment. In addition, social agencies for the aged usually are poorly equipped to treat alcoholic problems, and many alcohol treatment centers are geared to a younger clientele.

Restricted medicare coverage is an additional stumbling block to the treatment of alcohol-related problems among the elderly. Almost all of the elderly depend to some extent on medicare to pay for health services. Medicare is, however, a health insurance program designed to pay for inpatient care and physician services. Most of the nonphysician health and social services that are a part of comprehensive alcohol treatment programs are not covered by medicare.

NIAAA has a legislative mandate to encourage and give special consideration to the submission of project grants and contracts for the prevention and treatment of alcohol abuse and alcoholism among the elderly under section II of Public Law 96–180. In response to the recognized needs of the elderly and the legislative mandate, NIAAA has initiated a number of special activities targeted to this population, which are described in the following narrative.

INTERAGENCY ACTIVITIES

NIAAA, in cooperation with the Health Care Financing Administration, has undertaken a major demonstration program to improve medicare and medicaid coverage for alcoholism treatment services. NIAAA will provide up to $1 million in fiscal year 1981 to fund demonstration grants for the purpose of demonstrating the feasibility and effectiveness of providing alcoholism treatment services in free-standing residential and outpatient settings, which are less expensive than the inpatient services currently covered by medicare and medicaid.

Other interagency activities initiated in fiscal year 1981 include:

—Participation in the White House Conference on Aging to highlight the alcohol-related problems of the elderly and to stimulate social concern in this area.

—Participation on the National Council on Alcoholism Blue Ribbon Committee on Aging and Alcohol.

—Dialog with the Administration on Aging to explore cooperative activities.

TREATMENT

The elderly are receiving alcoholism treatment services throughout the country through most of the programs currently funded by NIAAA, with the exception of programs specifically designed for youth. These programs offer such services as outreach, referral, counseling, detoxification, and other forms of treatment on an inpatient, outpatient, or day care basis.

In addition, NIAAA presently funds two programs specifically designed to meet the needs of the elderly who are experiencing difficulties with alcoholism or other alcohol-related problems. NIAAA provides approximately $500,000 per year for these two programs. The programs are located in Vancouver, Wash. and New York City.

The Vancouver senior alcohol services project is administered by the Health and Welfare Planning Council of Clark County, Wash. The program is targeted for both men and women 60 years of age or older who live in Clark County and who have a problem with their use of alcohol. The program is also available to provide services to relatives or friends of the drinking person who are concerned with and/or affected by that person's misuse of alcohol. The program meets needs beyond alcohol treatment in such areas as nutrition, health, transportation, and other daily living activities. The program provides training in alcoholism and gerontology and evaluates the treatment and training efforts. In addition, research is being conducted on the drinking patterns of both alcoholic and nonalcoholic elderly persons.

The Bronx older American problem drinker driver project is administered by the Neighborhood Engaged Service Center, Inc. The target population for the program are the elderly residents of the Bronx, New York City, who exhibit symptoms of problem drinking. The program consists of day care facilities developed to insure that the elderly problem drinker receives a comprehensive array of direct physical and social services, including outreach, evaluation, referral, individual and group counseling, crisis intervention, alcohol education, family counseling, recreational therapy, client advocacy, transportation, hot lunches, and coordination of services with other social agencies.

During fiscal year 1981, the training branch will continue to stimulate applications and provide technical assistance to potential applicants for grants to provide training to serve the needs of elderly alcoholics.

Through its contractor, the National Center for Alcohol Education, NIAAA will develop prevention education materials for the elderly in fiscal year 1981. The materials will be developed in a handbook format with a companion curriculum guide. They will contain information about the effects of alcohol on the body, psychologically and physiologically; the influence of the aging process on consumption, the impact of changes in lifestyle on customary drinking behavior;

for example, retirement, change of geographic area, and loss of companionship. These materials will be targeted to staff of residences for the elderly, senior neighborhood centers, and nursing homes. This project will be coordinated with *Elder Ed*, an audiovisual training program developed by the National Institute on Drug Abuse, which presents material on the use of alcohol with prescription drugs.

In response to NIAAA's technical assistance efforts to encourage applications for programs to specifically serve the aging, four grant applications were received in fiscal year 1980. Only two of these were recommended for approval by the National Advisory Council.

In fiscal year 1981, NIAAA plans to develop a special announcement to encourage and stimulate grant applications to provide alcoholism treatment services specifically for the aging. Technical assistance will be provided to State alcoholism authorities and potential applicants to help insure quality grant applications.

RESEARCH

During fiscal year 1980, the NIAAA Division of Extramural Research funded a pilot study in Los Angeles, Calif., to investigate alcohol drinking practices among the aging. The pilot survey study will investigate the alcohol drinking practices in a sample of elderly community residents in Los Angeles County. Status changes which may be related to drinking patterns in this population will be examined in six life areas: Work, family, social networks, economics, age, and health. Social and psychological correlates of drinking patterns will also be assessed. These include life satisfaction, personal control of mastery, and tendencies to "give up" in dealing with problems.

During fiscal year 1981, the NIAAA Division of Extramural Research is planning to hold a workshop on "Alcohol Abuse Among the Aging," in collaboration with the National Institute on Aging. The workshop will enable investigators who are concerned with alcohol-related problems of the elderly to exchange information, serve as a forum for evaluation of ongoing research and provide future research directions. The proceedings and recommendations of the workshop will be published in the NIAAA Alcohol Research Monograph Series.

TRAINING

During fiscal year 1980, the NIAAA Training Branch funded two training programs for approximately $260,000 to train alcoholism service providers for the elderly.

One grant was awarded to the Mental Health Institute of Independence, Iowa to improve the quality of service available to the elderly population who have problems with alcohol. The program will provide training for health and social welfare personnel, and attempt to develop a training model for use by other programs. Specialized training in the alcohol problems of the elderly will be offered to such service providers as policemen, firemen, AA members, volunteer workers, health and social welfare personnel, and alcohol counselors.

The second grant was awarded to the School of Social Work of Adelphi University in Garden City, N.Y. The purpose of the grant is to train social work students in serving alcoholics residing in single room occupancy hotels located in the Upper West Side of Manhattan, N.Y. This project will put special emphasis on developing training approaches for intervention with the aging and aged alcoholics.

NATIONAL INSTITUTE ON DRUG ABUSE

INTRODUCTION

NIDA and its predecessor agencies were formed to address public health problems created by illicit drug use—particularly heroin use. In response, NIDA developed a nationwide treatment services network.

Illicit drug use/abuse has traditionally been most severe among adolescents and young adults. Consequently, the bulk of NIDA's efforts and resources have not been allocated for services to the aging. The number of people in NIDA-funded treatment programs who can be defined as elderly is small. However, NIDA has supported projects focusing on the elderly in the areas of research, public information, and training. NIDA estimates its combined expenditures on the elderly in fiscal year 1980 at approximately $3,602,300.

RESEARCH

During the past year, NIDA initiated a thorough computer search to identify all grants and contracts which include a focus on the elderly. NIDA identified virtually all the published literature concerning drugs and the elderly. On July 14, 1980, the Psychosocial Branch of NIDA's Division of Research sponsored a technical review entitled "Research Issues in the Study of the Drug Abuse Among the Elderly." Presentations were made by noted experts in the fields of gerontology and drug abuse, and these experts, together with the invited guests, discussed relevant research issues, and outlined a study to be conducted.

The elderly are at high risk for drug misuse and abuse because they generally face increased stress and decreased personal and social resources for coping. In addition, the elderly consume large numbers and quantities of drugs, prescription and nonprescription combined. In a recent NIDA-sponsored study, for example, David Guttman (1978), the Catholic University of America, found that 62 percent of his Washington, D.C., sample used prescription drugs and that more than one-third used between two and four prescription drugs; 69 percent used over-the-counter drugs; and 44 percent used alcohol at least several times a month. Approximately 14 percent of the prescribed drugs were for sedatives and/or tranquilizers and more than one-third of the respondents used an internal analgesic. Approximately half of the respondents used some type of combination of legal drugs and over-the-counter drugs in combination with alcohol. Other studies have reported that the hoarding and sharing of drugs among the elderly is not an uncommon occurrence.

NIDA has also produced the following publications as the result of recent grants, contracts, or conferences: (1) "The Aging Process and Psychoactive Drug Use"; (2) "A Study of Legal Drug Use by Older Americans"; (3) "A Survey of Drug Taking Behavior of the Elderly"; and (4) "Drug Abuse and the Elderly: Perspectives and Issues." The Services Research Branch is currently supporting one elderly project—a survey of drug use patterns and related behaviors—of a representative sample of the elderly in Houston, Tex.

PUBLIC INFORMATION

The elder-ed program consists of 30-minute films and booklets designed to assist the elderly to be fully aware of the benefits and risks of medicine and prescription drugs. Elder-ed is a program on wise use of prescription drugs and how to communicate effectively with health care practitioners. Two booklets make up the elder-ed publications kit. "Using your Medicine Wisely: A Guide for the Elderly" is a discussion of sensible precautions about taking medicines. "Passport to Good Health Care" is an 8-page, passport-size booklet which has space to write down medical emergency information as well as complete descriptions of all the medicines and prescription drugs the senior citizen takes.

TRAINING

During the past year, NIDA has reproduced and distributed two manuals, one aimed at providing instructions for service providers, entitled "Drug Misuse and Abuse Among the Elderly," originally published by the Door of Central Florida, Inc. The training package's basic objective is to improve service providers' understanding of the physical, psychological, and social problems of aging that may contribute to drug misuse and abuse by the elderly. The second training manual for pharmacists and pharmacy students, "Improving Use of Drugs by Elderly Patients," a learner's manual, was originally published by the Florida Drug Abuse Prevention and Education Trust in Operation PAR, Inc. This manual provides information and reference sources for pharmacists who provide medication to ambulatory elderly patients.

TREATMENT

The new "Statewide Services Grant Guidelines" require States to assess the need for drug abuse treatment services among the elderly and to put forward objectives for meeting those needs. Similarly, the "State Plan Guidelines" for implementation of section 409 now require that the plan address the needs of the elderly.

INTERAGENCY ACTIVITY

In addition to maintaining close contact with NIMH and NIAAA efforts related to the elderly, NIDA also exchanges information with officials from the Administration on Aging (AoA) and National Institute on Aging (NIA) regarding their ongoing efforts. Further, NIDA is represented on the planning committee for the 1981 White House Conference on Aging.

FOOD AND DRUG ADMINISTRATION

Laws enforced by the Food and Drug Administration (FDA) are designed to protect the health, safety, and pocketbooks of all consumers regardless of age. This protection, however, is particularly important to the elderly consumer, and many of FDA's actions are of special interest to this age group.

PATIENT PACKAGE INSERTS

In September, 1980, the Food and Drug Administration initiated a pilot patient package insert project which requires that pharmacies give patients easy-to-read information along with certain prescription drugs. The "patient package inserts" (PPI's) will describe what the drug is for, what side effects may occur and how to take the drug properly to get the most benefit. The leaflets will be produced by drug manufacturers and will also be available to hospitals and nursing homes. The leaflets, covering 10 drugs or classes of drugs, should be available in pharmacies beginning in mid-1981. Their benefits to the public and their cost will be evaluated over the next 3 years. Then, a decision will be made whether to require patient package inserts for other prescription drugs.

Patient package inserts already are required by FDA for some prescription drugs such as birth control pills and estrogens for menopausal use and a few manufacturers are voluntarily distributing patient information leaflets for other drugs.

The 10 drugs or categories of drugs for which patient package inserts will be required are: *Ampicillins*—a class of penicillin-type antibiotics; *benzodiazepines*—a class of minor tranquilizers, including Valium (chlordiazepoxide), Librium (diazepam) and Tranxene (clorazepate dipotassium); *cimetidine*—used for the treatment of ulcers: *clofibrate*—used to treat elevated fats in the blood; *digoxin*—for use in treating heart problems; *methoxsalen*—used in the treatment of skin pigmentation problems and, as an investigational drug, in psoriasis; *thiazides*—a class of diuretic drugs commonly used in the treatment of high blood pressure; *phenytoin*—a drug used to control epiliptic seizures; *propoxyphene*—a pain reliever, and *Bendectin*—a drug used to prevent nausea in pregnancy. (Bendectin replaced Warfarin as one of the drugs for which PPI's were originally proposed.)

In selecting these drugs, FDA considered whether:

—Precise use of the drug is essential to achieving its therapeutic effect.
—The drug is widely prescribed and used.
—The drug has the potential to cause significant adverse effects.
—There are likely to be severe problems if patients do not follow the dosage schedule and directions for use; and
—The use of the drug is largely a matter of personal choice by the patient (such as birth control pills or minor tranquilizers).

FDA believes that the need for such a program is clear. Patients who use prescription drugs improperly may not receive the intended therapeutic benefit and as a result prolong the need for medical care. They may stay sick longer, losing additional days of work, or they may suffer adverse reactions, requiring hospitalization. Since the elderly consume disproportionate share of medication they should benefit from the PPI program more than the general population.

FDA published draft guidelines for 10 patient package inserts in the September 12, 1980, Federal Register. FDA has published guidelines for three drug categories (Cimetidine, Clofibrate, and Propoxyphene) in final form on November 21, 1980. Bendectin replaced Warfarin on the list on December 1980. Three additional final guidelines will be published in December, and the final four in January. Pharmacists will have 6 months after publication of the final guidelines to begin distributing the patient package insert which will be printed by the manufacturers of the drugs. During the 3-year evaluation period, FDA will permit

the testing of alternative methods of distributing written information to consumers.

The policy on patient package inserts was proposed by FDA on July 6, 1979, with an opportunity for public comment. Hearings were held throughout the country to learn from manufacturers, health professionals, and consumers their views. FDA received and analyzed 1,500 written comments on the proposal.

OTC (OVER-THE-COUNTER) MONOGRAPH REVIEW

OTC drug monographs establish standards for specific classes of over-the-counter drug products to insure a specific level of quality among products of a given type. This standard permits the consumer to purchase the least expensive brand in safety. This is especially beneficial to the elderly. Most of them are on fixed incomes ,and they often use a great deal of medication.

FDA hopes to publish the tentative final monograph for analgesic in November 1981. The proposal was published in July 1977. The panel phase for laxatives was completed in 1975 and the tentative final monograph is scheduled for publication in September 1981. Nighttime sleep aids had their panel report published in December 1975, the tentative final monograph was published in June 1978, and the final monograph will be published in December 1981. The panel for digestive aid preparations adopted its report in January 1979 and hopes to publish the proposal in April 1981. The proposal for external analgesics was published in December 1979 and the tentative final monograph is scheduled for completion in April 1983. The proposed monograph for vitamins and minerals was published in March 1979, and it is hoped that the tentative final monograph will be published in July 1982.

DRUG EXPERIMENTATION IN ELDERLY

In the past, comparatively little clinical research has been performed upon the elderly. However, when it is performed the question of informed consent sometimes becomes an issue, and guidelines are being finalized which will establish parameters under which the institutional review boards must determine whether specific groups who may not be able to protect their own rights such as children, the elderly, and prisoners, are receiving adequate protection. These boards are appointed by the Agency to monitor research conducted in the development of new drug applications.

DESI DRUGS (DRUG EFFICACY STUDY IMPLEMENTATION)

During fiscal year 1980, the Bureau of Drugs removed 26 ineffective general products (those having new drug applications) and 405 specific drug products (abbreviated new drug applications) and approved 151 specific drug products. This program will help assure that consumers purchase only those drug products which will effectively treat the conditions for which they are indicated. Since the elderly use a disproportionately high percentage of drugs, this program should benefit them more than it does the general population.

THE MAXIMUM ALLOWABLE COST (MAC) PROGRAM

FDA is assisting in the Departmentwide MAC program which is aimed at reducing health care costs through the increased use of lower cost generic drugs which are determined to be medically equivalent. FDA develops lists of generic drug products which are medically equivalent to brand name products.

The MAC program is conducted to prevent medicare and medicaid (tax-supported programs) from paying premium prices for brand name drugs when lower cost, medically equivalent generic versions are available. The MAC program adopts those products on FDA's generic drug list which meet their requirements. The elderly are benefited by paying lower costs for their needed medication.

MEDICAL X-RAY GUIDANCE AND EDUCATION EFFORTS STEPPED UP

Of the approximately 270 million medical X-ray examinations conducted in the United States annually, a substantial proportion are performed on elderly patients. It is generally acknowledged that a significant number of X-ray procedures may not be medically needed; factors which contribute to X-ray overuse

the testing of alternative methods of distributing written information to part of physicians, and a lack of clear-cut criteria as to when certain X-ray procedures are indicated and when they are not.

FDA is seeking to address these problems with two new programs, one addressed to physicians and the other to patients. To provide better guidance for physicians on the indications for certain X-ray examinations, the Agency is convening expert panels of physicians to develop what it calls "X-ray referral criteria"—recommendations on which signs, symptoms and/or patient history warrant the use of X-rays in a particular clinical circumstance. As they are developed, these recommendations will be widely publicized to the medical community through professional journals, editorials, etc.

In a parallel program to educate consumers about medical X-rays, FDA has launched a nationwide public information campaign that, among other things, cautions consumers not to insist on X-rays, advises that they discuss with their doctors the need for an X-ray examination if one is being considered, and that they keep a record of previous examinations in an effort to avoid needless "repeats."

FRAUDULENT AND QUACK DEVICES

The Bureau of Medical Devices briefed an investigative team of the House Select Subcommittee on Aging about the Bureau's activities to protect elderly consumers against fraudulent medical devices, particularly those associated with arthritis. The investigative team was trying to gather evidence to request hearings on the special medical problems faced by the elderly. The Bureau explained its policies on fraudulent devices; the guidelines followed by field investigators for detecting and taking action against deceptive devices; the consumer education program implemented by FDA's Consumer Affairs Offices; and FDA's collaborative efforts with the U.S. Postal Service and the Federal Trade Commission to regulate deceptive devices. The team was shown samples of fraudulent devices and deceptive advertisements.

The FDA's quackery education program has been directed at generating local and national interest in recognizing medical and health frauds. The FDA prepared a series on device quackery for local television. The television spots discuss and describe various types of device quackery and medical fraud. The series, available through local Consumer Affairs Offices, illustrates examples of devices that make false and misleading claims. These examples include arthritis and pain relievers, figure enhancers, sex aids, hair growth and removal devices, and weight reducing devices.

FDA developed and is distributing a booklet entitled, "The Big Quack Attack: Medical Devices." The booklet contains information on device fraud and informs consumers of the steps they should take to protect themselves from device quackery. Included in the booklet are the names of devices and device manufacturers that the FDA or the U.S. Postal Service have acted against for false and misleading claims in their respective labeling and advertisements.

TESTING NONDIRECTIONAL HEARING AIDS

A program of testing nondirectional, behind the ear hearing aids for compliance with the Federal standard prescribed under 21 CFR 801.420 was completed. Samples from eight of the firms met all major requirements, although three of these firms or samples had minor labeling problems. Of the remaining samples, 12 failed in some way to perform according to specifications contained in the user instructional brochure and/or other analysis of labeling. Four other firm's samples revealed problems serious enough to require followup GMP inspections. FDA issued letters to the remaining firms enumerating minor device deficiencies.

INTRAOCULAR LENS INVESTIGATION

The Ophthalmic Device Section, an extra-Agency advisory group of the Ophthalmic, Ear, Nose, and Throat and Dental Devices Panel conducted public hearings on January 7 and February 12, 1980, reviewing testing of intraocular lenses (IOL's) in humans as part of the safety of ongoing IOL clinical investigation. IOL firms have investigations that track over 100,000 lens implantations per year. These investigations started in 1978 and are projected to run until 1981.

The advisory group submitted a report to FDA on March 7, 1980, which in part, recommended that:

(1) An ongoing biostatistical review of the study be continued to identify and correct any possible study-design deficiencies.

(2) A revised updated patient consent form be drafted for use in the study.

(3) Blue Cross-Blue Shield and medicare data on contract surgery and IOL implantation be compiled as auxiliary investigative data.

(4) FDA expand its informational activities to provide the public with more information on the progress of the IOL clinical investigation.

SODIUM AND POTASSIUM LABELING

FDA will publish, in early 1981, a proposal that will require sodium and potassium labeling and establish definitions for "low," "moderately low," and "reduced" sodium. This issue was addressed in FDA's 1979 Federal Register proposal on food labeling. The document is presently being reviewed within FDA.

CHOLESTEROL CONTENT LABELING

FDA is proposing that cholesterol and fatty acid content of food be included as part of the nutrition labeling when claims on these substances are made. It defines the terms: "cholesterol free," "low cholesterol," and "reduced cholesterol." FDA expects to publish this proposal in the Federal Register in late December 1980.

TOTAL DIET STUDIES

FDA is studying the possibility of modifying its market basket surveys of chemical contaminants and trace nutrients in the total diet, by basing it on dietary consumption data from the U.S. Department of Agriculture (USDA) and Health and Nutrition Examination Survey (HANES), Department of Health and Human Services. The current studies are based on dietary consumption data developed by USDA in 1965. Foods that are representative of a total diet are grouped in 12 categories (e.g., leafy vegetables; meat, fish, and poultry; etc.). These foods are collected and prepared as if in a typical kitchen. FDA then analyzes them for trace nutrients and for chemical contaminants. Presently, FDA is studying the diet of teenage males, 6-month-old infants, and 2-year-old children. By having more flexibility in developing data on levels of nutrients and contaminants, FDA will be able to estimate various food intakes for different age groups, including the aged. While FDA does not expect to begin work on this until fiscal year 1983, it is developing plans on how this will be accomplished.

COLOR ADDITIVES

Lead Acetate. On October 31, 1980, FDA published a final rule in the Federal Register to permit use of lead acetate as a color additive in cosmetics that color hair on the scalp. Lead acetate is an ingredient in some dyes that progressively darkens hair (e.g., Grecian Formula). FDA had conducted tests to determine whether a significant amount of lead acetate is absorbed through the skin when used as a hair dye. FDA found that the amount of lead absorbed from the use of such dyes is minuscule compared to total human exposure to lead. FDA is requiring, however, that all hair dyes containing lead acetate bear this statement:

"CAUTION: Contains Lead Acetate. For external use only. Keep this product out of children's reach. Do not use on cut or abraded scalp. If skin irritation develops, discontinue use. Do not use to color mustaches, eyelashes, eyebrows, or hair on parts of the body other than the scalp. Do not get in eyes. Follow instructions carefully and wash hands thoroughly after each use."

FOOD LABELING

In refining its food labeling strategy as a result of the 1978 food labeling hearings and the 1979 consumer food labeling survey, FDA is proposing several specific labeling regulations that pertain to:

—Declaration of all optional ingredients in standardized foods.

—Definitions of "low cholesterol," "reduced cholesterol," and "cholesterol-free."

—Specific fat source declaration if over 10 percent of dry weight.

—Quantitative declaration of sodium, potassium, and total sugars as part of nutrition labeling.

On July 8, 1980, FDA announced its plans for the development of alternative label formats. FDA awarded a contract to Robert P. Cersin Associates, Inc., for the development of new labeling formats. A series of public meetings will be held to provide direct input to the contractor effort. The first public meeting was held in Washington, D.C., on October 6, 1980. The contractor will present alternative formats for further study by early 1981.

HEALTH RESOURCES ADMINISTRATION

Programs That Impact on the Elderly

HEALTH PLANNING

The health planning program is aimed at developing a two-tiered structure of State and local health planning agencies which are responsible for carrying out a range of planning, regulatory, and resource development functions. This network is designed to deal with the problems of access to, and the cost and quality of, health services.

In doing so, the health systems agencies (HSA's) and the State health planning and development agencies (SHPDA's) address a broad range of health care system issues such as reimbursement methods, regionalization of services, maldistribution of manpower and other resources, "competition" versus "regulation," and capital investments for health facilities.

A study currently underway indicates that planning agencies continue to place a high priority in their plans and implementation activities on long-term care, particularly in the areas of SNF/ICF beds and home health care. 75 percent of the agencies studied have developed goals and objectives for SNF/ICF beds and/or home health care. While the review of specific project applications remains one of the primary means of implementing goals and objectives for long-term care, agencies are increasingly developing other approaches which rely more heavily on the involvement of consumers and coalitions of providers, government agencies, and interest groups. For example:

—The HSA of Southeastern Pennsylvania (Philadelphia) is participating with a coalition of providers and consumer groups in a Robert Wood Johnson Foundation demonstration grant to develop and improve the delivery of non-institutional long-term care services. The HSA has also received a grant from the Administration on Aging to coordinate the HSA's planning with that of the five agencies for the aging which serve the area.

—Working with local community groups the Florida Gulf HSA (St. Petersburg) has promoted the concept of share homes for the elderly as an alternative to institutionalization and has helped develop the Suncoast Gerontology Center which will serve as a resource for studying and seeking solutions to the problems of the elderly in the area.

Both HSA's and SHPDA's have continued to emphasize the appropriate distribution of long-term care beds through a variety of approaches including adding new beds, decreasing beds in areas where beds exceed the need, and conversion of beds—both conversion of other types of beds (primarily acute care) to SNF/ICF beds as well as conversion of SNF/ICF beds to other uses.

To accomplish this, agencies are developing more refined methods for estimating bed needs and more precise standards and criteria for determining how to allocate beds. For example:

—The Massachusetts SHPDA through a comprehensive process involving HSA's and provider groups has developed a set of specific standards and criteria for various types of services and beds. The SHPDA is using these standards and criteria to reallocate long-term care beds from areas of low need to areas of high need.

—Faced with a situation where it was difficult to accurately determine SNF/ICF bed needs on an HSA-wide basis because of the migration of patients across county boundaries the Philadelphia HSA has developed and implemented an innovative technique for estimating the need for and allocating beds on a small geographic area basis (i.e., service areas below the county level).

The Bureau of Health Planning, recognizing the priority placed on the development of home health services by planning agencies, has distributed to the agencies a technical assistance manual "Planning for Home Health Services" which provides basic information on the planning and development of home health care as well as references for sources of additional technical assistance.

Bureau of Health Professions

Fiscal year 1980 program efforts directed toward the development of human resources needed to provide health care to the aged are summarized below for the four program divisions of the Bureau.

DIVISION OF ASSOCIATED HEALTH PROFESSIONS

Medical and other health professions schools received 13 grants totaling approximately $1.5 million to continue projects designed to improve the knowledge, skills, and practices of health professionals in assessing nutrition status in health and disease and advising and instructing patients about diet and nutrition. The grant program impacts on all types of patients, including the aged, and emphasizes interdisciplinary team training which must include medical students and at least two other professions which typically are dietitians/nutritionists, nurse/nurse practitioners, and physician assistants.

Thirteen grants, totaling approximately $923,000, were also awarded to medical and other health professions schools to train and motivate health professions students to provide health services in a more effective manner through improvement of the affective relationships between health practitioners and patients. The program focuses on the roles of practitioners in the improvement of personal interactions, the provision of necessary and desired psychosocial support, and the motivation of behaviors that ameliorate illness and promote health. These factors are especially important in service to the aging. Programs that included hospices as a setting were given funding preferences.

Allied health special project grants which received continued support were: (1) University of Northern Colorado for training in geriatric aural rehabilitation ($35,191; prior 4 years—$265,684); (2) Quinnipiac College (Hamden, Conn.) for coordinated education leading to licensure in long-term care administration ($48,835; prior 4 years—$197,034); (3) State University of New York at Stony Brook for gerontology curriculum development to train students in the School of Allied Health Professions at both the undergraduate and graduate levels ($17,707; prior 4 years—$134,172); and (4) University of Texas for gerontology services administration program at the certificate and baccalaureate level ($19,714; prior 2 years—$111,986). Yale University was awarded $30,240 for the last year of a 3-year public health special project grant for long-term care planning, evaluation, and policy analysis. Another award ($58,789) went to George Washington University for the first of a 3-year project for a long-term care administration program.

A contract effort ($126,341) was completed with the Association of Schools and Colleges of Optometry for the development of a curriculum plan in rehabilitative optometry. The plan identified those specialized skills necessary to treat moderately severe to severe visual impairments primarily seen in the elderly.

DIVISION OF NURSING

Special emphasis was given in the Nurse Training Act of 1975 to the problems and health care of the aging. Grants and contracts were authorized for special projects to improve curricula in schools of nursing for geriatric courses and to assist in meeting the costs of developing short-term inservice training programs for nurses' aides and nursing home orderlies. The latter programs emphasized the special problems of geriatric patients and included training for monitoring the well-being, feeding and cleaning of nursing home patients, emergency procedures, drug properties and interactions, and fire safety techniques.

Under section 822 of the Public Health Service Act (PHS Act) nurse practitioner grants and contracts were authorized in fiscal year 1980 to educate nurses in the provision of primary health care to the elderly. The following active projects provide nurse practitioner training support in primary care for geriatric patients.

Applicant	Title	Fiscal year 1980 support
University of Pittsburgh, Pittsburgh, Pa	Adult, family, geriatric nurse practitioner (certificate program).	$169,242
State University of N.Y., Upstate Medical Center, Syracuse, N.Y.	Adult, family, geriatric nurse practitioner (certificate program).	180,495
University of California, Davis, Calif	An education network for nurse practitioners-family geriatric (certificate, master's option).	219,126
University of Miami, Coral Gables, Fla	Gerontological nurse practitioner (master's program)	61,483
Cornell University, New York Hospital, New York, N. Y.	Training program to prepare geriatric nurse practitioners (certificate program).	119,577
University of Wisconsin, Madison, Wis	Pediatric and geriatric nurse practitioner training (certificate master's option).	252,152
Seton Hall University, South Orange, N.J	Gerontological nurse practitioner program (master's degree).	111,232
Columbia University, New York, N.Y	Development of leadership programs in primary care (pediatric, adult, geriatric) (master's degree).	328,039
University of Lowell, Lowell, Mass	Graduate program: Gerontological nurse practitioner (master's degree).	144,846
Boston University, Boston, Mass	Nurse practitioner/clinician gerontological nursing program (master's degree).	136,026
University of Kansas, Kansas City, Mo	Primary care nurse practitioner-maternal child health, rural, adult, geriatric (certificate program).	127,256
University of Utah, Salt Lake City, Utah	Family gerontological program (master's level)	247,776
Total		2,097,250

Special project grant activities in 1980 under section 820 of the PHS Act have supported grants targeted toward curriculum revision, with a major focus on gerontological nursing, continuing and inservice education activities to upgrade and maintain competency and skills of practicing nursing personnel which include, but are not limited to, gerontological or geriatric content. A total of $1,423,753 was allocated in fiscal year 1980 to the following special project activities:

A. CURRICULUM REVISION GRANTS WITH A GERONTOLOGICAL/GERIATRICS FOCUS

Applicant	Title	Fiscal year 1980 support
Augustana College, Sioux Falls, S. Dak	Gerontological integration and practicum in nursing major	$41,500
Niagara University, Niagara, N.Y	Gerontological concepts in nursing practice	80,386
University of Tennessee, Memphis, Tenn	Primary care of the aged in the baccalaureate curriculum	70,589
University of Maryland, Baltimore, Md	Gerontology training program for nurse educators	45,891
Emory University, Atlanta, Ga	Community learning experiences to improve curricula	141,031
Carroll College, Helena, Mont	Improvement of baccalaureate nursing curriculum	50,222
University of Miami, Miami, Fla	Enhancement of a nursing curriculum to address health manpower needs.	61,371
Total		490,990

B. CONTINUING EDUCATION GRANTS WHICH INCLUDE GERONTOLOGICAL NURSING CONTENT

Applicant	Title	Fiscal year 1980 support
University of Vermont, Burlington, Vt	Continuing education program for nurses	$59,910
Old Dominion University, Norfolk, Va	Continuing education for nurses in Virginia's HSA-V	42,207
University of Rochester, Rochester, N.Y	Regional approach to continuing education	120,085
Research Foundation (Stony Brook), State University of New York, Albany, N.Y.	Continuing professional education for nurses	87,471
Arizona State University, Tempe, Ariz	Increased learning: Increasing the options	73,553
Hospital General de Castaner, Inc., Castaner, Puerto Rico.	Continuing education for nurses in rural areas	71,792
Michael J. Owens Technical College, Toledo, Ohio.	Program for continuing education for nurses	30,270
University of Pittsburgh, Pittsburgh, Pa	Regional continuing education in nursing	195,505
Total		680,793

C. INSERVICE EDUCATION WITH A GERONTOLOGICAL/GERIATRIC FOCUS TO UPGRADE SKILLS OF LICENSED PRACTICAL NURSES, NURSING ASSISTANTS, AND OTHER PARAPROFESSIONAL PERSONNEL

Applicant	Title	Fiscal year 1980 support
Westbrook College, Portland, Maine	Geriatric nurse assistant	$31,575
Donnelly College, Kansas City, Kans.	Upgrading skills of aides/orderlies in nursing homes	16,880
Miami Jewish Home and Hospital for the Aged, Miami, Fla.	Nursing special project grant	74,343
St. John's Medical Center, Tulsa, Okla.	N.E. Oklahoma continuing education project	129,172
Total		251,970

The following 20 advanced nurse training active projects under section 821 of the PHS Act provide support for the preparation of nurses in gerontological nursing at the graduate level. Some of these projects are exclusively devoted to gerontological nursing, while others, include a significant content area:

Applicant	Title	Fiscal year 1980 support
San Jose State College, San Jose, Calif.	Gerontological nurse specialist program	$100,198
University of Delaware, Newark, Del.	Advanced nursing training program	123,625
University of Kansas, Kansas City, Kans.	Training of gerontological clinical nurse specialists	58,930
University of California, San Francisco, San Francisco, Calif.	Graduate program in long-term/gerontological nursing	156,231
University of Pennsylvania, Philadelphia, Pa.	Gerontological nurse clinician	59,407
University of Kentucky, Lexington, Ky.	Outreach master's program	101,599
University of Michigan, Ann Arbor, Mich.	Ph.D. program in nursing	213,687
George Mason University, Fairfax, Va.	Master of science in nursing	107,994
Case Western Reserve University, Cleveland, Ohio	Post baccalaureate program in gerontological nursing	146,649
Montana State University, Bozeman, Mont.	Nursing specialists for underserved rural areas	89,010
Indiana University, Indianapolis, Ind.	Expansion of a doctor of nursing science program	131,003
University of Maryland, Baltimore, Md.	Doctoral education for scholarly nursing leadership	192,313
University of Wisconsin, Madison, Wis.	A program in community/gerontological nursing	74,293
Georgetown University, Washington, D.C.	Graduate nursing program	211,370
Syracuse University, Syracuse, N.Y.	Preparation for nursing of the rural aging	91,227
Murray State University, Murray, Ky.	Preparing rural clinician focus on aging and child	188,159
University of Rochester, Rochester, N.Y.	Gerontological nursing: Major and minor emphasis	85,032
University of Oregon, Portland, Oreg.	Medical-surgical nursing: A gerontological focus	177,126
Duke University, Durham, N.C.	Advanced training for leadership in nursing	177,963
State University of New York, Binghamton, Binghamton, N.Y.	Master of science clinical nurse specialist program	95,530
Total		2,581,346

The purpose of the following new research project grant under section 301 of the PHS Act is to identify components of health care provided to elderly women by nurse practitioners in primary ambulatory care settings which contribute most to patients' satisfaction and to their intent to adhere to the plan for their care. This is a 2-year project with an estimated total cost of $109,467.

Applicant, University of California, Los Angeles, Calif.; Title, Elderly Women's Evaluation of Nurse Practitioner's Care; fiscal year 1980 support, $75,271.

DIVISION OF MEDICINE

Grant and contract program support under title VI of the Public Health Service Act included geriatric activities. Under section 781(a), the University of Maryland School of Medicine received $87,000 to continue its development of an area health education center program which includes graduate and undergraduate geriatric medical training in an urban geriatric setting.

Twenty-five grants ($1,988,275) were awarded under section 788(d) to support the development, implementation, and evaluation of new geriatric course materials. Approximately half of the grants were in schools of medicine. The rest were distributed among schools of dentistry, optometry, pharmacy, public health, nursing, and allied health. The curriculum development grants are multidisciplinary, in many instances, and range in scope from a course on gerontology to a mobile health unit staffed by students.

The section 788(d) authority was also used to fund other efforts. First, the American Geriatric Society in New York received $199,081 for the final year of a 2-year contract to develop and implement a model geriatric undergraduate primary care curricula. Second, the minority-oriented primary care medical education program awarded $1 million to Morehouse Medical College where geriatrics specifically will be included in the curriculum to train primary care physicians to practice in medically underserved rural and inner-city areas.

Under section 786(a) the final year of a 2-year contract ($194,281) was awarded to the Gerontological Society of Washington, D.C., to develop a self-instructional model for the management and care of elderly patients. The New York State University Research Foundation received a 2-year contract ($126,487) under section 786(a) to develop, implement, evaluate, and disseminate a self-learning program in alcohol and alcohol abuse (one of the curriculum modules will be "Drinking and the Elderly"). Additionally, a number of training programs under this section have received funding specifically for the area of geriatrics. For example, the University of Maryland has received $21,240 to train its residents in geriatrics. The Medical Center of Beaver County, Inc. (Rochester, Pa.) pays 10 percent of the salary of the director of geriatrics training and medical director of Beaver Valley Geriatrics Center to teach courses in this area. The University of Louisville (Kentucky) received $366,769 in part to develop and implement a geriatric clinical program for its residents. Duke University Medical Center trained 39 residents in geriatrics and pharmacotherapeutics. The University of Minneapolis and the University of Colorado (Denver) were awarded $11,333 and $40,000 respectively to strengthen their curriculum activities in geriatrics.

A number of activities occurred under section 783(a) which had a direct or indirect impact on the elderly. Northeastern University developed a course on the aging process for its physician assistants (PA's). The University of Nebraska, as a part of its emphasis on geriatric education for PA's, received $1,200 to examine the psychosocial aspects of gerontological care. The Charles R. Drew Post Graduate Medical School received support for curriculum development and advanced training in geriatrics for graduate PA's and the University of Oklahoma Health Science Center received $20,700 to develop geriatric curriculum modules for its 60 trainees.

Over 30 grantees in the general internal medicine and general pediatrics residency program (section 784) have indicated the intent to provide training in the area of geriatrics.

DIVISION OF DENTISTRY

The provision of adequately trained professionals available to deliver primary dental care services to the geriatric patient is a major target area. Traditional delivery methods do not always provide access to dental care for many of these individuals both in terms of availability and cost. Training support is available through general practice residency programs which, in some instances, are in hospitals providing comprehensive dental services to the elderly, and in the capitation program which has an extramural training requirement directed at underserved population groups that include the elderly. Over 25 percent of the schools participating in the capitation program conducted remote site training activities within geriatric health care facilities.

A curriculum development grant ($65,140) was awarded to the University of Iowa School of Dentistry for education in geriatrics. Three other awards included dentistry in an interdisciplinary approach to education in geriatrics. The purpose of the grants are to facilitate efforts to instruct future health care practitioners about the health needs of the elderly in order to assist them to lead maximally productive and independent lives. Specifically, it is intended that these grants will lead to the development and implementation of new courses or segments of courses and training experiences devoted to the unique health care needs of the elderly.

HEALTH SERVICES ADMINISTRATION

I. INTRODUCTION

The Health Services Administration (HSA) is the agency within the Public Health Service (PHS) responsible for providing a comprehensive array of health care services to the medically unserved and underserved as well as statutorily defined beneficiary population groups such as American Indians and Alaska

Natives, migrants and seasonal farmworkers, and merchant seamen. The HSA administers and operates numerous health care programs which are available to older Americans as part of a broader beneficiary population. The Bureau of Community Health Services (BCHS) funds and administers over 1,200 primary health care projects and 61 grants to home health agencies. The Indian Health Service (IHS) operates 49 hospitals and over 300 clinics and field stations that provide health care to Indians living on and near reservations. The Bureau of Medical Services (BMS) operates 9 PHS hospitals and 27 freestanding clinics that provide medical services to such groups as merchant seamen and members of the Armed Forces and dependents.

It is well known that even with all the health care programs and services available to the elderly, millions of older persons often do not receive either adequate treatment for their chronic conditions or regular and comprehensive health care. This is due to a variety of factors including: A shortage of medical, nursing, and dental personnel; a generally fragmented and uncoordinated health and social services delivery system; and conflicting regulations and benefit packages.

Moreover, the health needs of older persons are diverse and wide ranging and cross traditional program approaches. For this reason, the HSA, primarily through community health centers (CHC's), migrant health centers, the National Health Service Corps (NHSC), hypertension and home health programs, as well as special health care initiatives promoted by the IHS Committee on Aging, is coordinating efforts to develop new approaches to better serve the elderly and the chronically impaired older person. As described below, interagency linkages and coordination have become a focus for such efforts.

Health Services Administration Programs

A. COMMUNITY HEALTH CENTERS

In fiscal year 1980, CHC's located primarily in medically underserved areas, provided a range of preventive, curative, and rehabilitative services to 4.2 million persons, of which 7.9 percent were 65 or older.

Formal and informal linkages have been established between some center grantees, the U.S. Department of Agriculture (USDA), and the Administration on Aging (AoA) to augment the number of social and nutritional programs available. These programs include the food stamp program, the meals-on-wheels projects, and programs in which the CHC's provide services to seniors in congregate housing and sponsor multiphasic screening clinics in senior citizen centers and recreational areas. Other linkages include transportation arrangements with long-term care institutions and individual service arrangements with nonprofit senior centers and home health agencies. Special efforts have been made to integrate home health services into a comprehensive medical care package as evidenced by the certification of several CHC's as medicare home health providers.

B. MIGRANT HEALTH

The migrant health centers program provides health care services for migrant and seasonal farmworkers and their families. Migrants live and work in predominantly rural areas where health resources are scarce. The elderly migrant, beset by increasing health problems, is placed in a vulnerable position—faced with inadequate health resources and manpower, and language and cultural barriers. In fiscal year 1980, services were provided to 581,000 migrant and seasonal farmworkers through 122 projects. Approximately 5 percent of those served were 65 or older.

The migrant health centers program authority, section 329 of the PHS Act as amended November 1978, includes language that broadens eligibility to include a significant number of elderly and disabled. With the new legislative authority, the migrant health centers program can serve "individuals who have previously been agricultural workers but can no longer because of age or disability, and members of their families within the area it serves."

C. NATIONAL HEALTH SERVICE CORPS

The NHSC was designed to improve the delivery of health services by providing health manpower to persons residing in communities designated as having a health manpower shortage. One of the factors used to determine whether an

area has such a shortage is the percentage of the area's population that is age 65 or older. The NHSC recruits and places health professionals in these areas. Since older persons residing in such areas often have reduced mobility, the presence of health personnel in their communities is of special importance. In fiscal year 1980, a total of 1,201,310 people were served by 2,058 Corps assignees. Of the number served, approximately 10 percent were age 65 or older. The Corps is closely integrated with the CHC and migrant health programs, providing assistance in recruiting health manpower for these programs. The estimated NHSC expenditure level for services for the 65 and over population in 1980 was $8,056,000.

In 1980, workshops focusing on geriatric medicine and other gerontological issues were conducted at five of the NHSC inservice conferences for NHSC assignees. Also, a series of case studies on issues in community health, to be done in 1981, will include a special case study on geriatric health care. These studies will be conducted at regional conferences or workshops at individual medical schools, and will be used to familiarize scholarship recipients with geriatric health concepts.

D. HOME HEALTH

Designed to offer medically desirable and often cost-saving alternatives to institutionalized care in hospitals and nursing homes, the home health program is specifically directed toward meeting the needs of the elderly by providing skilled nursing and therapeutic services in their homes. The program, administered by BCHS, awards two types of grants. One type is awarded to meet the initial costs of establishing and operating home health agencies in areas where such services are not otherwise available and to expand services available through existing agencies. The other grant type is awarded to train professional and paraprofessional personnel to administer and provide home health services. In awarding grants, the relative needs of States are considered. Preference is given to areas within a State in which a high percentage of the population to be served is composed of persons who are elderly, medically indigent, or both.

Prior to the establishment of the home health program in 1976, there were 788 counties in the Nation without the services of a medicare certified home health agency. As a result of the program, home health services are now available in 175 counties where such services were not available before the grant program. Home health services have been expanded so that these services are now available in 550 counties. In fiscal year 1980, a total of 61 service grants were awarded providing for the development of 15 new agencies and the expansion of 46 others. In addition, 22 training grants provided for the training of home health agency staff to enable them to upgrade the quality of patient care delivered and improve the administrative efficiency of the home health agency. As part of this effort, a curriculum and training guide was developed and distributed, which preliminary evaluation studies indicate have greatly improved the quality of care provided by home health aides. Since the inception of the program in 1976, a total of 345 home health agencies have been funded. Of those agencies, 85 were new and 260 were expanded. A total of 65 training grants has provided training for over 10,000 home health personnel. These activities have greatly increased the opportunity for homebound patients, predominantly older persons, to receive necessary adequate health care services.

E. HYPERTENSION

The hypertension program was established as a formula grant program providing funds for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension. In fiscal year 1980, the program continued to expand its focus on this condition which affects a significant proportion of the aging population. Key clinical indicators were used for assessing the effectiveness and quality of care in primary care centers. One of these requires that blood pressure measurements be done regularly on patients age 10 and over. The centers were held responsible for making sure that all patients with elevated blood pressure received followup services. Effective fiscal year 1980, the program changed from a formula grant to a project grant program. This change resulted in greater accountability, promoted uniform reporting, and insured that funds are targeted where the greatest benefit can be derived. It is estimated that screening services were provided to 7.8 million persons (among whom were a significant number of elderly).

F. THE INDIAN HEALTH SERVICE

The Indian health program provides health services to approximately 795,000 American Indians and Alaska Natives, many of whom reside on 250 reservations and Indian communities in 28 States and hundreds of villages in Alaska. It is estimated that 6 percent (48,000) of the American Indian and Alaska Native population is 65 and over. There is a preponderance of younger persons in the IHS population; the Indian and Alaska Native median age is 18.4 which is lower than the median age of 28.1 for all races in the United States. However, attention is being focused on the needs of the elderly primarily as a consequence of the 1978 Indian Conference on Health of the Elderly conducted by the National Indian Council on Aging.

Specific services and interagency linkages have been geared to serve the special health needs of the elderly. Services offered in conjunction with the AoA include congregate meals, meals-on-wheels, minor home repair, shopping assistance, transportation, health surveillance, outreach, and part-time employment. Other linkages include IHS medical and social service surveillance for nursing home and extended medical care patients, and assistance in obtaining services under medicare, medicaid, the USDA-administered food assistance program, Veterans' Administration, and other Federal and State programs.

G. PUBLIC HEALTH SERVICE HOSPITAL CARE

Health care services within the BMS, Division of Hospital and Clinics, are provided by 9 PHS hospitals (8 general medical-surgical and 1 specialty hospital for the treatment of Hansen's disease), 27 freestanding outpatient clinics, and more than 300 contract physicians and hospitals located throughout the United States. During the first 6 months of fiscal year 1980, of the 35,106 discharges from the PHS hospitals, in 9,900 instances, the patient was 60 years of age or more. Annually, it is estimated that approximately 149,100 inpatient days were utilized by this group at an estimated cost of $29,223,600, an average daily rate of $196. The average length of stay of 15.1 days for this age group is longer than the average for younger individuals. American seamen constitute a major PHS beneficiary group. There are probably more single males in this category than in the population at large. As a consequence, finding suitable nursing homes or other protective settings constitutes one of the major difficulties in discharge planning. During fiscal year 1980, it is estimated that patients 60 years of age or over made 512,500 visits to hospital emergency rooms, outpatient clinics or to freestanding clinics at a cost of $41 per visit. The total cost for outpatient care for this group, based on the above data, is estimated to be $21,012,500.

1. Hospital-Based Geriatric Day Treatment and Screening and Referral Services

The geriatric day treatment center (GDTC) has been operating on the campus of the PHS hospital, Baltimore, Md., since January 1976. It is jointly sponsored by the Family and Children's Society of Baltimore and the PHS hospital. Through a contract with the Maryland State Department of Health and Mental Hygiene, Office of the Chronically Ill and Aging, the GDTC received title XX of the Social Security Act funds. Each year the program has been in operation, title XX funds have increased. This program provides an alternative to institutionalization. Services are delivered by a multidisciplinary staff in a protective group setting. The program is structured around an organized regimen of activities of daily living and health services. Additional important program components include nutrition counseling, psychiatric consultation, and transportation. Family members are counseled and taught various techniques to increase their ability to be helpful to the program participants in the home. Program participants are persons 60 years of age and older referred from PHS beneficiary groups, the geriatric evaluation service of the Baltimore City Health Department, community organizations, and private physicians.

The GDTC program has continued to grow and expand in 1980. Building on this framework of services, the GDTC was selected to serve as a demonstration model for the HSA/AoA demonstration, to be described later.

The PHS hospital in San Francisco has operated a geriatric screening and referral service (GSRS) since 1977. This program was developed with several community groups and the San Francisco Health Department to examine persons 60 years of age and over who live in the Richmond and Sunset districts of

San Francisco. The goal is to maintain people at the highest level of functioning and self-sufficiency as possible. The staff includes a nurse practitioner and personnel from the PHS hospital and the San Francisco Health Department. Program participants receive a complete history and physical examination, laboratory workup, social work interview, and immunizations as appropriate, for example, flu vaccine. They are referred for eye and hearing examinations and for other services as needed. The scope of services also includes followup on an annual basis and more frequently if indicated. The GSRS works very closely with the San Francisco District No. 5 Community Board, which has a geriatric protective service and with the Richmond RAMS group which is a multilanguage, multicultural, yet predominantly Chinese, mental health program. The GSRS clinical sessions are held once a week and see 5 to 10 persons per clinic session. The number of patients served by the GSRS program in fiscal year 1980 was 294.

2. Hospital-Based Nutrition Programs

The PHS hospital in Boston established its nutrition program for the elderly in 1977. This program regularly services lunch to more than 75 people 60 years and over, 5 days a week. In addition to lunch and the associated socialization, nutrition information, and counseling are integral parts of the program. Further, the program has stimulated much interest in the possibility of linking these nutrition services with other services integral to the provision of primary care. Over the next year, efforts are being made to develop a wider scope of health and social services for program participants. Cost of the program during fiscal year 1980 was $63,027 for a total of 11,952 meals served.

3. Other PHS Hospital Programs for the Elderly

The San Francisco PHS Hospital has recently set up an extended care unit established to fill the need for extended care for "hard to place" patients drawn from the hospital's general medical and surgical wards, most of whom are over 60 years of age. The unit was opened during the last quarter of fiscal year 1980, and will be expanded during fiscal year 1981.

The Seattle PHS Hospital has a unique program for the rehabilitation of stroke and cardiac patients within the department of physical medicine and rehabilitation. An interdisciplinary team approach is used in patient treatment. The program is staffed by psychiatrists, physical therapists, occupational therapists, and nurses, and is affiliated with a teaching program at the University of Washington Medical School. Stroke patients are treated by the spinal cord injury team. Those over 60 years of age approximate 20 percent of all patients treated. Cardiac patients over 60 years of age approximate 60 percent of all cardiac patients treated. It is estimated that the cost of treating patients over 60 years of age in these programs during fiscal year 1980 was $50,500 for a total of 670 inpatient days and 1,020 outpatient visits. In addition to treatment programs, the Seattle PHS Hospital Occupational Therapy Department is presently conducting research on the "Development and Testing of a Scale to Measure the Activities of Daily Living of the Disabled Population." This research will have a great deal of impact on PHS programs for the population specified, many of whom are functionally disabled. The cost of the research will be absorbed by the occupational therapy department.

The Staten Island PHS Hospital has developed a "cancer support" program for patients who have the diagnosis of carcinoma. It is estimated that at least 75 percent of these patients are over 60 years of age. All patients with this diagnosis, whether inpatient or outpatient, are referred to the program coordinator. Weekly meetings are held for patient support and education. A group of individuals from the hospitals volunteer to visit patients at home, so that patients and their families may receive the support needed to remain together. The "cancer support" program will receive funds from bazaars and other functions held by the hospital to raise money for patients. It is hoped that funds received from these activities will help provide patient transportation services in the future. Staff inservice education is an ongoing component of the program. The estimated cost of the "cancer support" program for the population specified is $17,900 for a total of 5,780 inpatient days and 1,120 outpatient visits. It should be noted the actual treatment costs for these patients are counted within general medical-surgical and outpatient department costs. Thus, the figure of $17,900 reflects only the support function.

An additional program developed by the Staten Island PHS Hospital is the restorative care unit. The unit is organized to provide rehabilitation services to such patients as amputees, stroke and accident victims, and long-term post-operative orthopedic patients. It is estimated that 80 percent of the patients served by this unit in fiscal year 1980 were over 60. Patient days totaled 2,922. The unit is staffed by one physical therapist. Costs are difficult to estimate as the referring services, such as the neurology and orthopedic departments, absorb the costs for patients referred. It is important to note that this unit serves a patient population for whom most community hospitals do not provide service.

III. The Health Services Administration—Administration on Aging Demonstration Program

Recognizing the need of a growing elderly population for quality comprehensive health care combined with increasingly scarce program dollars, the HSA is concerned with integrating and coordinating services in order to create more effective and efficient health care delivery programs. A major initiative in 1979 was an HSA/AoA interagency agreement to develop program and funding linkages to increase the number and scope of health services available to older persons as well as coordinate efforts to address the social needs of the elderly.

The specific goals of the joint initiative are to be implemented on a limited demonstration basis over a period of 3 years. They are as follows:

—To increase the access of older persons to health care services in HSA-sponsored facilities within a given geographic area.

—To encourage opportunities for development of program planning, funding, and coordinating linkages between HSA-sponsored facilities and State and area agencies on aging; and

—To utilize the funding, manpower, and facilities available to area agencies on aging, HSA-sponsored facilities, and Indian tribal organizations to develop a comprehensive package of health and social services directed at the underserved and unserved elderly population within a given geographic area.

The funded demonstration projects aim to seek solutions to problems of older persons whose independence and self-sufficiency are threatened, and those whose ability to remain in their homes or to avoid institutionalization depends on family and community assistance for support. The projects also seek to resolve barriers to effective health/social care within a community setting, that is, they must seek to overcome service fragmentation and problems of community service coordination.

Eleven demonstration projects were developed (eight of these were funded during 1979 and are within their second year of funding). The demonstration projects focus on various services delivery models and approaches to increase and link health and social services to older persons in three HSA delivery settings: CHC's; PHS hospitals and clinics; and Indian tribal organizations/agencies supported by the IHS. The projects are summarized below.

A. Community Health Centers

Five CHC's are serving as model projects under the joint HSA/AoA demonstration initiative to provide information to the HSA as to how its primary care centers may better serve the elderly and the chronically impaired older person. The projects will identify the components of a program necessary to provide comprehensive services to meet the plan of care for each individual in the target population. Such components include outreach to potential recipients of services, health education and screening, nutrition education and counseling treatment (preventive, diagnostic, therapeutic), home care, and transportation. Each project must then provide such services either directly or through linkages with the area agency and community providers.

One such project is the San Ysidro Community Health Center demonstration in the South Bay area of San Diego. This project is concerned, in particular, with providing community outreach and health education services for a target population largely of Hispanic elderly who often do not use the health care services available to them as a consequence of real and perceived cultural barriers. A multidisciplinary team comprised of health educators, physicians, social workers, community health assistants, and health aides bring a full range of coordinated health and social services to the elderly in that area. Linkages have been estab-

lished with the three senior citizen centers and two nutrition centers in order to introduce and engage the elderly in the area into the service network.

The Boriken Neighborhood Health Center (BNHC) demonstration project in East Harlem, N.Y., is oriented to meeting four principal objectives. First, to meet the social and health needs of elderly, the BNHC is increasing the amount and scope of the health services offered. Second, to improve quality of care, the BNHC is developing a health team with expertise in prevention, diagnosis, and treatment of prevalent health problems/conditions among elderly. This bilingual team is composed of one physician, one nurse practitioner, three community health workers, one health educator, and a part-time social worker. Third, permanent linkages have been established between the BNHC, senior centers, and nutritional programs for the elderly to offer integrated social and health services. Fourth, formal structural linkages within existing social and health care delivery systems are being developed in East Harlem through the organization of an advisory committee with consumer and provider representation and through the involvement of the staff and clientele of participating senior centers in the planning and implementation of a comprehensive health care plan.

The Providence Ambulatory Health Care Foundation, which maintains seven CHC's in Providence and a geriatric health care clinic, is improving the health status of an elderly population living in designated census tracts by establishing linkages with other elderly serving agencies such as the Visiting Nurse Association of Providence, the Rhode Island Department of Elderly Affairs, the Providence Mental Health Center, Project Hope, and the Volunteers Intervening for Equity. Participating agencies will cooperate through establishment of reimbursement agreements, utilization of common referral forms, placement of all service information on the applicant agency's case record, and the monitoring of all care or services provided by the case manager from the applicant agency.

The Neighborhood Health Center, Inc., St. Louis, Mo., has developed a neighborhood-based case management system to provide outreach, assessment, plan of care, linkages, monitoring, advocacy and evaluation/reassessment to frail and semifrail elderly. It links and interfaces a variety of health-related services into a continuum of care network. Thus, 75 percent of the elderly in select neighborhoods can be identified and contacted. A continuum of services are being developed through the reconfirming of existing and establishment of new interagency linkages. Individualized service plans are implemented for 240 to 280 at-risk elderly neighbors. Gaps in services can be identified and solutions investigated. Finally, potential for replication of this system will be examined.

Senior Care, sponsored by the D.C. General Hospital, Washington, D.C., is coordinating efforts to improve the care of an elderly underserved population of 28,000, in the inner-city of the District of Columbia. An outreach program is being developed to increase the number of elderly in the defined service area who are receiving care in three inner-city CHC's (the Shaw Community Health Center, the Community Group Health Foundation, Inc., and the East of the River Health Association) and also to improve the quality of services the elderly receive in the general medical clinic of the D.C. General Hospital. This project relies on a nurse facilitator, a planner/administrator, three outreach workers, and an evaluation assistant. Project evaluation is performed by the Department of Community Medicine and Family Medicine of Georgetown University School of Medicine. Specific outcomes of utilization, health status, and patient satisfaction can be measured.

B. PHS HOSPITALS AND CLINICS

The BMS projects involve the funding of demonstration projects which focus on the elderly residing in the immediate geographic area served by three PHS Hospitals. The demonstration projects share the common goals of improving availability and the accessibility of services for the chronically impaired and frail adult.

The PHS Hospital in Baltimore, Md., proposes over the next 3 years to establish a geriatric health service that will provide a comprehensive set of medical-psychological services for a defined population of elderly persons. The project will develop several points of entry into the system by locating in existing community organizations, such as the Action in Maturity and the Northwest Senior Centers; develop a network of service provider points such as hospitals, CHC's and private practitioners; develop an integrated system of referrals to already

existing psychosocial services; and arrange for the transportation and tracking of elderly clients through the system. The staffing of the geriatric health unit will consist of a full-time nurse practitioner, social worker, secretary, and part-time health educator and physician.

The goal is to maintain and/or improve the functional ability of noninstitutionalized residents of Baltimore over the age of 60 through:

—Detection of disease and psychosocial problems in the elderly.

—Provision of limited primary health and social services.

—Providing a referral mechanism for appropriate medical treatment and psychosocial assistance.

—Conducting of health education programs.

This project will concentrate on meeting the health and psychological needs identified by community surveys in the Hampden-Woodberry-Remington area, the needs assessment of the area agency on aging, and those problems identified by case management at the participating senior centers. To the extent feasible, the project will try to become financially viable through third-party payments and a self-pay program for the clients. A sliding fee schedule will be instituted.

The PHS hospital in Boston, Mass., is located in the Allston-Brighton area which has a population of approximately 12,000 elderly aged 60 and over. Although social services are available for the elderly in the area, certain social needs continue to be identified, such as transportation, some housekeeping, and crime protection. Further, the supply of primary care in the area is inadequate. Between 1,000 and 2,000 elderly have reported problems with health status. Five percent of Allston-Brighton elderly are homebound. In 1978, a survey conducted by the Boston Commission on Affairs of the Elderly reported that about 17 percent or 2,000 of the population 60 years and older living in the Allston-Brighton area had no contact with a physician during that year. Further, half of the eight census tracts are identified as either a medically underserved area or a health manpower shortage area. The PHS intends to mobilize its resources in order to help alleviate problems of availability and accessibility of primary care. To carry out this purpose, the PHS will develop a primary care program aimed specifically at the elderly in Allston-Brighton. It will utilize physicians, nurse practitioners, case aides, and other specialty services in order to provide health treatment, education, nutrition counseling, health detection, and other services. In order to provide a comprehensive package of services to the elderly, the PHS will develop model linkages to the social services/health care system. The PHS will offer its services regimen at the hospital ambulatory unit, at the home site, through mobile clinics in the community, and at the PHS nutrition program currently in operation.

AoA funds have been requested jointly by the PHS hospital in Seattle, Wash., and the Central Seattle CHC, a BCHS grantee, to link primary care services with senior center activities, home health care, and chore services. Medical backup for outpatient, inpatient, and rehabilitative services is included. Participating agencies are the PHS hospital, Pike Market Community Clinic, Market Senior Center, neighborhood health centers, Seattle-King County Health Department, Visiting Nurse Service, Harborview Medical Center, Virginia Mason Hospital, Homemakers Upjohn, and Seattle-King County Division on Aging.

There will be a phased approach focusing on downtown Seattle in fiscal year 1981, developing additional projects in south Seattle in years 2 and 3. The overall goal is to create a citywide system of coordinated elderly services helping older adults remain independent active members of their communities with decreased reliance on high-cost health care. Project objectives include: The development of a well-coordinated package of health and social services emphasizing independence, self-esteem, and dignity; and the improvement of coordination between health and human service agencies serving the elderly by maximizing the use of home health services to replace short- or long-term care. To accomplish these objectives, AoA funds will support a nurse practitioner, outreach worker, social service advocate, public health nurse, health aide, and patient advocate. These individuals will provide primary geriatric health care; outreach services, including casefinding, patient education, referrals; patient advocacy for legal, housing, employment, food, and other social services; health screening; home visits; foot-care; and patient advocacy in hospital settings. Project coordination in fiscal year 1981 will be the responsibility of the Pike Market Community Clinic, a member of the central Seattle consortium.

C. INDIAN TRIBAL ORGANIZATIONS

The Yakima Indian Nation, in conjunction with the IHS and its area agency on aging, propose to supplement preventive health care, develop coordination methods for social and health services to the Indian elderly, and establish a certified inhome health program on the Yakima Indian Reservation. Professionals in the program, or through other coordinating offices, work with the client and his family to develop an individual care plan promoting a maximum level of health and activity independence. The demonstration project provides for a community health nurse, part-time licensed physical therapist, three homemakers, and three home health aides. These staff members work solely for the Indian elderly, aged 60 years and over. This grant was awarded in the amount of $84,363 for fiscal year 1980.

The geriatric health program developed by the Cherokee Nation will provide preventive health care services to Cherokee elders by the establishment of programmatic linkages with existing health care and human service agencies in the Cherokee Nation, the provision of extensive community and individual counseling, increased involvement of the Cherokee elder in community activities, and an emphasis on preventing and promptly treating illness. The staff of the geriatric health program, which consists of a director, two bilingual geriatric specialists, two elderly health aides, and one licensed practical nurse, coordinate the efforts to improve the health status of the Indian elder in the Cherokee Nation. This grant was awarded in the amount of $96,637 for fiscal year 1980.

The intent of the Navajo Nation project is to demonstrate the use of geriatric nurse specialists to increase the access of high-risk elderly to primary health related services in the Navajo Nation. The principal aims of the project are: To assist in the identification of Navajo elderly at risk of being institutionalized; to increase the access of this group to health care of all types; and assess and eventually improve existing system of referral, followup, and case coordination. Involved in this demonstration project will be the Department of the Divisions of Health Improvement Services and Social Welfare, the community health nursing program and various agencies within the Office of Direct Care Services of the Navajo area. The IHS will be involved as will be the Navajo Area Bureau of Indian Affairs Branch of Social Services. Finally, programs of the Office of Navajo Economic Opportunity, such as those funded by ACTION and title V, of the Elder Americans Act, will also play a part. It is anticipated that this grant will be awarded in the amount of $84,096 in June of 1981.

IV. Evaluation of Aging Efforts

Over the long run, collaborative efforts between the AoA and HSA will build on the demonstration projects and evaluation findings with the goal being to develop methods of linking AoA/HSA resources with other health care and social services resources so as to insure the availability and accessibility of comprehensive health care to the unserved and underserved elderly. Through the implementation of these projects the AoA and HSA aim to foster the development, testing, and adoption of models which will improve the existing system of health and social services and enhance the well-being of socially and economically deprived older persons. Each funded project should be the forerunner which other agencies and organizations can adopt or adapt to their use. Projects are expected to incorporate the best of current knowledge and practice by demonstrating more effective, more acceptable, more efficient and more economical ways of serving older persons.

An evaluation methodology is being developed by the HSA to specify the analytical methods and approaches used to measure, assess, and monitor accomplishment of program requirements which have currently been established by the HSA and AoA. These requirements have been addressed by each of the successful grantees in their applications for award. There are 13 program requirements which must be met by the CHC's and PHS hospital/clinic applicants and 11 requirements imposed upon IHS grantees.

The evaluation methodology is directed toward the question of whether the demonstration projects have, in fact, improved the health status of older persons by:

—Increasing the number of older persons served in primary health care facilities.

—Increasing the amount and/or scope of services available to older persons.
—Increasing the quality of health care delivery; and
—Coordinating existing social and health service delivery systems operated by the AoA and HSA to achieve appropriate improvements in the availability and accessibility of services.

The major hypothesis being tested involves a determination of whether the above objectives can be measured, assessed, and/or monitored through the use of HSA/AoA performance requirements. It is assumed that an evaluation methodology can be built around the performance requirements and directly related to the above objectives. Similarly, it is assumed that appropriate monitoring approaches and analytical methods can be designed to continually track and assess grantee performance over a 3-year time frame.

The magnitude of grantee achievement of performance requirements will be dependent upon an array of variables associated with their particular model and target community. Those variables (demographic, socioeconomic, linguistic) will be identified and assessed in terms of impact upon the availability and accessibility and continuity (referrals) of grantee services to the aged (i.e., target population). Both the barriers and facilitating factors relating to the use of health and social services will be identified and may be used by other agencies or organizations to improve service delivery effectiveness.

In addition, the HSA is examining the services its programs presently provide for the aged. This assessment of current policy and program activities as they relate to the aged will contribute to the development of an agencywide strategy to meet the health and health related needs of a growing "older" population who are medically underserved.

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE ON AGING

Now in its fifth full year of operation, the National Institute on Aging (NIA) is working to sharpen the distinction among aging, disability, and disease. Some of the biomedical, social, and behavioral research the NIA conducts or funds may lead to ways to moderate the costs of long-term care and contribute to the improvement of the scientific basis for the diagnosis, treatment, and prevention of diseases and disabilities that occur frequently among the Nation's 25 million older persons. The NIA also focuses on the development of knowledge to promote maintenance of health and well-being in the elderly, a topic that grows in importance as the older population increases. More than that, the Institute stimulates studies and policy considerations concerning the elderly through conferences and collaboration with a variety of Federal and private organizations. This includes preparations for the 1981 White House Conference on Aging.

The intent of the Research on Aging Act of 1974, which authorized the NIA, is not only being realized in increased research on aging at universities and other non-Federal institutions of learning, but also through the vigorous research programs of the NIA's Gerontology Research Center (GRC), renowned for the scope and solidity of its investigations. The GRC program includes the Baltimore Longitudinal Study of Aging, one of the longest and largest studies of human aging. The center is a training ground for young and established scientists and clinicians, including visitors from abroad.

Thus, the Institute's work is of increasing utility to policymakers, clinicians, health professionals' education, the research community, and the lay public.

SENILE DEMENTIA OF THE ALZHEIMER'S TYPE: AN INITIATIVE

In the past year, the NIA has continued to promote research on senile dementia of the Alzheimer's type (SDAT) and related brain disorders of old age. These devastating illnesses afflict 3 to 4 million Americans, yet little is known about how to treat them effectively. The NIA funds a number of research grants aimed at finding the cause or causes of SDAT, with the hope that this will lead to guidelines on treatment or prevention.

The NIA program on epidemiology, demography, and biometry is initiating a study designed to define the causes and usual course of dementia in the elderly with particular emphasis on SDAT. The NIA has also supplemented an ongoing community-based survey of mental illness conducted by the National Institute of Mental Health. These efforts are aimed at locating victims of SDAT and determining the prevalence of dementing illness outside of institutions.

In October 1979, the Institute played a major role in bringing together a number of family groups from around the country who are interested in encouraging family services, research, and education in the area of SDAT. A national organization, the Alzheimer's Disease and Related Disorders Association, was formed at the meeting.

In early 1980, the NIA staff completed preparation of a report on the National Institutes of Health consensus development conference on treatment possibilities for mental impairment in the elderly. This report, which was published in the "Journal of the American Medical Association," outlines suggestions for accurate diagnosis of reversible mental impairment, which may account for as much as 30 percent of serious dementing illness.

WORKSHOPS AND MEETINGS

Geriatric Medicine Academic Award

In an attempt to meet the present and future training needs of medical students and physicians in the care of the aged, in 1978 the NIA introduced a new initiative, the Geriatric Medicine Academic Award. This was part of the NIA's effort to assist in the development of a curriculum in geriatric medicine in those schools of medicine and osteopathy that do not have one, to strengthen and improve the curriculum in those schools that do have one, and to foster research and careers in the field of aging. The grant includes a requirement that awardees attend an annual meeting, the first of which was held on June 16–17, 1980, in Bethesda, Md.

This meeting provided an opportunity for the 15 grantees to meet one another and the NIA staff, to exchange information, to discuss ongoing activities and future program plans, and to consider the important issue of program evaluation. Each awardee reported on accomplishments to date, and then heard presentations by representatives of other Federal agencies having a serious interest in geriatrics.

Workshop on Dietary Restriction and DHEA

In July 1980, a 2-day workshop addressed the questions of dietary restriction and the effects of the steroid dehydroepiandrosterone (DHEA) on aging, blood lipids, and tumor formation in laboratory animals. A small group of researchers interested in various aspects of these two related fields of investigation met informally to present the results of their work.

Some studies on dietary restriction (a reduction in the total number of calories consumed daily) in laboratory rats have shown that animals given restricted diets weighed less and lived longer than rats fed *ad libitum* (given unlimited amounts of food). In addition, the restricted animals had a lower percentage of fat in total body weight and developed fewer tumors later in life than did the control rats fed *ad libitum*. One investigator has also observed a decrease in the incidence of some tumors (especially mammary) in restricted mice. A separate but related observation is the apparent antiobesity and antitumor effects of treatment with DHEA in mice. The workshop participants agreed on the need for future studies to confirm these preliminary findings.

Research Frontiers in Aging and Cancer: International Symposium for the 1980's

The possibility that aging and cancer involve similar body processes was explored at an unusual scientific meeting, held September 21–26, 1980. Supported by the NIA, the National Cancer Institute (NCI), and Bankers Life & Casualty Co., the meeting represented a government-private sector partnership to spur research in the fields of aging and cancer.

Approximately 45 well-known scientists, including five Nobel laureates and one who later received a Nobel Prize, presented the results of current research on such topics as the organization of genetic material; regulation of gene activity; viruses in aging and cancer; and aging and cancer as genetic phenomena.

The symposium concluded with formal hearings before the House Select Committee on Aging, chaired by Congressman Claude Pepper. Testimony was presented by the Directors of the NIA and the NCI; Lewis Thomas, M.D., president of the Memorial Sloan-Kettering Cancer Center and chairman of the symposium; and the chairmen of the meeting's eight scientific sessions.

This symposium was the starting point for a series of future workshops to deal with other aspects of aging and cancer research. It also provided the impetus

for a cooperative arrangement between the NIA and the NCI to include geriatric patients in appropriate studies designed to evaluate new methods of cancer treatment.

Biological Mechanisms in Aging Conference

Opportunities for research to refine or validate current theories of aging or to formulate new theories were explored at an NIA conference on Biological Mechanisms in Aging in June 1980. Some 100 leading scientists—in fields ranging from genetics and molecular biology to endocrinology and thermodynamics—attended the meeting. The focus was on seven areas of research: Mechanisms of aging and the human condition; dynamical aspects of senescence; structural pathology of DNA and the biology of aging; the influence of aging on protein synthesis; posttranslational changes (after protein synthesis) in cells and tissues; immunological aspects of aging; and neutral and endoctrine theories of aging.

The conferees not only attempted to put the latest data in context, but also to illuminate areas for future research, to identify models for aging studies, and to attract new and established scientists into aging research.

Fifth Anniversary of the NIA

In May 1980, the NIA marked the fifth anniversary of the National Advisory Council on Aging with a special meeting. A program of scientific presentations was held in addition to the normal review of grant applications by council members. Among the topics discussed were some of the findings of the Baltimore Longitudinal Study of Aging; aging in the life course in American society; and future geriatric medicine needs. The anniversary meeting was useful in gaining perspective on past achievements of the Institute, while increasing an awareness of the many areas of growth open for the future.

RESEARCH ADVANCES

Disease, Not Aging, Defeats the Mammalian Brain

The notion that serious decline in old age is the inevitable fate of the healthy mammalian brain has been challenged by GRC scientists.

Based on experiments in rats, the researchers believe that—in the absence of disease, trauma, or overwhelming stress—the aging brain does not become exhausted. Over time, the brain may lose neurons or may sustain some damage, but it has the capacity to compensate and keep going. Among the adjustments the aging brain can make is to create new cell connections to make up for lost cells, according to Stanley Rapoport, chief of the GRC Laboratory of Neurosciences.

In experiments with Fischer 3444 rats aged 12 months (young adult) and 34 months (old), GRC scientist Edythe London found no change with age when measuring regional cerebral glucose utilization, an indirect measure of cerebral function during the waking, active state. Postmortem examination under the light microscope showed no evidence of neural disease in the old rats.

By contrast, when beagle and monkey brains in old age show a decline in the same measure of cerebral function, they exhibit senile plaques (inert or dying material) and other structural abnormalities also seen in the human disease SDAT.

It is disease, not aging, that makes the difference in cerebral function as measured by regional utilization of glucose in the brains of experimental animals, says Rapoport. To describe normal cerebral function in old age, the laboratory has begun studying cerebral glucose uptake in healthy persons. After baseline values are established, the laboratory plans to study patients with SDAT and other forms of senile dementia in an effort to identify differences of potential use in diagnosis and drug treatment.

Biofeedback and Habit Retraining Can Treat Incontinence

One of the three leading reasons for admission to nursing homes is incontinence, the inability to control the excretion of waste from the human body. Aside from the health hazards and emotional difficulties related to this condition, it costs 2½ times more to care for the patient with urinary or fecal incontinence than for other long-term care patients.

Yet little is known about which patients can be trained to regain continence and how to train them. To remedy this situation, the NIA recently established a pioneer Geriatric Continence Clinic to evaluate biofeedback and habit retraining as methods for urinary and fecal control. Located on the grounds of the Baltimore City hospitals, this small, multidisciplinary research clinic may be unique in the United States. The clinic employs consulting specialists in urology, gastroenterology, and nursing; a part-time graduate student; and a guest scientist, clinical psychologist, William Whitehead, who overseas the clinic.

The clinic's training cycle takes 3 months: 1 month for baseline measurements and 2 months for training. So far, 10 outpatients aged 65 to 86 have been treated, with these results: Five have become continent, three are improved (that is, the frequency of incontinence has been reduced by at least 75 percent), and two have not benefited.

In biofeedback, the patient observes a continuously made record of abdominal and sphincter pressures as he or she tries to sense internal cues and to respond to them in a manner that changes the record appropriately. Desired responses include relaxing the bladder or contracting the anal sphincter so as to gain time to reach bathroom facilities.

Conventional habit-retraining techniques—often reserved for patients who have lost intellectual ability—either teach the individual to recognize early cues for defecation or urination, or place the patient on a voiding schedule.

If the results are sustained in a larger series of outpatients, Bernard Engel, chief of the GRC Laboratory of Behavioral Sciences, plans to expand the program to include nursing home patients whose physical and mental status may be more seriously impaired than the community-living individuals the clinic has treated so far.

The Heart: What Makes it Beat?

What makes the heart beat? By analyzing the scatter of light produced by shining a laser beam through heart muscle fiber, GRC scientists are studying the sequence of events in the excitation and contraction of the heart muscle as it beats. Understanding this process may be a steppingstone to remedies and preventives for heart failure and other cardiac diseases.

The innovative light-scatter method has shown that the heart muscle is not entirely at rest between beats. Fluctuations in the light-scatter indicate movement of calcium ions in interaction with muscle filaments.

According to Edward Lakatta, chief of the GRC's Cardiovascular Section, in many instances the light fluctuations which precede excitation of the muscle can predict the strength of the subsequent contraction. By being able to characterize basic heart action, scientists in aging can then examine changes that occur normally at various ages as well as in various disease states.

The Aging Heart: Strength Through Exercise

Direct evidence that tissue of the aging heart benefits significantly from moderate exercise has been obtained through GRC experiments in rats. These investigations also show that the tendency of the aging heart to stiffen, to take longer to contract, and to spend less time relaxed can be overcome by a relatively light exercise regimes.

In a study by Harold A. Spurgeon of the center's Cardiovascular Section, old and young rats were exercised daily for 30 minutes on a motorized wheel and were then compared to unexercised old rats and to exercised and unexercised younger rats. Muscle isolated from the exercised old rats showed a significantly shorter contraction duration than did muscle from the unexercised old rats, and was reduced to that of the younger rats.

These findings indicate that the increased stiffness and prolonged contraction duration in the old heart are not fixed, but can be modified by physical conditioning. The study has potential clinical significance by demonstrating the value of exercise in avoiding age-related impairment of heart function.

In other GRC studies, scientists have found that female subjects show the same thickening of the heart wall and slowing of ventricular filling as was previously observed in male volunteers. These findings—which were not unexpected—represent some of the first results in women since the NIA's Baltimore Longitudinal Study of Aging was expanded 3 years ago to include women as well as men.

With highly advanced techniques, 600 longitudinal participants were studied for heart flow characteristics in an attempt to find predictive measures of ischemic heart disease (caused by the constriction or obstruction of a blood vessel) as well as to portray normal changes with age in cardiac structure and function.

The techniques are: Two-dimensional echocardiography, through which an entire plane of the heart can be visualized at once during rest and during exercise; and thallium scanning, which permits left ventricular blood flow to be analyzed. Both techniques are noninvasive; that is, they require no cutting or use of indwelling tubes.

This investigation, conducted by the Johns Hopkins University under contract to the GRC, is in the third of 5 years. Investigators believe that thallium scanning of individuals during exercise may provide a useful epidemiological tool for detecting coronary heart disease. Two-dimensional echocardiography during exercise may also help to detect early disease-related changes in heart muscle function.

Saliva Flow, Taste Change Little With Time

Neither saliva flow nor keenness of taste change dramatically over the adult years in a healthy person, according to studies by GRC scientist Bruce J. Baum. Drastic change represents an effect of disease or drug, not aging.

A study of 146 healthy men and women in the Baltimore Longitudinal Study of Aging revealed that the efficiency of saliva production upon stimulation probably remains the same throughout life in healthy, nonmedicated persons. However, individuals on medication—especially postmenopausal women—did show a decrease in the flow of saliva. Baum notes that changes in the quantity or quality of saliva may set the stage for tissue deterioration in the mouth.

The belief that taste sensitivity fades dramatically with age also appears to be generally false. In a study of individuals in three age groups (20 to 39 years, 40 to 59 years, and 60 to 89 years), only 10 percent of the healthy subjects reported loss in taste, but 30 percent of those taking medications reported taste changes.

In terms of taste materials in ordinary concentrations. men show no age losses but women have a diminished perception of sweet and salt. This would tend to make women more likely to increase the amount of salty and sweet foods or flavorings they eat. With further substantiation, these findings could be useful to the elderly and their caregivers in dealing with dental decay, diabetes obesity, and hypertension.

In terms of thresholds, or lowest concentration of a tasted material to be recognized as different from water, Baum found a modest increase in saltiness and bitterness and no change in sweetness or sourness thresholds with age, irrespective of health status.

Personality Influences the Reporting of Pain

Personality appears to influence how people experience and report chest pain due to heart disease, according to an unusual study made possible by personality records gathered on individuals before they began having the pain.

Researchers at the GRC have found that individuals who are less emotionally stable have more complaints about illness than other persons. An understanding of personality styles in reporting chest pain could promote early recognition of serious heart conditions. according to the investigators, psychologists Paul Costa, Jr. and Robert McCrae and physicians Jerome Fleg and Edward Lakatta.

For example, the physician who recognizes that a patient typically does not report pain may order a precautionary electrocardiogram when that patient admits to a little bit of chest pain on exertion.

The NIA study helps to clear up confusion about the issue of whether emotional distress is a cause of the complaints or a result of illness. Personality measures were gathered on longitudinal study subjects at least 1 year before the first sign of coronary heart disease or report of angina (chest pain). These data make it possible to conclude that illness did not cause the personality differences.

Subjects who complained of angina but who lacked other evidence of heart disease were found to have the lowest scores in tests of emotional stability. They were also found to have the highest number of physical complaints before reporting their first experience of angina.

At the other extreme were subjects who never complained of angina but whose electrocardiograms indicated heart disease—they were highest in emotional stability and lowest in physical complaints. In an intermediate range of emotional stability and complaining were individuals having angina and electrocardiographic signs and individuals having neither.

Alterations in the Immune System Brought About by Dietary Restriction

Cancer is clearly recognized as one of the major diseases associated with old age. Approximately 50 percent of all cancers occur in those over 65 years old, and as more people live longer, the number of cancers in this age group will undoubtedly rise.

Evidence now points to a malfunction in the body's immune system—the defense system whereby an organism's own cells respond to and then resist disease-producing material—as a possible cause for some cancers. As part of a larger study, NIA grantees at Cornell University and the Sloan-Kettering Institute for Cancer Research in New York are examining various aspects of the immune system in older humans and animal models. As part of this work, Gabriel Fernandes has found evidence that dietary restriction markedly decreases the frequency of mammary tumors in the C3H/Bi mouse strain. When fed an unrestricted diet, the C3H/Bi mice are particularly prone to developing mammary tumors.

In addition, the mice fed restricted diets were found to have lower levels of immune complexes (a harmful combination of antibodies and antigens) in their blood. This may be a significant finding in light of other studies showing that the level of circulating immune complexes in the blood normally increases with age. Although the mechanisms are not yet clear, scientists believe that manipulation of the diet, at least in animals, plays a role in the regulation of the immune system.

Pain-Relieving Effects of Morphine Last Longer in the Elderly

Narcotic analgesic drugs—such as morphine, meperidine, and methadone—have great value in controlling pain, especially in patients with advanced stages of cancer. In elderly patients, the reduction of pain lasts longer, according to Robert F. Kaiko and his associates at the Sloan-Kettering Institute for Cancer Research. They are studying the pharamacokinetics (absorption, distribution, and elimination) of such analgesics in large groups of cancer patients of various ages. As part of this study, the researchers have carried out a well-controlled, double-blind experiment to determine the degree and length of pain relief experienced by nearly 1,000 cancer patients after morphine was given postoperatively.

The initial degree of pain intensity was similar in all age groups. When patients reported their pain as being moderate or severe, morphine was given intramuscularly. Patients were then asked to rate their relief from pain using a five-level scale (no relief, slight, moderate, nearly complete, or complete), and to indicate the duration of pain relief. At both dose levels, patients in the 70- to 89-year-old group experienced pain relief for a considerably longer period compared to other age groups. Kaiko later confirmed these results in a second population of over 1,000 cancer patients suffering from chronic pain.

Studies were also carried out to determine age-related differences in the distribution of morphine in postoperative cancer patients. Blood samples were taken from 82 patients at various intervals after the intramuscular injection of morphine, and radioimmunoassay techniques were used to determine morphine equivalents in the plasma. In patients 70 years of age or older, the highest level of morphine in the blood occurred at 48 minutes, compared to 25 minutes in younger patients. Systemic clearance studies also showed that older patients eliminated morphine from their bodies more slowly than did younger patients.

These results add further support to the growing body of evidence that, in the elderly, drugs are often cleared from the system more slowly and may therefore have longer lasting effects.

Effects of Estrogen on Incidence of Bone Fractures

Older women have a higher likelihood of suffering from fractures of the hip, forearm, and vertebrae than do younger women or men. It is generally agreed that osteoporosis, a decrease in bone density seen most frequently in older

women, is the predisposing factor for this increased risk of fracture. Although the causes of osteoporosis are not entirely clear, one important factor in women is the reduced estrogen production that occurs after menopause.

In recent years, studies have shown that loss of bone density is slower in women using estrogen supplements after menopause than in women not receiving estrogens. However, it had not been established that taking estrogens will significantly reduce the risk of fractures. In an attempt to shed more light on the subject, Noel Weiss and others at the Fred Hutchinson Cancer Research Center in Seattle, Wash., have been conducting extensive surveys of postmenopausal women in the Seattle area to determine if estrogen supplementation actually decreases the risk of fracture.

Interviews were conducted with 327 women who had suffered a hip or lower forearm fracture when they were between the ages of 50 and 74. These women were asked health-related questions to determine their body's production of estrogens and their use of estrogen-containing supplements prior to the date of the fracture. The data from this survey were compared to data obtained from a random survey of 567 female control subjects, also between the ages of 50 and 74.

The results of the survey showed that women who had used estrogen preparations for 6 years or more had a 50- to 60-percent lower risk of fracture than women who had not used estrogens. However, women who had been taking estrogens for less than 6 years or who had discontinued the drugs had less benefits from the hormone treatments.

Estrogen therapy has previously been shown to increase the risk of developing cancer of the uterus. Therefore, although it now seems clearer that estrogen therapy may be one possible means of reducing the risk of fracture in postmenopausal women, this beneficial effect must be weighed against the potential risks of developing uterine cancer.

The Role of Beta Cells in Sugar Metabolism

Diabetes, a condition characterized by elevated levels of sugar in the blood, is associated with a higher incidence of heart and circulatory disease, blindness, and other disabilities. Increased blood sugar levels occur much more frequently in the elderly than in the young, although many older people may never show any of the other symptoms typical of diabetes. It is important to understand whether an elevated blood sugar level is a normal part of aging or indicates the presence of a disease which should be treated.

In most individuals, when the blood sugar level rises after a meal, the beta cells (located in microscopic structures in the pancreas called islets of Langerhans) secrete the hormone insulin, which in turn causes the tissues to take up more glucose (sugar). As a result, the concentration of sugar in the blood returns to its normal level.

The NIA is supporting a study of Eve Reaven at the Veterans' Administration Medical Center in Palo Alto which is aimed at obtaining a better understanding of the role played by beta cells in the changes in glucose metabolism seen with advancing age. She has found that islets of Langerhans isolated from 12-month-old and 18-month-old rats (whose average lifespan is 24 months) secrete less insulin in response to glucose than do islets from 2-month-old rats. However, the islet insulin content increases with advancing age as the number of beta cells and the size of the islets grow. These studies (as well as other investigations at the GRC) demonstrate that the decrease in insulin secretion occurs even though increased insulin stores are present in the older cells. Further studies are needed to define the mechanisms involved in this age-related decrease in beta cell responsiveness, and to determine whether this alteration in glucose metabolism is a normal compensation for some other age-related change or is a basic change itself.

Error Theory of Aging Examined

Scientists have proposed an "error theory" of aging, suggesting that errors in the synthesis of proteins (which combine to form enzymes) result in abnormal biological activity. This theory appears to be incorrect, according to NIA grantee Morton Rothstein, who is investigating age-related changes in the enzymes of rat tissue and nematodes (roundworms used as a model system for aging research). Rothstein and his colleagues at the State University of New York at Buffalo studied enzymes from young and old animals. Some

enzymes become denatured, or inactive, as an animal ages. This may be due to changes in the enzyme's conformation (the shape it takes after folding, a process that occurs after the enzyme is completely formed).

By unfolding and then refolding the enzymes, Rothstein was able to show that enzymes from old animals retained their basic structure but that changes occurring in their conformation, not errors in protein synthesis, resulted in altered function. This has led him to speculate that the slowdown with age in the turnover of proteins allows enzymes to remain in the cell for a long time, which may result in enzyme conformation changes. This hypothesis suggests that alterations in regulatory processes may be involved in aging.

The Elderly Can Overcome Memory/Intelligence Decline

What happens to our ability to remember as we age? While it is obvious that totally losing recall of an event may signal a physical or emotional disorder, is it true that we might expect to forget some of the details of past events? Or can we expect to remember as much and as well as we have throughout life?

Researchers are beginning to understand more about memory than ever before, in part because of the relatively new way of studying memory as part of an information-processing model. Simply put, information is received and converted by the senses and then held briefly in a sensory storage, from which it is retrieved by the attention process before being lost or overlaid by other incoming information. The information is then passed on to short-term memory from which it will be transferred to a relatively permanent long-term storage. This model for the study of memory is particularly interesting to researchers in the field of aging. Not only does it provide a means of pinpointing at which stage memory may be failing, it also suggests the possibility of intervening in the process should a defect be discovered.

If there is a tendency toward increased forgetfulness with age, it may simply be a matter of failing concentration. In one aspect of his study supported by the NIT, John Horn of the University of Denver measured concentration by asking volunteers to trace a set of lines as slowly as possible while keeping their pencils moving at all times. He found that a person's capacity and/or willingness to concentrate in doing such a simple task declines with age—and may be responsible, at least in part, for what is reflected as short-term memory loss and decreased speed.

Fear of increasing forgetfulness in old age is often coupled with fear of decreasing intelligence. Horn and his associate Raymond Cattell were the first to provide a model for the study of intelligence and aging, and the first to make sense of the contradiction between the accumulation of wisdom and experience with age and the intellectual decline that may occur in some older people. Their theory suggested two kinds of intelligence: Fluid intelligence (which is thought to be related to an easily compromised function of the body's nervous system) and crystallized intelligence (a learned intelligence dependent upon education and experience). Based on NIA-supported research by K. Warner Schaie, it is generally accepted that crystallized intelligence continues to increase throughout the "vital years" of adulthood, while fluid intelligence declines in some but not all older people.

A number of theories have been advanced to explain the apparent decline in fluid intelligence with age, including decreased speed, concentration, and a failing ability to register and retrieve information on a short-term basis. Regardless of the cause, NIA-supported research is beginning to indicate that despite numerous age-related deficits, many older persons compensate, or can learn to compensate in various ways.

Horn and his colleagues find that if an older person is sufficiently motivated, he or she will show greater persistence as a compensation for decreased speed by taking the time to study a problem before abandoning it. Older persons in this study are also generally more careful than their younger counterparts, and give fewer wrong answers to problems.

In related research, NIA grantees Paul Baltes and Sherry Willis at Pennsylvania State University find that it is possible to train people to overcome decreases in fluid intelligence. Working with subjects aged 60 to 80, the research staff coach volunteers and encourage them to practice problem-solving skills designed to improve their performance on selected intelligence tests. As a result, subjects perform better on these tests, maintain the ability to perform better,

and are able to transfer their training to other intelligence tasks. Thus, even though it is thought that the decrease in fluid intelligence with age is primarily a result of physiological mechanisms, it may still be possible to stop or at least slow that decrease with special training.

The NIA Explores Role of Brain Chemistry/Metals in Senile Dementia of the Alzheimer's Type

Over the past several years, investigators from a variety of disciplines have been involved in an intensive search to uncover the cause or causes of SDAT, which produces memory loss and confusion in adult life. To date, consistent—and many feel, highly promising—findings have been related to brain chemistry, specifically, the cholingeric system (a system in the brain that releases the neurotransmitter choline).

In 1976, Peter Davies and his associates reported a significant decrease in the activity of the enzyme choline acetyltransferase (ChAT) in the brain tisssue of Alzheimer patients at autopsy. With support from the NIA, Davies and his colleagues at the Albert Einstein College of Medicine have now confirmed and expanded upon these earlier findings. The most exciting results show a correlation between this change in neurochemical activity and changes in both cognition (such as memory loss and disorientation) and in brain pathology (particularly the number of plaques characteristic of SDAT seen at autopsy).

In other studies, Davies is looking at ChAT levels in the brains of persons who were considered healthy. Here he finds that many persons aged 65 to 90 have low levels of ChAT and show signs of dementia before death, but not all show the characteristic pathology (abnormal physical changes) in the brain at autopsy. By age 90, however, low levels of ChAT without physical manifestations are uncommon. This leads him to speculate that the dropoff of ChAT precedes the development of any pathological lesions like those in SDAT.

If it is true that the cholinergic system is implicated in the development of SDAT, then we are closer to the possibility of treatment than ever before. In this regard, many experts have compared SDAT to Parkinson's disease, in which a deficient chemical process is involved and the patient's symptoms can be treated by employing restorative drugs. Unfortunately, early attempts to manipulate the neurotransmitters that may be involved in SDAT have been somewhat disappointing. Much remains to be done before we can hope to treat the symptoms of SDAT with consistent success.

While some researchers have been exploring neurochemical changes in SDAT, others have been looking at the role of trace metals in the development of neurofibrillary tangles—jumbles of filaments which appear in large quantities in the outer layer of the brain as a classic feature of SDAT.

As early as 1965, investigators working with experimental animal models induced the development of neurofibrillary tangles by injecting aluminum salts. These studies stimulated Canadian researchers who, in 1973, reported an increase of 10 to 30 times the normal concentration of aluminum in the brains of individuals who had died having SDAT. Still, there has been a great deal of controversy involving the possible role of aluminum in the development of the disease.

Now, NIA-supported researcher Daniel Perl and his colleagues at the University of Vermont and the National Institute of Environmental Health Sciences have not only confirmed the findings of earlier studies, they have also devised a means to pinpoint the site of aluminum concentrations in the brain's hippocampus. Using a new, extremely sensitive method to identify and analyze the makeup of biological tissues in SDAT, they found that 90 percent of brain nerve cells with neurofibrillary tangles had aluminum in the nuclear region of the cells, while adjacent, nontangled nerve cells were virtually free of detectable amounts of the metal.

Still yet to be determined are: The role of normal levels of aluminum in the brain; how aluminum gains access to the brain; why some people may be more susceptible to aluminum uptake; and, most importantly, any cause-and-effect relationship among aluminum, neurofibrillary tangles, and SDAT.

At the present time, however, there is no evidence that consumption of food which has been cooked or stored in aluminum results in this abnormally high level of trace metal in the brain. After all, aluminum is found in all kinds of soil and therefore in airborne dust, to which everyone is exposed.

Biological Rhythms Tied to Some Sleep Problems

Biological rhythms may cause or complicate some serious sleep/wake disorders. Biological rhythms may also be responsible for deleterious, but easily correctable, changes in sleep patterns.

At Montefiore Hospital's Laboratory of Chronophysiology in New York, Elliot Weitzman allows research subjects to "free run," or establish their own schedules of waking and sleeping in a unique setting where subjects are totally isolated from any temporal clues. Weitzman finds that the subjects—some of whom are healthy elderly individuals—typically develop a schedule that more nearly approximates a 25- than a 24-hour day. Over the course of 1 month in temporal isolation, subjects slowly "phase delay"—they go to bed later and wake later each day. It is possible that this same phenomenon may occur in aged individuals in the community who are isolated from normal social cues, such as the older person who has sensory loss, or one who has retired after years of getting up at a certain hour and no longer faces the same demands.

More commonly, however, the older person tends to go to sleep earlier and wake up earlier with less sustained sleep during the night. There is a growing suspicion that these changes in sleep patterns may be caused by an age-related change in biological rhythms.

Weitzman's findings also have important implications for older persons subjected to schedules in chronic care institutions, where the times of lights on, lights out, medication administration, and meals are often dictated by operational rather than patient needs. Understanding the role of biological rhythms may make it possible to treat some of the more disturbing sleep disorders, particularly those involving phase-shift abnormalities, without depending on drug therapies.

Still, Weitzman and his colleagues do not claim that most of the problems the elderly face in their sleep/wake schedules can be explained by biological rhythms. In addition to regular fluctuations in biological rhythms, there are a number of disorders—insomnias, hypersomnias, sleep apnea, and neurological or psychiatric disorders—which cause sleep problems. Many of these become more prevalent with age.

At the 16 accredited centers within the Association of Sleep Disorder Centers (ASDC), special techniques and tools are making possible more accurate diagnosis of the range of complaints and syndromes which interfere with a good night's sleep and daytime alertness. The sleep centers also present alternatives to drugs as a cure for sleep disorders. This is especially significant for elderly patients, among whom hypnotic drug use is extensive, often with harmful results.

The sleep centers also serve as major sites for research on normal sleep/wake patterns. Although the clinical implications are not yet clear, one of the most exciting findings at Montefiore is that a person's total sleep time correlates with cyclic body temperatures but not with prior wakefulness. Under free-running conditions, a person who goes to sleep when his or her temperature is high will sleep longer.

Once the norms for biological rhythms and physiological functions are established, it may be possible to take a closer look at sleep disorders and age-related changes in sleep/wake patterns which take their toll on the routine daily activities of millions of adults.

Unsuspected Visual Handicap Among the Elderly Reported

Using the familiar eye chart to test older people's vision may significantly underestimate their eye problems. The eye chart is one of the fundamental instruments used by ophthalmologists and optometrists. It measures vision in terms of the smallest letter which can be read. and provides the practitioner with a basis for prescribing corrective lenses or therapy. Yet with the exception of reading, most daily activities depend upon a person's ability to see large- or intermediate-sized objects rather than small ones.

In a study at Northwestern University, NIA grantee Robert Sekuler compared groups of healthy young and old adults judged to have normal or near-normal vision. He found that the greatest performance differences were in the ability of the older subjects to see large objects and to detect moving targets. Such deficits might make it difficult to distinguish a figure from its background or to recognize a familiar face; it might even affect an older person's balance and coordination.

At the same time, Sekuler notes that the amount of contrast may help or hinder an older person's ability to discern objects. The eye chart test is generally done under optimal conditions of high contrast, while many routine activities are performed under low-contrast conditions (driving in fog or rain, for example). Since low-contrast conditions call upon an individual's ability to detect an object's gross features rather than small detail, this might place certain older persons at a disadvantage.

Although Sekuler and his colleagues speculate that the visual impairment they have observed may be a result of the normal aging process, they insist that their findings should not be used arbitrarily to define the capabilities—or limitations—of older people. With improved detection of any problems that occur, it may one day be possible to correct or prevent those problems.

Epidemiological Aspects of Aging Examined

The NIA has continued to strengthen its knowledge on the epidemiology, demography, and biometry of aging by adding funds to existing studies conducted by other agencies and organizations, as well as by conducting its own research.

The Institute has recently awarded contracts and reached important agreements on protocols for three major epidemiological studies on normal aging being conducted by investigators from Harvard University, Yale University, and the University of Iowa. Eleven thousand older people living in three communities are being interviewed to learn about basic processes of aging and the effect of social support systems on how they grow old.

Another study on mortality by birth cohort (people grouped by birth date; in this case, in 5-year periods) has shown that heart disease death rates for females have been dropping since at least 1940. The male heart disease mortality rate began to show a pronounced downturn in the period between 1960 and 1965, but male death rates remain higher than those of women.

A special arrangement between the NIA, the Census Bureau, and the National Center for Health Statistics is providing a more detailed age breakdown on the Census and other national surveys. Previously, all respondents aged 65 and over were grouped together. Now, data are being gathered by 5-year groups (65 to 69, 70 to 74, 75 to 79, etc.) to obtain more precise information about the elderly.

FUNDS FOR PROGRAMS ON AGING

[In thousands of dollars]

	1978	1979	1980	1981 estimate
Public Health Service:				
National Institutes of Health:				
National Institute on Aging	$35,057	$56,472	$69,725	$76,091

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASES

The programs of the National Institute of Arthritis, Metabolism, and Digestive Diseases encompass a wide range of common and important chronic diseases, affecting millions of Americans of all ages. Of particular significance to persons over age 65 are NIAMDD's research activities involving arthritis, particularly osteoarthritis and osteoporosis; maturity-onset diabetes; benign prostatic hyperplasia, and nutrition as well as education and community demonstrations primarily associated with the Institute's Multipurpose Arthritis Centers and Diabetes Research and Training Centers.

Because research activities which specifically address the aging problem are assigned to the National Institute on Aging, NIAMDD has few projects in this category. They are:

Project No.	Project title	Fiscal year 1980 amount
5 R01 AM 20978-03	Aging and insulin effects on cyclic amp metabolism	$57,776
5 R01 AM 13710-11	Metabolism of testosterone (androgens) in man	49,717
5 R01 AM 21190-02	Lifestyles and bone densities of the aged	122,029
1 R01 AM 28176-01	Age and liver adrenergic receptor systems	76,157
	Total	305,679

As the U.S. population ages, the number of people at risk for the chronic, disabling diseases studied with NIAMDD support is expected to increase sharply. NIAMDD is committed to fostering fundamental and clinical research toward improving the Nation's means of coping with these diseases.

NATIONAL CANCER INSTITUTE

While the primary focus of research supported through the National Cancer Institute does not deal specifically with aging or the elderly, this area is an integral part of the study of cancer. It is thought, for instance, that the aging and carcinogenic processes may be directly related. Cancer, moreover, can occur at any age, but some cancers seem to strike particularly heavily at certain age groups. The study of certain cancers, therefore, may result in particular interest in the over-65 age group.

Investigation of the relationship between aging and cancer, as well as the study of cancers of the elderly is, like all biomedical research, a slow and painstaking process and does not change dramatically from year to year.

National Organ Site Program

The National Organ Site Programs Branch consists of grant supported national projects of targeted cancer research, each project oriented toward cancer at a specific organ site. Currently there are national organ site projects concerned with cancers of the urinary bladder, large bowel, pancreas, and prostate. Although the population affected by cancers at these organ sites is broadly based in terms of age, bladder and prostatic cancer tend to be heavily associated with, but not limited to, the over 65 age group.

Data from the SEER program of the Epidemiology Branch, NCI, indicate that the median ages of men and women at the time of initial diagnosis of bladder cancer are 69 and 72 years, respectively. There are 24,100 new cases of bladder cancer in men and 9,300 new cases in women each year. The median survival after diagnosis is about 4 years. Research on bladder cancer is being carried out under the aegis of the national bladder cancer project (NBCP), one of the NCI organ site programs. Because bladder cancer is a chronic disease which extends over a long portion of a patient's life, as long as 15 years, it is important that basic and clinical research take into account the prolonged natural history of the disease.

A close and effective relationship between basic and clinical research workers is being fostered by the NBCP. An example of this cooperation, and of the beneficial result which it can produce, is the development and use of the drug *cis*-platinum in the treatment of advanced and metastatic bladder cancer. This compound was first tested for its efficacy in bladder cancer in an experimental animal test system developed through the NBCP. Persuaded by its effectiveness in this experimental system, the compound was tested through clinical trials, where it was shown to be effective in patients. The next step was more extensive clinical trials, and these are now being conducted by a collaborating group, Clinical Collaborative Group A (CCGA), of several institutions across the country, all working through the national bladder cancer project.

The organization of CCGA is based upon the concept that bladder cancer is a relatively slow progressive disease and that increased understanding of the progression for various subgroups of patients under treatment will contribute to improved therapy through improved diagnosis and the classification of patients. Consequently, a basic protocol of this group is a study of the natural history of bladder cancer in all patients admitted by the participating physicians.

A multidisciplinary research program has been developed by the NBCP to encourage collaboration and effective exchange of information between clinical and laboratory scientists engaged in studies related to bladder cancer. Studies are supported which seek: (1) To identify carcinogenic factors and develop methods for minimizing their effects; (2) to identify new high risk human populations; (3) to increase understanding of bladder carcinogenesis and find methods for interferring with this process; (4) to increase knowledge of the pathogenesis of bladder tumors and develop means for interrupting this sequence of events; (5) to develop improved methods of detection and diagnosis and to find better means for matching diagnosed patients with the most effective and specific treatment regimens; and (6) to identify better means for improving the quality of life as the post-treatment interval is extended.

Information derived from studies on bladder cancer carcinogensis is providing a basis for promising new approaches which are being pursued. The demonstration that carcinogenesis of the urinary bladder is a multistep process, opens many potentially important areas of research which in the future may provide information on which the prevention of bladder cancer can be based. Worthy research objectives relate to the development of a rapid test for bladder carcinogenesis based on markers of preneoplastic lesions, further improvements in methods for identifying known bladder carcinogens and their metabolites in urine, and further development of methods of testing in the urine or other body fluids for metabolites which have been related to bladder carcinogenesis.

The new information from laboratory studies as to the carcinogens involved in the etiology of bladder cancer has increased the need for epidemiologic studies on various population groups. In many instances, relating epidemiologic results to laboratory results increases the understanding of each. In the rapidly developing area of bladder carcinogenesis, the formats of some of the epidemiology studies include several case-control studies in which populations having high incidence of bladder cancer are compared with populations having low incidence of this disease.

It is important to determine the role of seeding from primary tumors in the reestablishment of superficial carcinoma away from the site of the primary tumor. The role of cytology in the proper management of spreading superficial carcinoma of the bladder is so essential that continued efforts are being made to develop automated procedures for the identification of populations of cancer cells shed in the urine. Attempts to isolate a tumor-associated antigen from cancer cells shed in the urine of bladder cancer patients has been encouraging. This would be a useful indicator of cancer, and support of this area is continuing.

At present, transurethral resection is suitable for removing small to moderate-sized, localized, superficial cancer lesions. When superficial lesions are numerous or large, this form of surgery is inadequate and cystectomy is carried out. There is a need to develop an intravesical or systemic treatment less destructive than cystectomy. Results to date with the drug thioTEPA injected into the bladder are encouraging, and other chemotherapeutic agents such as mitomycin are available and are being tried.

Carcinoma of the prostate is the second most common site of cancer in men, accounting for 17 percent of malignant tumors occurring in U.S. males. The prostate cancer-related death rate (15 deaths annually for every 100,000 U.S. males) has not changed significantly over the past 30 years. In 1979 an estimated 64,008 new cases of prostatic cancer were diagnosed and over 21,000 deaths of American men are expected from this disease. In spite of these figures, prostate cancer has been the subject of only limited clinical and laboratory research through the early 1970's. In response to the need for a comprehensive and coordinated research effort, the national prostatic cancer project (NPCP) was activated in 1973, with headquarters at Roswell Park Memorial Institute, in accordance with the objectives of the national organ site program. The project has developed a research program that encompasses the areas of etiology and prevention, detection and diagnosis, and treatment of prostatic cancer. The pursuit of targeted research through investigator-initiated efforts has resulted in application of a broad spectrum of experimental research disciplines to prostate cancer, as well as the development and evaluation of single and combination therapy modalities for local, regional, and metastatic disease.

The focal point toward which the efforts of the national prostatic cancer project are directed is the prevention and improved treatment of prostatic cancer. This objective is complemented by immediate project endeavors aimed at decreasing morbidity and increasing survival time of prostate cancer victims.

The widespread use of endocrine therapy for prostatic carcinoma dates back to its first introduction in the early 1940's and continues to result in objective and subjective responses in the majority of patients. However, since hormonal therapy was unable to cure metastatic disease, the desirability of studying drugs which may affect this type of cancer was recognized and led to the July 1973 initiation of the cooperative clinical trials program of the national prostatic cancer project. This was the first national clinical cooperative program on chemotherapy of prostate cancer with criteria of patient randomization and clinical response tailored to the biological characteristics, metastatic behavior, and age of patients with this disease. Beginning with randomized studies of the effects of single chemotherapeutic agents on patients who fail to respond or no longer respond to con-

ventional treatment, the program has expanded to include clinical trials using both single agents and combinations of agents aimed at patients with metastatic disease who are stable after previous treatment or who are previously untreated. Trials have also been initiated to determine the efficacy of chemotherapy as adjuvants to surgery or definitive radiotherapy in patients with earlier stages of the disease. Finally, the national prostatic cancer project supports efforts in the treatment category that are directed toward the synthesis of compounds with specific prostate cytotoxicity. Agents with potential activity are screened in animal, cell, and organ culture test systems, which are useful in selection of those chemotherapeutic agents for use in phase I and II trials.

In the detection and diagnosis category, a major effort continues to be directed at developing and testing specific and sensitive immunochemical assays for prostatic acid phosphatase as diagnostic tools. Identification and development of other potentially useful biological markers are being tested. This work is supported by tissue and serum repositories which provide investigators ready access to cell cultures, tissue samples, and sera samples from men with normal, benign hypertrophic, and carcinomatous prostates.

The search for factors associated with prostate cancer and a better understanding of the nature and history of the disease continues. Ongoing and new projects in the etiology and prevention category are directed at further characterization of established animal tumor models and development of new animal models. Complementing these model systems are organ and cell culture studies of human prostate tissue. The relating of prostatic carcinoma specific antigens to immune mechanisms continues. To date, virologic studies of prostate cancer have shown that viral particles do not play a significant oncogenic role in human prostate cancer. Models of prostate cancer are being studied extensively for risk factors associated with the development of the disease, and epidemiologic studies are probing the relation of genealogic, dietary, occupational, socioeconomic, sexual, and medical factors to human prostate cancer.

Division of Cancer Biology and Diagnosis

Our research has been concerned primarily with studies of abnormal, accelerated aging phenomena in humans who have diseases characterized by inherited defects in mechanisms which repair damaged DNA. Since DNA is the important chemical of human chromosomes which directs the metabolism of the cells, it is crucially important that it be maintained in an undamaged condition. The principal organs we have been interested in are the skin and the central nervous system. One feature of sun-exposed aged skin in the elderly is the development of skin cancers. From our studies of the disease xeroderma pigmentosum (XP) we have learned a great deal about the role of DNA repair processes in the development of sunlight-induced skin cancers. We have also learned from studies of XP that DNA repair processes protect all normal human beings from premature death of nerve cells. These studies are shedding light on possible pathogenic mechanisms responsible for the premature death of neurons in certain degenerative disorders of the nervous system, e.g., Huntington's disease. It is possible that information gained from studies of these degenerative diseases of the nervous system may elucidate mechanisms involved in normal, as well as abnormal, aging of the human brain.

There follows below an introduction to these topics from relevant publications: (Robbins, J. H. and Moshell, A. N., Journal of Investigative Dermatology volume 73, pages 102–107, 1979) (references have been deleted):

"Xeroderma pigmentosum (XP) is an autosomal recessive disease in which patients exposed to small amounts of sunlight rapidly manifest skin changes resembling the chronic solar damage that occurs in normal persons who have received excessive sun exposure over many years. Such cutaneous damage comprises degenerative changes including atrophy of the epidermis; 'solar degeneration' of the dermis; and development of pigmentation abnormalities, telangiectases, actinic keratoses, and cutaneous malignancies. The primary pathogenetic abnormalities in XP are inherited defects in DNA repair mechanisms. Even though individuals without XP do not have such inherited defects, it seems highly probable that at least some of the chronic solar damage to their skin develops through physicochemical pathways similar to, if not identical with, those producing the damage in the skin of XP patients. Thus information obtained from studies on XP patients and their cells may elucidate mechanisms resulting in solar damage in normal persons.

"One aspect of the definition of 'aging' expounded by Montagna and Parakkal is especially pertinent to the premature development of chronic solar damage in XP patients. ' "Aging" may mean either growing old or maturation. Since (in the former context) the word usually connotes loss of function, so-called age changes often apply to degenerative alterations rather than to those that are an integral part of the normal development of tissues. In this discussion, age changes encompass all of these, from embryonic life through senescence.' In light of this definition, the premature solar skin degeneration in XP patients can properly be referred to as an abnormal aging of the skin. Similarly, the premature death of neurons that results in the neurological abnormalities present in certain XP patients is also properly considered an abnormal aging process. The abnormal aging of XP skin and of the XP central nervous system is the result of inherited defects in the patients' DNA repair processes. However, since XP patients differ relevantly from other human beings only by virtue of their homozygosity for certain mutations in genes controlling DNA repair processes, we can conclude that certain levels of the functional capacity of these gene loci are required for the prevention in all normal human beings of the premature aging that occurs in XP patients."

Field Studies and Statistics Program

The field studies and statistics program supports epidemiologic research designated to generate and test ideas concerning the origins of cancer by studying environmental and genetic factors that contribute to the occurrence of the disease. Studies attempt to identify groups of persons at high risk of cancer and test hypotheses that relate to specific risk factors. Data are collected and analyzed on cancer incidence by geographic location, race, age, economic status, and occupation. These studies are not primarily geared toward aging; however, they have shown that the incidence of cancer rises sharply with age. Analysis is made of age curves for the various cancer sites to provide precise information on how the risk of cancer varies with advancing age. The surveillance, epidemiology and end results program (SEER), covering approximately 10 percent of the U.S. population, has produced data that shows more than one-half of the cancers occur among persons 65 years of age and older. A monograph on cancer incidence and mortality in the United States from 1973 to 1977 will be produced in fiscal year 1981. This monograph will contain detail on specific cancers by geographic location, sex, race, and age. In addition, a number of publications on cancer of specific sites will be published covering the above variables as well as data on the problems of survival among those diagnosed as having cancer.

Through case-control and cohort studies we are attempting to determine what age groups are especially vulnerable to carcinogenic hazards, including chemical agents and ionizing radiation and gain a better understanding of the mechanism involved in carcinogenesis and how the aging process may increase the risk of cancer to those exposed to known carcinogens.

Several studies are being conducted to evaluate the relationship between menopausal estrogens and various cancers. There is conclusive evidence that the incidence of endometrial cancer is greater among women between the ages of 55 and 70 who have taken post-menopausal estrogens, and suggestive evidence that the risk of breast cancer is also increased in this group.

To clarify the mechanisms responsible for the link between cancer and aging, the Branch undertakes studies of population groups with conspicuous defects that may be more subtly associated with the aging process. For example, immune defects are seen with advancing age, and groups with pronounced immunodeficiency (e.g., genetic syndromes, kidney transplants) are prone to some neoplasms, notably lymphoma, but not all cancer across-the-board as might be expected on the basis of the immunosurveillance theory of cancer.

Cancer Control

Within the context of the cancer control mission of the National Cancer Institute (NCI), the Division of Resources, Centers, and Community Activities (DRCCA) is proceeding with an initiative begun in 1979 which focuses on the impact of old age on cancer patient management. The effort has been broadened to include early detection and diagnostic issues as well. NCI wishes to determine whether there are special problems related to prevention or treatment of cancer in the older population.

DRCCA plans to convene a group of knowledgable experts from the fields of cancer prevention, cancer treatment, geriatrics and related professions and disciplines to determine whether there are problems and needs unique to the elderly which must be considered in order to facilitate prevention, detection, diagnosis, or treatment in this segment of the population. A working conference is being organized, in consultation with the National Institute on Aging (NIA), for September 1981. A planning committee has been formed and the first meeting has been held to specify the goals of the conference, identify participants, and delineate the areas in cancer and aging which should be addressed. It is anticipated that approximately 60–70 persons will meet to identify problems in cancer prevention and treatment that are unique to the elderly.

DIVISION OF CANCER TREATMENT

The Division of Cancer Treatment sponsors research which encompasses all aspects of the treatment of cancer. The majority of the research protocols include patients across the age spectrum and patients over age 65 are not separated for special treatment. However, in selected situations patients over age 65 have been the focus of a specific research interest and these will be discussed.

The investigators in the Eastern Cooperative Oncology Group have addressed the question of whether elderly patients experience more frequent or more severe side effects from anticancer treatment. They compared patients under age 65 with patients over age 65 who had received the same chemotherapy program. Older patients did not experience more frequent or more severe side effects compared with younger patients. This observation supports the philosophy of including patients in treatment protocols without regard to age if they satisfy other criteria for receiving the specific treatment.

In some diseases patients over age 65 have a poorer prognosis than younger patients. As an example, the Brain Tumor Study Group has documented that patients with malignant brain tumors who are over age 65 have a shorter survival than younger patients. The group has noted improvement in survival with administration of radiation therapy and chemotherapy but the negative effects of age persist even in the improved results. This is receiving continuing attention by this group.

In a few diseases older patients may respond differently to therapy than younger patients. An example is breast cancer where older patients have a more favorable response to hormone therapy than do younger patients. Three studies currently in progress demonstrate efforts to capitalize on this principle.

The Eastern Cooperative Oncology Group (ECOG) activated protocol 1.178 in April 1978. It is a randomized study comparing the antiestrogen, tamoxifen, to placebo in the surgical adjuvant therapy of patients with lymph node positive breast cancer who are 65 years of age or older. As of November 1980 a total of 97 patients had been entered on this study, 87 of them evaluable at the time of the update. So far, only four patients have relapsed. The study has not been followed long enough to permit conclusions. The Group continues to enter patients into the study.

Dr. Gianni Bonadonna in Milan, Italy, under contract with the Division of Cancer Treatment, is conducting a study in women over age 65 who have undergone mastectomy for breast cancer and who have involved axillary lymph nodes. The randomized trial compares combination chemotherapy consisting of cyclophosphamide, methotrexate, and 5-fluorouracil (CMF) with CMF plus the antiestrogen tamoxifen. The study is continuing to accrue patients. Again, the followup is too short to allow meaningful analysis of treatment results.

The ECOG also has a trial in women over the age of 65 with advanced, surgically unresectable breast cancer. This randomized trial compares hormonal therapy (tamoxifen) with the CMF combination previously referred to. At relapse patients are treated with the alternate therapy. As of June 1980, 161 patients have entered this study. There were no significant differences between the two treatments with respect to percentage of patients showing tumor regression, proportion relapsing, or duration of survival. This study continues to accrue patients.

In conclusion, there are important similarities and important differences between older and younger patients. Where differences exist an effort is made to capitalize on this for the patients' advantage.

We estimate that 15 percent of all nonpediatric research support goes to patients over age 65. The two ECOG breast protocols alone represent 3 percent of ECOG activity.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

In fiscal year 1980, the NHLBI supported 19 projects specifically related to aging, including 6 grants to study systolic hypertension in the elderly at a funding level of $1,855,712. The NHLBI also supports a very large program of research on arteriosclerosis, much of which relates to the elderly population. In fiscal year 1980, this program included over 350 projects and a total funding level of $91,861,000. Ninety-six of these projects had some direct relationship to the aging population, and were supported by $15,798,000.

NHLBI PROGRAMS ON AGING

Project No.	Project title	Fiscal year 1980 amount
1R01HL23913-01	Systolic hypertension in the elderly (human)	$285,271
1R01HL23917-01	do	270,063
1R01HL23919-01	do	410,419
1R01HL23914-01	do	[1] 226,639
1R01HL23916-01	do	[1] 291,999
1R01HL23924-01	do	[1] 263,610
5R01HL06736-20	Biogenic-mechanical factors in microcirculation (rats, gerbils)	137,953
5R01HL10018-12	Effect of aging on beating heart cells in culture (rats)	71,375
5R01HL17865-06	Studies on aging—Effects of sex hormones (rats, dogs)	104,798
5R01HL18284-06	Aging erythrocytes—bio-recognition and elimination (monkeys)	67,065
2R01HL18629-06	Influence of aging and hypertension on the myocardium (rats)	54,063
5R01HL20546-03	Chemical analysis of human arterial lastin	32,410
5R23HL21393-03	Cardiac adaptation to aging and stress (rats)	36,772
5R01HL22313-03	Lung elastic recoil—age and disease (human)	14,099
5R01HL23353-02	Age related changes in cardiac autonomic interactions (dogs, rabbits, mice).	138,153
5R01HL24138-02	Prostaglandin synthesis and function in adult cardiac cells (rats)	48,960
5R01HL23399-02	Cerebrovascular changes in age and hypertension (rats)	33,052
5R01HL25408-02	Plasma activators of human pancreatic proelastase 2 (dogs)	36,495
1R01HL25786-01	Quality of life and health status of former athletes	34,764
	Total	1,855,712

[1] Funded by the National Institute on Aging.

OFFICE OF THE INSPECTOR GENERAL

The mission of the Inspector General is to prevent and detect fraud and abuse in the Department of Health and Human Services (HHS) programs and to promote economy and efficiency in its operations. It is the Inspector General's responsibility to report to the Secretary and to the Congress any deficiencies or problems related to HHS programs and to recommend corrective actions.

The HHS Inspector General's Office is the first statutory position of its kind established in the Federal civil government. It was created by Public Law 94-505, enacted on October 15, 1976, and was the result of a congressional initiative, inspired at least in part by disclosures of fraud, abuse, or waste in Federal/State medical and welfare programs. The legislation places equal emphasis on the Inspector General's obligation to prevent or detect wrongdoing and his obligation to make recommendations for program improvements in HHS.

A basic philosophy of the Office of Inspector General (OIG) is to work in a coordinative and cooperative way with other organizations to accomplish its mission except when such a relationship would compromise the OIG independence. Close working relationships have been with the Health Care Financing Administration (HCFA), the Social Security Administration (SSA), and other major components of the Department in order to maximize resources devoted to common problems.

The Inspector General's Office is organized as follows:

The Assistant Inspector General for Auditing directs the HHS OIG Audit Agency which prepares or reviews more than 5,000 audits of HHS and its contractors and grantees annually.

The Assistant Inspector General for Investigations directs a staff that investigates activity of a potentially criminal nature against HHS programs.

The Division of Special Assignments is comprised of attorney/investigators (experienced prosecutors) and senior criminal investigators augmented by investigators from the Office of Investigations (OI) and auditors from the Audit Agency.

The Division of State Fraud Control has a primary responsibility of working with the States to improve the detection and elimination of fraud against HHS programs and is the OIG manager of the State medicaid fraud control unit (SMFCU) program.

The Assistant Inspector General for Health Care and Systems Review directs a small staff of senior analysts with specialized experience across the range of HHS activities. This office also manages the Service Delivery Assessment (SDA) staff function for the Secretary.

The Executive Assistant Inspector General is responsible for management and legislative functions of the Office of the Inspector General.

The Audit Agency and Office of Investigations have regional and branch offices. Each has 10 regional offices. The Audit Agency has 51 branch offices and OI has 18 branch offices.

The OIG has a number of projects which have an impact on the programs for the aging. A few are listed:

Home health agencies.—During the last 1½ years, the OIG has been conducting indepth investigations into home health management organizations in Florida. While the results of those investigations are not complete, we have identified some problems where corrective action should be considered. The inherent problems that need correction are:

(1) Startup and contractual arrangements, including consultant costs, fees for accounting and computer services, and management agreements.

(2) Salaries and fringe benefits; and

(3) Patient solicitation.

Reimbursement of hospital-based physicians.—Hospital-based physicians practice in a hospital setting and are compensated by or through the hospital. We reviewed the adequacy of medicare controls to ensure that payments to such physicians were reasonable. The result of our review at 61 hospitals in Oklahoma and Louisiana indicated that compensation received by such physicians may not be reasonable. Specifically, we found that:

—There were extreme variations in the amounts paid such physicians at hospitals of similar size, type and location.

—The compensation paid such physicians has dramatically increased over the last few years. Example: pathologists' compensation increased as much as 102 percent.

We concluded that the medicare program does not have procedures in effect to control the reasonableness of payments for services of such physicians.

Continuing attention is required to complete current plans to (1) completely revise the hospital based physicians regulations concerning compensation, and (2) provide simplified and mandatory guidelines for allocation agreements to assure uniform application of the regulations on a national basis.

End stage renal disease.—Ratesetting has not been done on the basis of audited costs. Recent audits have shown unaudited costs are not usable for this purpose. Additionally, early activities by OIG components show that there is no system established to review claims on a national basis to control fraud and abuse. The rapid growth of costs in this program (that treats relatively few individuals) indicates that administrative changes are necessary to control Federal expenditures.

Durable medical equipment project.—This project is under development and involves charges to Medicare for DME for extended periods after the patient has died or recovered. It is projected that the potential loss to the program is in the hundreds of thousands of dollars.

Project 90+.—This is a pilot project in Illinois which involves a computer match of vital statistics death tapes against SSA beneficiaries who are over 90 years of age. A preliminary manual match disclosed potential losses through payments to persons long ago deceased to be in the hundreds of thousands of dollars. If the pilot project is successful, it would be utilized in selected additional states.

Reimbursement of physicians in teaching hospitals.—Despite a 1972 law, regulations have never been issued. Presently no basis exists under administrative law to control abuse or fraud under medicare by teaching physicians who bill for services performed by interns and residents when these house staff are not truly supervised. Clear criteria are lacking as to what is a reimbursable service. This has prevented successful investigations leading to prosecutions.

OFFICE OF THE GENERAL COUNSEL

SIGNIFICANT HHS LITIGATION DURING 1980 AFFECTING THE ELDERLY

A. BUSINESS AND ADMINISTRATIVE LAW

1. *Thomas H. Casey* v. *Secretary of HEW* (4th Cir. 1979).—The Government's oral argument in this case was presented in the Fourth Circuit on December 4, 1979. The appeal arose from a dismissal of a former Black Lung Administrative Law Judge's Age Discrimination in Employment Act (29 U.S.C. §633a) claim that the nonrenewal of his term appointment at age 72 was discriminatory. The District Court had held that as the plaintiff was beyond the statute's upper limit, he failed to state a claim. There was no appeal from the transfer to the Court of Claims of the plaintiff's due process claim that he allegedly was not renewed because he was "too solicitous" of claimants' rights.

B. HEALTH CARE FINANCING ADMINISTRATION

1. *Caldwell* v. *Blum*, 621 F.2d 491 (2nd Cir. 1980).—This action was brought by and on behalf of aged, disabled or blind New York residents, challenging New York transfer of assets restrictions. Those restrictions provided that a voluntary transfer of assets in order to qualify for or maintain eligibility for beneficiaries rendered a "medically needy" person ineligible for medicaid benefits. The district court granted a preliminary injunction restraining enforcement of the New York statute, and the New York Department of Social Services appealed.

The Court of Appeals affirmed the district court decision, holding that New York's eligibility requirements were inconsistent with the applicable provision of the Social Security Act, 42 U.S.C. § 1396a(a)(10)(C)(i). Under that provision, a "categorically needy" applicant for supplementary security (SSI) benefits could by disposing of his assets become eligible for medicaid benefits. The court ruled that the State could not impose more restrictive eligibility requirements on the "medically needy" than what was provided for the "categorically needy" under the Social Security Act Section 5 of Public Law 96-611, a recent amendment to 42 U.S.C. §1696a enacted subsequent to *Caldwell*, may substantially affect the impact of this decision).

2. *Gray Panthers* v. *Administrator, Health Care Financing Administration, Department of Health and Human Services, et al.*, 629 F.2d 180 (D.C. Cir. 1980).—In this case, the Gray Panthers Organization challenged the validity of regulations of the Department of Health and Human Services implementing the medicaid program. The district court decision, holding the regulations invalid, was affirmed on appeal.

In its decision, the Court of Appeals held that the Secretary failed to take relevant factors into account in promulgating the medicaid regulations, which applied in nonsupplemental security income States and which permitted a certain amount of a noninstitutionalized spouse's funds to be "deemed" available for use by the institutionalized spouse. The court suggested that the Secretary consider the following factors: (1) The expectation that spouses should support each other; (2) that the statute provides for differing determinations of availability of income to be made under certain differing circumstances; (3) the deterrence of fraud and abuse; (4) the extent to which the assumption that spouses who maintain a common household will share income and expenses and constitute a single economic unit is undermined by the separation of the spouses by institutionalization; (5) the impact of deeming on the family under these circumstances; (6) whether the spouses were living apart before their separation by institutionalization; and (7) if they were living apart before institutionalization, whether support payments were being made on a regular basis from one spouse to another.

The Department has filed a petition for certiorari before the Supreme Court in this matter.

3. *Himmler* v. *Califano*, 611 F.2d 137 (6th Cir. 1979).—Plaintiffs brought a class action in this case challenging Department regulations. Under the regulations, a fiscal intermediary could decide to initially reject medicare payment for those services it deemed not "medically necessary" when such services had previously been certified as necessary by the beneficiary's physician and by a utilization review committee.

The Court of Appeals, reversing the district court decision, ruled for the Department, holding that the regulatory scheme at issue violated neither the Social Security Act nor the due process clause of the fifth amendment.

4. *Monmouth Medicare Center, et al.* v. *Harris* (D.C. N.J. 1980).—In this decision, the District Court of New Jersey held that the medicare program could not be required to subsidize periods of custodial care for hospital patients who were awaiting placement in medicaid intermediate care facility (ICF) beds. Plaintiffs have subsequently moved to amend their complaint with regard to seven beneficiaries whom, they assert, were receiving skilled services while awaiting placement in ICF's (In 1978, Administrative Law Judges had concluded that each of the named beneficiaries were receiving custodial care).

5. *Norman* v. *St. Clair,* 610 F.2d 1228 (5th Cir. 1980).—Plaintiffs in this case challenged Mississippi's practice of "deeming" the income of one spouse available to the other spouse for determining medicaid eligibility and "medicaid income," both where the spouses lived together and where one spouse was institutionalized. The district court had struck down "deeming" where the spouses were separated and permitted it where the spouses lived together with the limitation that only income in excess of those expenses necessary for the noneligible spouse to live in the community could be deemed.

On appeal, the Fifth Circuit Court of Appeals, after a lengthy analysis of the statutory language and legislative history, held that "deeming" of income of one spouse to the other for medicaid purposes, both where the spouses live together and where one spouse is institutionalized, does not conflict with the medicaid statute or the constitution. The court also held the state in the formulation of its applicable standards could not act arbitrarily or inflexibly, but must in determining the amount of protected income use a realistic and reasonable estimate of expenses necessary for the fulfillment of the spouse's basic living needs. Eleven district courts which had considered the issue had all invalidated deeming. but the Fifth Circuit declined to adopt their rationale. The Fifth Circuit also held that the State's treatment of the income of dependent children of medicaid applicants did not constitute "deeming" and that the State's inclusion of one spouse's old age, survivors and disability insurance in calculating the other spouse's eligibility for medicaid was not an unlawful garnishment.

6. *O'Bannon, Secretary of Public Welfare of Pennsylvania* v. *Town Court Nursing Center,* 100 S. Ct. 2467 (1980).—This case involved the issue of whether patients in a nursing home are deprived of due process when they are not given notice and opportunity to be heard prior to decertification, for purposes of medicaid payments, of a particular nursing home in which they reside. The Third Circuit Court of Appeals had held such notice and hearing to be constitutionally mandated. The United States Supreme Court, however, reversed and held the patients to enjoy no such rights.

The Supreme Court held that medicaid patients have no interest in receiving benefits for care in a particular facility that would entitle them, as a matter of constitutional law, to a hearing before the Department of Health and Human Services and the State agency can decertify the facility. The Court reasoned that the Government may decertify a facility, even if such action results in the transfer of patients. Simply stated, the patients were not subjected to a withdrawal of direct benefits, despite the immediate adverse impact suffered by some patients as a result of the decertification. The Court concluded that such impact is merely indirect and incidental, and does not amount to a deprivation of any interest in life, liberty or property.

7. *Starnes* v. *Harris* (D.S.C. 1980).—Medicare beneficiaries and suppliers of CT scan services have brought suit against the Secretary and medicare part B carriers in North Carolina, South Carolina, and Georgia seeking declaratory and injunctive relief from the "cap" on the allowable charge for CT head scans suggested to carriers by part A/part B Intermediary 78–38 and currently in effect nationwide. Plaintiffs allege that the "cap" was imposed by the Department acting outside the scope of its authority and contrary to the "reasonable charge" methodology mandated by 42 C.F.R. 1395u and 42 C.F.R. 405.502. Plaintiffs further allege that, even if the Department had authority to impose a "cap," that authority could only be exercised through issuance of regulations and not through an intermediary letter.

The Department filed, on December 18, 1979, a memorandum opposing the injunctive relief being sought by plaintiffs. The Department argued that there was no likelihood plaintiffs would succeed on the merits because (1) the Court

lacked subject matter jurisdiction to hear a medicare part B reimbursement dispute, (2) the reimbursement limits adopted by the carriers are consistent with the medicare act and implementing regulations, (3) the reimbursement limits were not imposed by HCFA in violation of the rulemaking requirements of the Administrative Procedure Act, (4) plaintiffs would not suffer irreparable harm if preliminary relief were not granted since there was no evidence that any plaintiff would either be denied medically necessary services or subject to undue financial hardship as a result of the cap, and (5) issuance of an injunction would harm the public interest in preventing needless and improper expenditures of medicare funds.

On March 7, 1980, the court granted plaintiffs motion and entered a preliminary injunction directing the Secretary to refrain from enforcing the challenged payment cap until further order or until regulations governing the imposition of cost limits currently under preparation are adopted.

8. *Williams* v. *St. Clair*, 610 F.2d 1244 (5th Cir. 1980).— Plaintiffs in this action challenged the medicaid policy of allowing institutionalized applicants to project medical expenses in determining their spend-down amount, but requiring noninstitutional persons to accrue actual expenses.

The Court of Appeals affirmed the district court and upheld the Department's position against both statutory and constitutional challenges. The court held that the Department could be more liberal with institutionalized persons because their expenses are more predictable and reliable whereas because of the possibility of fraud, abuse, and unreliability, the Department could require non-institutionalized persons to accrue actual expenses. The court ruled that such a distinction has a rational basis and furthered a legitimate State interest.

C. SOCIAL SECURITY ADMINISTRATION

1. *Chambers* v. *Harris* (D. N.M. 1980).—In this decision. the district court affirmed the Secretary's denial of a mother's insurance benefits to plaintiff because of the latter's failure to meet the marriage requirement of § 202(g) of the Social Security Act. Under that provision, a "widow" of a deceased wage earner who has his entitled child in her care may qualify for a mother's benefit. Plaintiff met all the requirements of the act, except that she was never married to the deceased wage earner. However, she argued that because she had lived with the deceased for a number of years prior to his death, under the 1976 California Supreme Court decision in *Marvin* v. *Marvin* she should be considered a "widow" for purposes of the Social Security Act. The court rejected this argument, stating that *Marvin* may be relevant for determining the proper disposition of property for interstate succession purposes, but did not grant plaintiff the status of "widow" for purposes of the pertinent Social Security Act provision.

Plaintiff has appealed the district court decision to the tenth circuit.

2. *Cockrum, et al.* v. *Harris* (D.C. Cir. 1980).—On September 15, 1980, the United States Court of Appeals for the District of Columbia Circuit stayed the adverse judgment entered by the district court and remanded the case to that court for it to consider dismissal when the time limits regulations submitted to the *Blankenship* district court are approved.

The *Cockrum* district court had earlier found that the processing of hearing requests under titles II and XVI was "unreasonably" delayed and ordered the Secretary to establish a plan for processing of hearing requests within a "reasonable" time. The court offered 120 days as a "benchmark" of that time period. The decision of the Court of Appeals deferred to the Sixth Circuit mandate in *Blankenship* v. *Secretary of HEW*, 587 F. 2d 329 (6th Cir. 1978), which required the Secretary to promulgate nationwide regulations for the processing of hearing requests within a "reasonable" time.

3. *Cook* v. *Harris*. 617 F. 2d 906 (2nd Cir. 1980).—In affirming the district court decision, the Court of Appeals in this decision held that where a wife's entitlement to social security benefits was derived from, rather than independent of, her husband's eligibility, it was not illogical that the benefits paid to both should be reduced when the husband's entitlement to full benefits was affected by his postretirement earning. Thus, the court concluded, section 203(b) of the Social Security Act, which reduced social security benefits due to postretirement earnings and charged part of such deduction against the benefit of the spouse of the retired wage earner, was not unconstitutional.

4. *Daisy Griffin, et al.* v. *Harris* (5th Cir. 1979.—The Fifth Circuit Court of Appeals has denied plaintiff's petitions for rehearing by the panel and rehearing

en banc. The court upheld the Secretary's policy of automatically offsetting supplemental security income gross "overpayments" against gross "underpayments" and applying the waiver of overpayment criteria to only *net* overpayments. *See* 20 C.F.R. §§ 416.537, 416.538. This class action suit had alleged that the Secretary could not offset a payment of more than the correct amount for one month against payments of less than the correct amount for a different month without first providing the recipient an opportunity for an administrative hearing.

5. *Jimmy Swain* v. *Harris* (M.D. Fla. 1979); *Arlene Weaver* v. *Harris* (M.D. Fla., 1979).—These cases were heard jointly by the magistrate, who reversed the Secretary in both cases. He stated that because the Florida statute in question provided for the offset of disability benefits against workmen's compensation benefits, the Secretary of Health, Education, and Welfare could not offset the workmen's compensation benefits against disability even though the Florida statute did not apply this offset to retroactive social security benefits.

Citing *Tarver* v. *Califano*, (M.D. Fla. No. 76–969) and interpreting § 224(d) of the Social Security Act, the District Court affirmed. The Department thereupon filed a Rule 59 motion, bringing to the court's attention the case of *Durrance* v. *Califano*, (S.D. Fla. 1978), wherein the court held that if Florida chose not to offset disability benefits against workmen's compensation benefits even though they had offset provisions in their statutes, the Secretary could apply the offset by workmen's compensation against disability. The court's reasoning was that Congress intended to "prevent the payment of excessive combined benefits" in response to "the concern that has been expressed by many witnesses in the hearings about the payment of disability benefits concurrently with benefits payable under State workmen's compensation programs." S. Rept. 404, 89th Cong. and Admin. News p. 1943 at 2040. Therefore, the court concluded that if the State did not utilize the offset provisions, the Social Security Administration may do so.

6. *Morris* v. *Harris* (E.D. Mo. 1980).—The district court here entered judgment for the Secretary, sustaining the constitutionality of section 202(f)(1)(A) of the Social Security Act, which requires as a condition of eligibility for widower's insurance benefits that the widower has not remarried. The comparable provision for widow's benefits, section 202(e)(1)(A), provides a benefit if a widow "is not married."

After plaintiff's wife died, he entered a second marriage which ended in divorce. Plaintiff's subsequent application for widower's benefits on his first wife's account was denied because he had remarried. He argued that a similarly situated widow would be eligible, and that his denial thus violated equal protection principles. A reviewing magistrate approved of the statutory difference, finding that the legislative history for the provision of widow's benefits to a woman who "is not married" demonstrated a congressional concern to protect nonwage earning women whose second marriage terminates.

7. *Mozelle Clark* v. *Harris* (5th Cir. 1980).—Plaintiff in this action has contended that the Court should adopt a per se rule that all claimants are prejudiced unless they are represented by counsel at a disability benefits hearing before an administrative law judge. Further, she contended that the written notice she received informing her of her right to counsel was, in actuality, insufficient to inform her of that right. The Department's position is that whether a plaintiff receives a full and fair hearing depends upon the facts of each case: having counsel is not necessarily a prerequisite. In this case, plaintiff had sufficient intelligence to understand the nature of her right to counsel and voluntarily waived that right. In addition, the Department has maintained that the facts indicated that plaintiff, despite her lack of counsel, had received a full and fair hearing; therefore, there is no need to remand the case for another hearing.

8. *Schwingel* v. *Harris*, 631 F.2d 192 (2nd Cir. 1980).—In this case, the Second Circuit reversed a district court judgment affirming the Secretary's determination that plaintiff had been overpaid SSI benefits and that waiver of recovery was not available.

Plaintiff had been notified that, due to her excess resources, she was ineligible for SSI benefits and had accordingly been overpaid. This decision was reversed by the Administrative Law Judge (ALJ) on appeal, who found that plaintiff's "excess resources" (retroactive supplemental security income payments) were not countable. Since the ALJ concluded that plaintiff had not been overpaid he never reached the issue of waiver. The Appeals Council subsequently reviewed the ALJ's decision and notified plaintiff that she could submit additional evi-

dence on the matter within 20 days and could request oral argument. Plaintiff submitted an affidavit after the close of the 20-day period. The Appeals Council reversed the ALJ's finding on the overpayment issue and based on the record before the ALJ (but not plaintiff's affidavit), determined that waiver was not available, since plaintiff was "at fault in receiving the overpayment." The Court of Appeals held that since plaintiff's credibility was relevant to a finding of fault, she was entitled to a determination on that issue by an agency official who had heard her testimony. It also held that the Appeals Council's decision on this issue, without the benefit of plaintiff's testimony, deprived her of her right to a fair hearing as required by the act. The court remanded the case for further administrative proceedings.

9. *Stallings* v. *Harris*, 493 F. Supp. 956 (W.D. Tenn. 1980).—The district court here, on July 10, 1980, affirmed the Secretary's decision denying the claimant's application for disability benefits and upheld the constitutionality of the vocational factors "grid" regulations which became effective on February 26, 1979. The court also ruled that these regulations should be applied retroactively to claims brought before their effective date.

The district court decision has been appealed and currently is pending before the Court of Appeals for the Sixth Circuit.

ITEM 7. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

JANUARY 30, 1981.

DEAR MR. CHAIRMAN: Enclosed please find two copies of the Department's annual report to the Senate Special Committee on Aging—1980 highlights. The report is intended for inclusion in the committee's annual report, "Developments in Aging," and was to have been submitted by January 15, 1981.

The report was prepared under the supervision of former Secretary Landrieu's staff. If we can be of any further assistance, please let me know.

Very sincerely yours,

SAMUEL R. PIERCE, Jr.

Enclosure.

ANNUAL REPORT TO THE SENATE SPECIAL COMMITTEE ON AGING—1980 HIGHLIGHTS

I. OFFICE OF HOUSING

A. Office of Special Assistant for Elderly Housing

The Office was established on January 30, 1980, by the Secretary; the Special Assistant was designated that date at a meeting in HUD with the Elderly Housing Coalition. Since that time the Office has conducted a number of activities.

The Office cooperated with the White House Conference on Aging, particularly in setting up, and participated actively in the Mini-White House Conference on Housing the Elderly. Other Mini-White House Conferences in which the Office played a role included the Conference on Long-Term Care, Energy and the Elderly, Interlinking the Generations, and Vision and the Aging. The Special Assistant participated actively in more than two dozen other conferences, workshops and institutes on aging during the year.

The Office also is producing a series of publications; a significant one is on the theme of shared housing and living arrangements utilizing existing housing occupied by single persons. A single directory of assisted elderly housing is being assembled with the help of the Office of Management Information. A booklet on retirement housing planning for individuals and another on energy conservation for the elderly are also planned.

B. Public Housing

Legislative Background.—Public Housing, under the United States Housing Act of 1937, as amended, has always included the elderly as eligible residents. It was only in 1956 that public housing especially designed for the elderly, with safety and security features, etc., was expressly authorized by the Congress.

Handicapped persons with low incomes are statutorily included as "elderly," though they need not meet the minimum age specification of 62 years for residents. Public housing agencies develop and operate the housing, financed through direct HUD loans and the sale of bonds and other obligations. The Federal Government assists with annual contributions to repay the PHA borrowings and operating subsidy to assure that low rents and adequate services are available.

In 1970, legislation was enacted encouraging PHA's to build congregate rental housing for the elderly and handicapped. Contracts for such housing are limited to 10 percent of contracts entered into in each fiscal year. Congregate housing is intended to help avoid premature or unnecessary institutionalization for frail, elderly, and handicapped persons. The term "congregate housing" generally refers to projects which have a central kitchen and dining facility and in which some or all of the dwelling units do not have full kitchens. The management then has the responsibility to see that meals and other certain housing-related supportive services are made available to the residents as necessary. This arrangement permits some of the conveniences and economies of communal living to be built into rental projects, and allows elderly and nonelderly handicapped persons to remain semi-independent through management provision of meals and supportive services. An example of this housing—Arthur King Manor—was completed by the Duluth (Minn.) Housing and Redevelopment Authority in 1980 and a second project is now being built. Occupants of King Manor are a mix of relatively independent and frail in need of meals and housekeeping and personal services, and people receiving board and lodging care (nonmedical, but around the clock). The services are funded in part through a grant under HUD's congregate housing services program, authorized by congressional legislation in 1978 and discussed elsewhere in this report.

Current Statistics.—In fiscal year 1980, a total of 15,223 public housing units was completed; 5,200 of these were for the elderly. Construction starts in 1980 totaled 36,365 units of which 10,561 were for the elderly. By comparison, a total of 44,372 units—both family and elderly housing—was completed in the previous fiscal year. Cumulatively, there are well over 1 million public housing units in the Nation, at least 44 percent of which have elderly residents. Housing for low-income elderly provided under section 8 legislation—rent certificates—is not included in the above figures. The percentage of total section 8 housing—especially new construction—for the elderly is considerable. (See discussion of section 8 that follows.)

C. Section 8

The section 8 program provides assistance to encourage the construction of new units, the moderate or substantial rehabilitation of units, and the use of standard existing units. It encourages the participation of both private developers and public housing agencies. And, importantly, section 8 can maximize the use of the existing housing stock, while inducing production of additional units in markets where the supply of existing housing is inadequate to meet the need.

The legislation requires that section 8 projects serve lower income and very low-income families. Further, some projects are developed with a mix of assisted families.

No family assisted under section 8 may pay more than 25 percent of its income for rent. The rental payment may be as low as 15 percent, however, depending on family income, size, and medical or other unusual expenses.

Several other features of the section 8 program are of special advantage to older Americans:

Eligibility for section 8 assistance, like public housing, includes two or more unrelated elderly, disabled, or handicapped persons who are living together, or one or more such individuals living with another person who is essential to their care and well being.

FHA multifamily mortgage insurance programs are available to both section 8 developers and nonprofit sponsors to provide the project financing for new construction or substantial rehabilitation. Public housing agencies may also finance construction or rehabilitation of section 8 assisted units by issuing tax-exempt obligations under section 11(b).

Assistance for congregate housing is available under the section 8 program. In fiscal year 1980, the Department reserved 212,000 section 8 units, of which 73,000 or 34 percent were for elderly.

D. Indian Housing

The Office of Indian Housing administers HUD housing activity on Indian reservations. The following accomplishments on behalf of elderly occurred during 1980:

—Of the 4,893 Indian housing units reserved, 429, or approximately 9 percent, were designated for elderly Indians;

—Of the 4,163 Indian housing units reaching construction start, 469, or approximately 11 percent, were for elderly Indians; and

—Of the 5,379 Indian housing units made available for occupancy, 282, or approximately 5 percent, were for elderly Indians.

E. Section 202—Direct Loans for Housing for the Elderly or Handicapped

The section 202 program was first enacted as a part of the Housing Act of 1959 to provide direct Federal long-term loans for the construction of housing for the elderly or handicapped. The program was intended to serve elderly persons whose income was above public housing levels but still insufficient to secure adequate housing on the private market. The section 202 program was amended by the 1974 Housing and Community Development Act to change the method of determining the interest rate (which had been set at 3 percent statutory maximum in 1965) and to permit the use of section 8 housing assistance payments for projects constructed or substantially rehabilitated under the program. The interest rate applying to loans closed during the fiscal year ending September 30, 1980, was 9 percent during the construction period and 8½ percent during the 40-year amortization period. In fiscal year 1981, a single rate of 9¼ percent will be charged both during the construction period and the amortization period.

HUD has been authorized to lend up to $5 billion through fiscal year 1980. At the end of fiscal year 1980, 1,679 projects with nearly 116,000 units had received funds reservations for nearly $4 billion (unadjusted). This includes approximately $65 million which had been allocated in total over 3 years for a demonstration program for housing for the chronically mentally ill, including elderly persons, of which $25 million were allocated in fiscal year 1980, the third year of the demonstration. Congregate housing is permitted under the section 202 program.

As of September 30, 1980, a cumulative total of 734 projects with over 69,000 units had been placed under construction since reactivation of the program. Of these, 247 projects with about 26,200 units already were completed. A total of $830.8 million, expected to finance the development of about 18,000 units, will be available for fund reservations for fiscal year 1981. Section 202 staff also continues to assist in the congregate housing services program.

F. Section 231—Mortgage Insurance for Elderly Housing

Under section 231 of the National Housing Act, as amended, the Department is authorized to insure lenders against losses on mortgages used for construction or rehabilitation of rental accommodations for older persons (aged 62 years or more, married or single).

Section 231 is HUD's principal program designed solely for unsubsidized rental housing for the elderly. Nonprofit as well as profit-motivated sponsors are eligible under the program, and section 8 housing assistance payments can be made available on competitive basis. Section 231 permits congregate housing projects to be built.

During fiscal year 1980 the Department insured 17 projects consisting of 1,641 units, bringing the total number of projects currently insured under the section 231 program to 490 projects consisting of 65,318 units.

G. Sections 221(d)(3) and 221(d)(4) of the National Housing Act—Mortgage Insurance Programs for Multifamily Housing

While these programs are not specifically for the elderly only, they are available to sponsors as alternatives to the section 231 program.

Sections 221(d)(3) and 221(d)(4) authorized the Department to provide insurance to finance the construction or rehabilitation of rental or cooperative structures. Special projects for the elderly are provided under these programs. A priority in occupancy is given to those displaced by urban renewal or other governmental action. (Because they tend to be residential occupants of older

and deteriorating urban neighborhoods, a greater proportion of older persons than younger persons are affected.)

In fiscal year 1980, 887 projects containing 95,777 units were insured under these programs. Since their inception, these programs have insured 7,945 projects containing 865,151 units, of which about 7 percent are for the elderly.

H. Section 223(f) Mortgage Insurance for the Purpose of Refinancing Existing Multifamily Housing Projects

This program offers mortgage insurance for existing facilities, including housing for the elderly, where repair costs do not exceed 15 percent of project value. The program can be used either in connection with the purchase of a project, or for refinancing only. To the extent that real estate liquidity is enhanced, the availability of section 223(f) encourages investment in residential real estate of all kinds. Prior to its being added to the National Housing Act in August 1974, project mortgage insurance could be provided only for substantial rehabilitation or new construction.

I. Section 232—Mortgage Insurance for Nursing Homes/Intermediate Care Facilities

The primary objective of the section 232 program is to assist and promote the construction and rehabilitation of long-term care facilities. Since program enactment in 1959, the Department has insured mortgages for 1,291 facilities providing 147,632 beds.

Approximately 90 percent of the residents of nursing homes are elderly. HHS's medicare and medicaid programs have made it possible for many, who would not otherwise have been able to do so, to benefit from the services provided under this program.

Section 312 of the Housing and Community Development Amendments of 1978, Public Law 95-557, amends section 232 of the National Housing Act to allow space for day care for the elderly and others in nursing homes and intermediate care facilities with HUD-insured mortgages. The purpose of day care for the elderly and others is to provide protective care and offer social contracts with others, plus providing useful creative activities. Day care enables family members to work without having to worry about elderly or other infirm persons left alone at home all day. Additionally, day care is a cost-saving measure and can prevent premature or unnecessary institutionalization. Final regulations have been published and the program will be operational in the near future.

II. OFFICE OF NEIGHBORHOODS, VOLUNTARY ASSOCIATIONS AND CONSUMER PROTECTION

A. Human Services Division

The Human Services Division has, in addition to its other duties, responsibilities related specifically to the elderly. It participates in the development or provision of HUD policies, programs, and procedures affecting the elderly; coordinates HUD elderly initiatives and responses; and represents HUD in activities with other Federal, State, and municipal or private organizations relating to the elderly. The Division gives high priority to maintaining liaison with the Administration on Aging (AoA) and with national organizations for the elderly.

In this role, the division staff in the past year attended numerous meetings and conferences and participated in a number of other activities. Staff participated in the initial planning for the White House Miniconference on Housing for the Elderly and made presentations at the conference.

The division has continued work as the Department's representative on the Federal Council on Aging's Long-Term Care Committee, the AoA Task Force on Nutrition, and the Inter-agency Task Force on Information and Referral.

Congregate Housing Services Program

The Human Services Division has committed extensive effort to the continued development and implementation of the congregate housing services program (CHSP). The program authorizes HUD to extend multiyear grants (3 to 5 years) to eligible public housing authorities and nonprofit section 202 borrowers. The funds provide meals and other supportive services to frail elderly and nonelderly handicapped residents to assist them to remain independent. These

services are intended to prevent or delay unnecessary or premature institutionalization of residents. The program ties services to housing in order to assure a more stable source of funds to housing management for the services needed by residents. Further, the funds give incentive to builders to produce needed congregate facilities.

All fiscal year 1979 moneys have been committed to grantees except for the $1 million legislatively required to be held back from each year's appropriation to cover the costs of inflation and other adjustments. Twenty-nine of these grants are in operation serving approximately 1,300 residents. Seven new construction projects will not be negotiated until initial occupancy (1981 or 1982).

Ten million dollars was available in fiscal year 1980 for grantees; of this amount, the $66 million allocated to existing projects was committed to grantees in September, 1980. These grants will be for 5 years. They will serve approximately 800 residents a year, and are now in the process of final contract negotiations. The grantees selected were chosen from among the total of 140 nominated by HUD's regional offices; of the 140 nominated, 56 actually applied for funds.

The $3 million of fiscal year 1980 funds reserved for new construction projects will be competitively announced in the near future.

All grantees offer a meal service as required by the act, though the pattern of meals varies, e.g., some offer lunch and dinner, while others offer breakfast and dinner. With few exceptions the grantees are also offering personal assistance and housekeeping/chore services. Many of the grantees are providing other services with transportation the next most popular offering.

During 1980, the evaluation of the CHSP was designed by HUD's Office of Policy Development and Research. A contract was awarded to the Hebrew Rehabilitation Center for the Aged in Boston in September and the contractor is now in the field collecting the first round of data. Some initial findings will be incorporated in HUD's second annual report to Congress which will be submitted early this winter. AoA, through an interagency agreement with HUD, is assisting in financing the evaluation.

B. Interstate Land Sales Registration

Congress passed the Interstate Land Sales Full Disclosure Act in 1968 to give the public a measure of protection against fraudulent and deceptive land sales operations. The act is administered through HUD's Office of Interstate Land Sales Registration. Although the act is intended to provide protection for all consumers, it is evident that a great number of potential victims of fraudulent land sales could be the elderly.

The property report is the key to the protection available to consumers under the act, since developers are required by law to give the prospective purchaser a property report prior to or at the time of signing a contract. The disclosure contained in a property report covers such items as the following: (1) Existence of mortgages, liens, and other encumbrances; (2) whether contract payments are set aside in a special (escrow) fund; (3) cost and availability of recreational facilities or of roads, water, and septic systems.

In the last few years allegations of overregulation by the land development industry and increased congressional interest resulted in extensive amendments to the act in December 1979. These amendments, which became effective in June 1980, created new exemptions from the act's registration requirements in certain cases where lack of disclosure to purchasers is deemed not to have an adverse effect.

The act's antifraud and antimisrepresentation provisions still apply to these sales programs. These recent amendments also extended the purchasers' cooling-off period from 3 to 7 days, added extensive new contract rights and expanded, both in scope and duration, purchasers' rights to sue developers in civil court for violations of the act. Revised regulations became effective on June 21, 1980, incorporating the amended legislation, and represent the product of 2 years' efforts toward simplifying procedures for developers while simultaneously providing readable disclosure information for purchasers and meaningful consumer protection.

C. Neighborhood Self-Help Development Program

The neighborhood self-help development grant program provides financial support of neighborhood development organizations to prepare, finance, and implement specific neighborhood revitalization projects. To be eligible, organizations

must have a track record or demonstrable capacity for the proposed project and must be representative of and accountable to the neighborhood where the project is located. Almost any specific project related to a neighborhood revitalization strategy can be eligible provided the application meets certain requirements, including a certification from the chief elected official that the project is consistent with local plans. Grant funds support the costs of project preparation (e.g., architectural services, financial packaging, etc.) and a portion of the costs of project implementation. The balance of the costs of project implementation is derived from other public and private sources.

The program provides training and technical assistance to eligible neighborhood development organizations, HUD area office personnel, local units of government, and related public/private sector organizations in order to increase the success rate of neighborhood development organizations in planning, financing, managing, and evaluating neighborhood revitalization projects. This training and technical assistance includes workshops on program development and management skills in various parts of the country; onsite assistance to neighborhood organizations; publishing and distributing trainer and resource manuals; and establishing cooperative agreements with national organizations to undertake training workshops for their constituency groups and member organizations.

A program of information exchange and technology transfer has also been established to publicize successful neighborhood revitalization models which may assist neighborhood self-help groups in developing new projects. The program includes maintenance of a mailing list for national, regional, and local neighborhood organizations; the periodic publication of an ALERT newsletter on programs available to neighborhood self-help organizations; the nationwide operation of a neighborhood information sharing exchange which enables groups to share their knowledge and experience; and the development and dissemination of how-to and resource publications and audiovisuals.

In the first year of the program, operating with funding of $15 million, the Office made grant awards to 125 neighborhood organizations. Although most of these organizations are not generally elderly oriented, their activities can and often do include projects designed to meet the needs of elderly residents. For example, the International District Improvement Association in Seattle, Wash., is assisting elderly Chinese/American residents, many of whom have been farmers, to produce lower cost food. The Santa Barbara Community Housing Corp., in Santa Barbara, Calif., is managing the financing, construction, and development of neighborhood facilities associated with the construction of a housing cooperative for the elderly. Amigos Del Valle, in McAllen, Tex., is rehabilitating 40 low-income houses for the elderly utilizing the group's work crews. The Walnut Hills Redevelopment Foundation, in Cincinnati, Ohio, is preparing and packaging the construction of 100 units of elderly housing and implementing the adaptive reuse of an adjacent school for low-income housing and social service facilities.

Other activities of the program address the needs of elderly residents. Six workshops were given on neighborhood technologies for 720 participants from units of local government and neighborhood organizations. One technology discussed was the delivery of services to the elderly, incorporating them into neighborhood activities.

III. OFFICE OF POLICY DEVELOPMENT AND RESEARCH

Title V of the Housing and Urban Development Act of 1970 authorizes and directs the Secretary to undertake programs of research, studies, testing, and demonstrations relating to the mission and programs of the Department. Section 815 of the Housing and Community Development Act of 1974 strengthened the role of HUD research in the areas of elderly and handicapped by specifically encouraging demonstrations related to the housing problems of members of special user groups, including the elderly and handicapped.

The HUD research program serves as a stimulus for positive change in housing and urban conditions by conducting research and by demonstrating new methods for application of government and private expertise to the solution of housing problems. The program serves as a national focal point for housing and community development research and as a central point for research, analysis, and data collection and dissemination on these issues for the Department.

The focus on research related to the problem of the elderly and handicapped is in HUD's program of special user research, although other program areas such

as community design research and economic affairs also support research which impacts on the elderly and handicapped.

The mission of the special user group research program is to design, conduct, and support research and demonstration projects whose results will improve housing conditions and related housing and community services for the elderly, the handicapped, and other members of identifiable special user groups.

A. Current Special User Research

The Office of Policy Development and Research has recently completed or is currently sponsoring several projects related to the housing problems of the elderly; work will continue in 1981. The following list demonstrates the scope of these recently completed and ongoing projects:

—Work continued on the design of a longitudinal study of the relationship between important changes which people experience as they grow older and various housing changes which they undertake. The national survey will be conducted annually for 10 years. Some of the housing activities to be investigated include alterations to the physical structure, routine maintenance, and shifting uses of rooms, as well as relocation to a different residence. Individuals selected for inclusion in the first year of the study will be followed during the subsequent years so that the data do not provide a one-sided picture of nonmovers.

—Another initiative, begun in 1978 and continued through 1980, was an evaluation of Baltimore's experimental home maintenance program. The program's objective is to help eligible households living within the target area with minor maintenance and repair problems which, if unattended, can lead to serious deterioration of individual properties as well as negative effects on neighborhood stability. Persons living in the area who are either 55 years of age or older, physically handicapped, or single parent householders are eligible for the program. Early evaluation results of this two-stage study form the basis for a multicity demonstration of the home maintenance and repair program concept.

—Design and development work are completed on the elderly home maintenance demonstration in 1980. Cofunding by several private foundations was secured and service delivery is now underway at all seven cities. Contracts were awarded for administrative support services and for evaluation of the demonstration. The evaluation design is being completed and baseline data are being gathered for the 2-year project.

—The Gerontological Society is developing a research agenda for HUD on issues related to the housing needs of the elderly. The agenda will guide our program over the next several years.

—A companion to the book "Low Rise Housing for the Older People" is being prepared and will focus on the special design problems of providing mid-rise and high-rise elevator buildings to meet the social needs of the elderly.

—A contract was awarded for the evaluation of the congregate housing services program which is being jointly sponsored by the Office of Housing and the Office of Neighborhoods, Voluntary Associations and Consumer Protection. P.D. & R. is working closely with evaluation staff from AoA, which is helping to sponsor the evaluation.

—A 6-month study of the housing needs of the elderly and handicapped in rural areas was completed. Required under the Housing and Community Development Amendments of 1979, this study looked at housing resources available through HUD as well as at the Farmers Home Administration.

—Several P.D. & R. publications reflect concern for the elderly: (1) "Occasional Papers in Housing and Community Affairs;—Volume I," "The Housing of Independent Elderly," (2) "Volume III: Housing Options for the Elderly," (3) "How Well Are We Housed? The Elderly," and (4) "Annual Housing Survey: 1973—Housing Characteristics of Older Americans in the United States."

Other Studies

The second major focus of the special user research program is on the handicapped; much of that research has major implications for the elderly.

—An evaluation of the demonstration for housing the chronically mentally ill, including the elderly, which is being conducted by the Office of Housing, is

underway. Phase I, which examines the problems of implementing such a program, is nearing completion. Phase II, now being designed, will examine the costs and benefits of such housing.

—A cost study of the implications of section 504 for the retrofitting of public housing, combined with a similar analysis of the costs of retrofitting for energy conservation and modernization, is near completion.

—A major accomplishment has been the development of a new American National Standard on accessibility for the handicapped, published by the American National Standards Institute (ANSI). Although ANSI standards are voluntary, they gain the force of law by being referenced or included in State or local codes and Federal regulations. The ANSI project also resulted in the publication of eight volumes of research report which received a *Progressive Architecture* award in 1979.

—The construction of four out of six demonstration units being built in accordance to the new ANSI standard has been completed and those four units are occupied. The costs of each unit are being carefully compared with identical, but nonaccessible, units so that we can identify the true costs of accessibility. The units have been open to the public and their market acceptability is being evaluated.

Future Research

During fiscal year 1980, most of the special user budget will continue the longitudinal study, the Baltimore evaluation and the multicity demonstrations. If additional funds are available, one or two of the projects included in the new agendas will be started.

IV. OFFICE OF FAIR HOUSING AND EQUAL OPPORTUNITY

Congress passed the Age Discrimination Act of 1975 to prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. The Department of Health and Human Services is the agency responsible for coordinating the governmentwide implementation of the Age Discrimination Act.

Under HHS's governmentwide implementation plan each Federal agency was asked to publish a proposed regulation defining Age Discrimination Act policies and procedures which apply to recipients of Federal financial assistance. HUD's proposed regulation defining Age Discrimination Act policies and procedures which apply to recipients of Federal financial assistance. HUD's proposed regulation was published in the Federal Register on November 4, 1980, with comments due by January 5, 1981.

HUD's annual training course in 1978 included training on the Age Discrimination Act. Brochures are provided to Age Discrimination Act complainants and recipients named in complaints alleging age discrimination that are received by the Department. Recently a public meeting was held with seven groups (which deal with the problems of the elderly and the young) explaining the proposed HUD regulations.

HUD has received approximately 20–25 complaints alleging age discrimination. The majority allege age discrimination in obtaining housing. On the age complaints received and referred to the Federal Mediation and Conciliation Service, approximately 15 have been successfully mediated.

V. COMMUNITY PLANNING AND DEVELOPMENT

A. Community Development and Block Grant (CDBG)

The community development block grant program is the major funding source for cities to conduct a wide range of community development programs. It is a $4 billion program, $3 billion of which goes to 650 cities and urban counties by entitlement, amounts determined by formula, and $1 billion goes to approximately 2,000 small cities (under 50,000 population) which compete through States and area offices. Block grants may be expanded to help low- and moderate-income households, to eliminate slums and blight and to meet urgent needs. The primary objective of the legislation is the development of viable urban communities by providing decent housing and a suitable living environment and expanding economic opportunities, principally for persons of low and moderate income.

Block grant applicants are required to develop housing assistance plans (HAP's). The distribution of housing assistance in these HAP's varies by the type of housing assistance planned by local communities. Thirty-three percent of the new construction planned by communities is targeted for elderly and handicapped households. This percentage of assistance would meet nearly 40 percent of the housing assistance goals for the elderly and handicapped in the fourth program year. Another 25 percent of their housing assistance goals would be met by rehabilitated housing and 20 percent by existing units.

CHART I

PERCENT OF TOTAL EXPENDITURE OF BLOCK GRANT FUNDS BY PERCENT OF ELDERLY CONCENTRATION BY NEIGHBORHOOD LOCATION, 1976, 1977, 1978, AND 1979

Neighborhood location	Elderly concentration												Total (percent)
	Low concentration (0 to 9 percent)				Medium concentration (10 to 19 percent)				High concentration (20 to 100 percent)				
	1976	1977	1978	1979	1976	1977	1978	1979	1976	1977	1978	1979	
Residential	38.2	39.6	33.8	37.5	54.6	53.6	53.6	54.9	7.3	6.8	8.6	7.5	100
Central business district	.7	2.6	7.6	13.2	28.7	22.3	23.5	39.7	70.6	75.1	68.9	47.1	100
Other commercial areas	29.1	33.9	26.6	33.3	60.8	56.2	60.2	52.0	12.5	9.9	13.3	9.6	100

Local plans for fiscal year 1978 called for 29 percent of their total housing assistance to be distributed among the elderly and handicapped. Elderly and handicapped households represented 33 percent of the total needy population.

A performance report for fiscal years 1975–77, based on a 147 cities sample-covering, shows that of housing for which a financial commitment was made, 52 percent of the units are to benefit the elderly and handicapped. In this same time period the elderly need was 33 percent of the total need for local housing assistance.

CHART II

PERCENT OF RESIDENTIAL EXPENDITURES ON CDBG FUNDED ACTIVITY BY PERCENT OF ELDERLY CONCENTRATION, 1976, 1977, 1978, AND 1979

CDBG funded activity	Elderly concentration												Total (percent)
	Low concentration (0 to 9 percent)				Medium concentration (10 to 19 percent)				High concentration (20 to 100 percent)				
	1976	1977	1978	1979	1976	1977	1978	1979	1976	1977	1978	1979	
Clearance related	33.2	42.5	35.1	37.1	59.1	48.4	48.8	52.1	7.8	9.2	16.1	10.2	100
Code enforcement	33.7	30.0	33.0	33.0	59.7	61.0	58.3	59.5	6.6	8.2	8.6	7.5	100
Housing rehabilitation loan grants	28.9	34.3	33.9	33.0	64.2	57.5	56.7	59.0	6.9	8.1	9.5	8.1	100
Services related	27.2	55.1	38.5	36.7	61.4	42.4	44.4	52.1	11.3	2.5	17.1	11.2	100
Public services	35.8	43.0	39.0	37.3	56.4	51.2	53.2	54.3	7.7	5.8	7.9	8.5	100

B. Urban Development Action Grants (UDAG)

The urban development action grant program provides grants to cities and urban counties which meet minimum standards of physical and economic distress. The purpose of the program is to improve the economic base of those cities and provide permanent jobs, especially for low- and moderate-income persons. The program seeks to attract private investment to distressed localities; no grants are approved unless there are firm commitments of private funds to carry out project development. Preliminary approvals of action grants are based upon nationwide competition on a series of factors including the relative distress of the city, how much private money is attracted by the UDAG grant, the number of jobs created, the seriousness of the economic problems of the locality and other factors. In 1979, a "pockets of poverty" provision was added to the program, permitting localities which are not distressed to apply for grants to assist areas of the city which have many low-income households.

Since 1978, 44 projects in 22 States and Puerto Rico, have been awarded funds which have as their only or a major purpose meeting needs of the elderly. The UDAG grants range in size from a $100,000 grant for a residential development in Pico Rivera, Calif., to a $7 million grant in Chicago.

Attached at the end of this report is a list of some of the projects approved during fiscal year 1980 which directly benefit elderly households.

C. Section 312

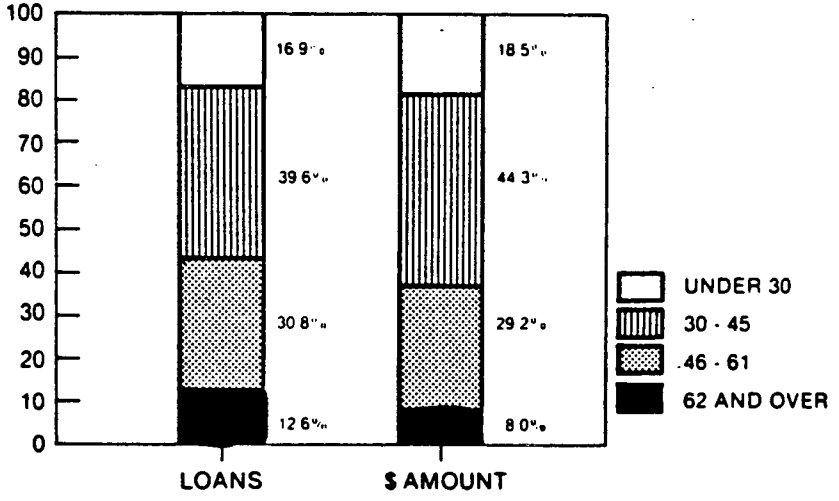
Section 312 loans are direct loans to owners, and sometimes tenants, of properties located in specific HUD assisted areas, the most common being community development block grant activities areas The localities and cities receiving HUD block grant assistance process loan applications in conformance with the law and the regulations. The Congress has directed that priority be given to low- and moderate-income occupants. Multifamily loans are required to be for structures: (1) In low- and moderate-income areas, or (2) with the majority of tenants having low or moderate incomes.

Loans may be made on most kinds of properties, where consistent with the locality's community or economic development strategy. The priorities for making loans have directed funds primarily to properties containing fully defined dwelling units. However, recent legislative amendments clarified the authority of localities to make loans to properties containing congregate housing dwelling units and to single room occupancy properties. Rehabilitation loans are made at low interest rates, 3, 6, or 9 percent, depending upon the family income for residential single family properties or upon the type of property for other loans. The term of the loan shall be the shortest reasonable term consistent with the borrower's ability to pay; but, in no instance more than 20 years.

In fiscal year 1979, 12.6 percent of section 312 rehabilitation loans were made to persons who were 62 years of age and older. These loans accounted for 8 percent of the total of funds available under section 312 for fiscal year 1979 (chart III). This probably indicates that elderly borrowers tend to use section 312 moneys to do basic repairs to their homes, rather than to undertake major rehabilitation projects.

CHART III

FY 1979 SECTION 312 LOAND AND LOAN FUNDS, BY AGE OF BORROWER
OWNER-OCCUPIED
(PERCENT)



Another indicator of benefit to the elderly from section 312 loans is that 56.5 percent of section 312 loans in fiscal year 1979 were made in census tracts where the proportion of residents who were retired was greater than the overall proportion of retired residents in the city. This is to say that section 312 is targeted to neighborhoods that have a relatively high proportion of elderly residents.

CHART IV
COMPARISON BETWEEN SEC. 312 TRACT LOCATIONS AND THE CITY AS A WHOLE—PERCENT RETIRED

Percent retired	Number of tracts	Percent of tracts
Greater than or equal to city	287	56.5
Less than city	221	43.5

D. Secretary's Discretionary Fund

Community Planning and Development administers the Secretary's discretionary fund for HUD, a fund of up to $104 million. Out of that fund, assistance can be obtained for technical assistance, innovative grants, Indian programs, and disasters. There are a number of programs being conducted by CPD that benefit elderly households, but those which are directly focused on elderly households are several of the innovative grants and at least one technical assistance program.

In 1979, a major innovative grant competition was held for communities to request funds for antidisplacement projects. Of the 12 which were selected, a number are either directed specifically at the elderly or have implication for elderly tenants. For example, in Brookline, Mass., and King County, Wash., the innovative grant is being used to help elderly and other low-income renters stay in apartments converting to condominiums, and in Denver, Colo., to convert a surplus school into housing for the elderly.

CPD also has a technical assistance contract with Maintenance Central for Seniors in Detroit, an organization which has done an outstanding job of offering home repair and rehabilitation services for the elderly, under foundation grants and CDBG funds.

Under the contract, Maintenance Central is sponsoring three conferences in Baltimore, Milwaukee, and Oakland to teach other cities and nonprofit organizations about the philosophy of repair rather than replacement and their management techniques which include doing the work directly for elderly homeowners rather than leaving it up to them to get their own contractors.

E. 701 Comprehensive Planning Assistance

Comprehensive planning assistance (701) is available to regional bodies and other units of government not receiving CDBG. Its purpose is to increase the capacity of local governments to carry out comprehensive planning. Grant recipients are required to undertake activities which achieve:

(1) Conservation and improvement of existing communities.

(2) Expansion of housing and employment opportunities and choices for low-income and minority households; and

(3) Promotion of orderly and efficient growth and development.

During 1980, the planning assistance (701) program legislation was revised and it now addresses housing needs of elderly and handicapped persons, among other groups. When this legislation is implemented all 701 recipients will be required to give consideration to the housing needs of the elderly and the handicapped.

VI. INTERAGENCY AGREEMENTS

A. Alcoholism—HUD/HHS

A HUD–HHS agreement was formulated and signed to organize and present a series of alcoholism outreach programs at selected PHA's across the country. The alcoholism programs were designed to deal with the problems of alcoholism as it affects family life, especially the lives of youth and the elderly. Attention was also given to the interaction of alcoholism and housing management.

B. Congregate Housing Services Work Group

Coordination with and involvement of other Federal agencies offering benefits to HUD's public housing for the elderly continued and expanded in fiscal year 1980. Programs of the Department of Health and Human Services (especially those under the Administration on Aging (AoA)) have been drawn upon to serve

nutrition and other needs such as home-health care. With the implementation of the congregate housing services program, close collaboration between HUD and AoA became necessary. The CHSP has entered its second year of grants to eligible PHA's and section 202 sponsors, with the interagency CHSP work group playing a role in discussion and approval of HUD's selection criteria and program operations standards. The work group consists of representatives from HUD, Administration for Developmental Disabilities, Administration on Aging, and others, including Farmers Home Administration.

C. Congregate Housing Services Program Evaluation—HUD/HHS (AoA)

An agreement between HUD and AoA was formulated and signed. The agreement provides for the transfer of AoA funds to HUD to assist in the financing of the CHSP evaluation. The agreement also outlines the mutual responsibilities of HUD and AoA in administering the evaluation contract.

D. Public Housing Urban Initiatives/Social Service Agreement—HUD/HHS

The Administration for Public Services (APS) of the Department of Health and Human Services and the Offices of Public and Indian Housing and Neighborhoods, Voluntary Associations and Consumer Protection (NVACP) completed an agreement to cooperate in implementing the Public Housing Urban Initiatives/Social Service Agreement in support of the President's Urban Policy. The goal of the agreement was to insure the delivery of comprehensive human services to those in need of the services. It was specifically designed to improve service access to public housing residents in the 33 cities designated in the targeted rehabilitation component of the Public Housing Urban Initiatives/Social Service Agreement.

E. Anticrime Program—HUD/HHS/Justice/Labor

The anticrime program involves three Federal agencies with HUD as the administrative lead. It is a comprehensive attempt to reduce crime and the fear of crime in public housing developments and their neighborhoods. Thirty-nine localities across the country were funded for anticrime programs through interagency agreements with the Department of Labor, the Department of Justice, and the Department of Health and Human Services, along with the Department of Housing and Urban Development.

F. Interdepartmental Working Group on Development and Implementation of a Federal Manpower Policy for the Field of Aging

HUD is represented in the Interdepartmental Working Group on Development and Implementation of a Federal Manpower Policy for the Field of Aging. This work group is charged with the preparation of a biennial report to Congress on the status of personnel working in the field of aging.

G. White House Miniconference on Housing for the Elderly

HUD was active in the development of agenda for the White House Miniconference on Housing for the Elderly which took place in October 1980, in Washington, D.C. HUD staff served as facilitators and resource persons during the conference.

H. Title IIIc Nutrition Program—HUD/HHS (AoA)

Agreements in effect between HUD and the Administration on Aging on nutritional and social services for the elderly in HUD-assisted housing continue to produce programs and services. For example, as reported last year, over 1,500 local housing authorities and section 202 sponsors provide onsite facilities for the AoA title IIIc nutrition program under an agreement between HUD and AoA. We estimate these sites serve at least 25,000 elderly.

ATTACHMENT 1.—*Sample of fiscal year 1980 UDAG projects which directly benefit the elderly*

Mobile, Ala	Construct convalescent center with nursing home, medical clinic, and apothecary and elderly care facility.

Wilmington, Del	Nursing home site improvements, new construction and equipment purchase.
Pollock, La	Conduct nursing home, paved parking area, sewage facility and furnishing.
Denton, Md	Construct water improvements for nursing home.
Boston, Mass	Develop elderly health facility on urban renewal site.
Gowanda, N.Y	Construct nursing home, purchase capital equipment, construct offsite water and sewer facilities.
Jamestown, N.Y	Improve street and site, water, sewer, parking and construct intermediate care facility.
West View, Pa	Construct neighborhood commercial center, elderly high-rise, and townhouses.
Toledo, Ohio	Acquire land and construct nursing home, develop medical facility, expand training.
Salem, W. Va	Nursing home facility, public improvements, and energy efficient solar/gas heating system/installation.
Hillman, Mich	Construct nursing home and extend water/sewer facility and access road to site.
Princeton, W. Va	Construct sewer line to nursing home.

APPENDIX

A Summary of HUD Housing Units for the Elderly*

All figures represent number of projects/units currently insured by FHA unless otherwise noted.

Construction Projects

Section Number	Program	Status	No. of Projects	No. of Units	Value	App. No. of Eld. Units	% of Eld. Units	Report Period
Title II	Low-income Public Hsng.	Active	10,750	1,200,000	Not Available	552,000[1]	46%±	Cum.thru 9/30/79
202	Direct Loans for Hsng. for Elderly & Handica.	Inactive[2] Active[3]	330+ 1,211	45,275 91,716	574,580,000 3,325,074,000	45,275 87,522	100% 95%	Cum.thru 1972 5/31/80
231	Mortgage Insurance for Hsng. for Elderly	Active	477	64,116	1,082,966,264	64,116	100%	Cum.thru 12/79
221(d)3	Multifamily Rental Hsng. for Low & Moderate	Active	3,417	346,383	5,337,537,561	55,602	7%	Cum.thru 12/79
221(d)4	Income Families	Active	3,874	447,938	8,939,941,234			
235	Home Ownership Asst. for Low & Moderate	Inactive[2]	472,059[7]	473,032	8,456,660,790	Figures not Currently Available		Cum.rev. Program thru 5/80
	Income families	Active	40,862	40,893	1,352,920,895			
207	Multifamily Rental Hsng.	Active	2,639	285,108	3,937,745,205	3,421	1.2%	Cum.thru 12/79
236	Rental and Coop. Asst. for Low Income families	Inactive	4,052	434,645	7,479,970,182	53,799	12%	Cum.thru 12/78
202/236	202/236 Conversions	Inactive	182	28,306	482,032,750	28,306	100%	Cum.thru 12/78
232	Nursing Homes & Intermediate Care Facilities	Active	1,271	(beds) 145,262	1,581,565,981	145,262	100%	Cum.thru 12/79

Non-Construction Programs

8	Low-Income Rental Asst.	Existing[4]	Active	9,446	821,418	N/A	240,742	29%	Cum.thru 5/31/80
		New Const.[4,5]	Active	8,393	538,561	N/A	290,447	54%	5/31/80
		Substantial Rehabilitation[4,5]	Active	1,650	112,828	N/A	40,107	35%	5/31/80
312	Rehabilitation Loans		Active[6]	75,913	N/A	780,225,000	N/A	App.25% of Loans	Cum.thru 9/30/79
23	Low Rent Leased Hsng.		Inactive[2]	N/A	163,267	N/A	54,000+	35%±	Cum.thru 12/75

1 Data does not indicate how many of these units are designed specifically for the elderly.
2 Figures for original program reported through program revision.
3 Figures for revised Section 202/8 represent cumulative project reservations as of 5/31/80.
4 Figures represent cumulative fund reservations through reporting date.
5 Figures do not include Section 8 commitments attached to Section 202/8 fund reservations.
6 Figures represent loan commitments only.
7 Figures represent number of mortgages.

This table was compiled by the Office of the Special Assistant for Elderly Housing and Special Programs, with the assistance of the Housing Budget Division, Management Information Systems Division, Multifamily and Single Family Insured Branches, and the Data Systems and Statistics Branch in the Office of Housing.

ITEM 8. DEPARTMENT OF THE INTERIOR

DECEMBER 18, 1980.

DEAR MR. CHAIRMAN: In response to your letter of October 30, 1980, we have summarized below the services provided to Indian elderly under the Bureau of Indian Affairs' Housing Improvement Program (HIP).

"The Bureau of Indian Affairs has a Housing Improvement Program (HIP) which is a repair and renovation program of existing housing on Indian reservations and in Indian communities. This program is aimed at improving the standards of housing for those people who are not qualified to receive this assistance from any other source. Although eligibility to participate in HIP is not based upon the age of the applicant but rather upon need for decent housing, a good many recipients of HIP involve elderly since their qualifications and participation in other federally assisted housing programs are more unlikely."

We hope that the above information will be of use to you in the preparation of your annual report, "Developments in Aging."

Concerning other programs and activities of the Department of the Interior that may have an impact on the elderly, please note that a separate direct response will be sent to you by the Heritage Conservation and Recreation Service.

Sincerely,

THOMAS W. FREDERICKS,
Deputy Assistant Secretary—Indian Affairs.

ITEM 9. DEPARTMENT OF JUSTICE (LAW ENFORCEMENT ASSISTANCE ADMINISTRATION)

DECEMBER 4, 1980.

DEAR MR. CHAIRMAN: This is in response to your letter requesting information from the Law Enforcement Assistance Administration for use in the Special Committee on Aging's annual report, "Developments in Aging."

In March of this year, the President recommended elimination of the financial assistance programs authorized by the Justice System Improvement Act of 1979 and administered by LEAA. The fiscal year 1981 Department of Justice appropriations bill approved by Congress includes no funds for LEAA grants. While the Agency has been active in the past in supporting various types of programs to assist the elderly, I regret that it appears that we will not be in a position to fund any new projects. Action has been taken to prepare for an orderly phaseout of LEAA activities.

The Special Committee on Aging's past interest in and support for the programs of the Law Enforcement Assistance Administration is appreciated.

Sincerely,

HOMER F. BROOME, JR., *Administrator.*

ITEM 10. DEPARTMENT OF LABOR

JANUARY 12, 1981.

DEAR MR. CHAIRMAN: Enclosed, in accordance with the recent request of the committee, is a summary of the programs and activities of the Department of Labor for 1980 related to aging. This summary describes the services provided under programs administered by our Employment and Training Administration and Pension and Welfare Benefits Program. I hope this will be of assistance to you in preparing your report, "Developments in Aging."

Sincerely,

RAY MARSHALL, *Secretary.*

Enclosure.

EMPLOYMENT AND TRAINING ADMINISTRATION PROGRAMS

The Employment and Training Administration has responsibility for providing or administering employment, training, and related services for the Nation's older citizens through a part-time community service employment program, comprehensive employment and training, and public service employment programs, and the employment service system.

The extent of the increasing need to assist older workers to obtain jobs is related to a number of trends in our society:

—The difficulty older workers experience in obtaining jobs because of such factors as discriminating personnel policies, obsolete skills, limited training opportunities, and lack of confidence.

—The disproportionate impact of inflation on older workers because of increasing prices, fixed annuity incomes, and inadequate retirement income.

—The real and anticipated impact of funding problems of retirement income systems, including the social security system.

—The increasing number and proportion of older people, resulting from declining birth and death rates (those persons over 55 years of age will increase from 46 million in 1980 to 54 million in 2000, whereas the 18–24 age group will decrease from 29 million in 1980 to 24.7 million during this same period); and

—The high incidence of poverty among older people (The Census Bureau reports over 8 million people 55 and over are classified as poor or near poor).

In order to respond to these trends, the Department of Labor provides support for the activities which are discussed in this report.

Senior Community Service Employment Program

The U.S. Department of Labor administers the senior community service employment program (SCSEP). This program, authorized by title V of the Older Americans Act, offers subsidized part-time employment to low-income persons age 55 and above. Although theoretically almost 8 million older workers are eligibile for this program, the number is much smaller due to health and other reasons. Nevertheless, it is safe to say SCSEP serves less than 1 percent of those eligible. Program participants work an average of 20–25 hours a week in a wide variety of community service activities and facilities including day care centers, schools, hospitals, senior centers, and beautification, conservation, and restoration projects. In addition to subsidized community service jobs, SCSEP participants receive yearly physical examinations, personal and employment-related counseling, job training and, in some cases, referral to unsubsidized jobs. Because of its exclusive focus on economically disadvantaged older people, its economic and socio-psychological benefits to participants, and its contribution to community services, many consider SCSEP one of the best Federal programs for the elderly.

Activity under this program was, in earlier years, sponsored by a group of four national organizations (Green Thumb, Inc., the National Council of Senior Citizens, the National Council on the Aging, and the National Retired Teachers Association/American Association of Retired Persons) and the U.S. Forest Service. Until July 1, 1977, they sponsored all local projects being conducted in 47 States, the District of Columbia and Puerto Rico. During the July 1976 through June 1977 program year, the Department also awarded SCSEP grants directly to three State governments and four territories not covered by the national organizations (Alaska, Delaware, Hawaii, American Samoa, Guam, The Trust Territories of the Pacific Islands, and the Virgin Islands).

During the program year, from July 1976 through June 1977, the SCSEP subsidized about 15,000 jobs. Financial support for that period was provided by a $55.9 million supplemental appropriation during the last quarter of fiscal year 1976.

For the program year of July 1977 through June 1978, SCSEP was expanded to provide a new total of 37,400 jobs. Financial support for this period totaled $90.6 million and was provided from the Economic Stimulus Appropriations Act.

Funding for the 1978–79 program year totaled $200.9 million. This supported 10,100 new community service jobs, increasing the total to 47,500.

Beginning with the 1977–78 program year, SCSEP funds were divided with 80 percent going to national sponsors and 20 percent going to State governments.

In addition to the national organizations that have historically operated SCSEP projects, the Department added three new national sponsors in July 1978. Selected through a competitive process were the National Urban League, the Association Nacional Pro Personas Mayores, and the National Center on Black Aged.

The fiscal 1979 appropriation for SCSEP was $211.7 million. This amount was sufficient to sustain the 47,500 jobs, and an additional $8.9 million in funding was needed to support continuation of the 47,500 jobs during the 1979–80 program year.

The fiscal 1980 appropriation for SCSEP was $266.9 million. This included 4,750 new jobs, a 10 percent increase, bringing the total SCSEP jobs to 52,250. A portion of the appropriation was released early in 1980, in order that the 4,750 new jobs could be filled before July 1, 1980, the start of the 1980–81 program year. The 4,759 jobs were divided so that 55 percent (2,612 jobs) were administered by State sponsors and 45 percent (2,138 jobs) were administered by national sponsors. The other 47,500 jobs were allocated in the same manner in the past. A report covering SCSEP activities for the program year ending June 30, 1980 follows.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

Performance report for the 1979–1980 program year
(July 1, 1979–June 30, 1980)

I. Funding (in millions)	$229.1
II. Enrollment levels:	
Authorized positions established	52,250
Unsubsidized placements	6,251
III. Summary of characteristics—persons actually enrolled:	
Sex:	*Percent*
Male	34
Female	66
Education:	
8th grade and under	38
9–11	22
High school grad or equivalent	27
1–3 years college	9
4 years college and above	4
Veteran	9
Racial/ethnic groups:	
White	69
Black	21
Hispanic	6
American Indian/Alaskan	2
Asian/Pacific Islands	2
Economically disadvantaged (100 percent of poverty level)	87
Age:	
55–59	21
60–64	28
65–69	28
70–74	15
75 and over	8
IV. Areas of community service in which participants were employed:	
Service to the general community	51
Education	11
Health/hospitals	4
Housing/home rehabilitation	2
Employment assistance	1
Recreation, parks, and forest	9
Environmental quality	2
Public works and transportation	5
Social services	11
Other	6
Services to the elderly	49
Project administration	3
Health and home care	5
Housing/home rehabilitation	4
Employment assistance	1
Recreation/senior citizens	8
Nutrition programs	13
Transportation	3
Outreach/referral	9
Other	3
V. Average hourly wage: $3.21.	

The 1981 fiscal year has retained the same number of job slots, 52,250. The budget, however, increases slightly to $267.1 million in order to sustain the current level of activity.

Comprehensive Employment and Training Programs and Public Service Employment Programs

Persons in all working age groups participate in activities under the Comprehensive Employment and Training Act (CETA), which provides for comprehensive employment and training programs and public service employment. One of the changes in the statute was a major reordering of programs under different titles. The following table indicates the numbers of persons in the upper age groups who participated in comprehensive employment and training programs (new title II–A, –B, –C) and public service employment (new title II–D and VI) during fiscal 1980.

ENROLLMENT TABLE, CETA, FISCAL YEAR 1980

[Preliminary estimates]

	Total	Percent	Title II A, B, C	Percent	Title II–D	Percent	Title VI	Percent
Total participants	2,075,430		1,190,722		482,952		401,756	
45 to 54	120,384	5.8	50,010	4.2	38,636	8.0	31,738	7.9
55 and over	80,340	3.8	30,959	2.6	26,079	5.4	23,302	5.8
Total over 45	200,724	9.7	80,969	6.8	64,715	13.4	55,040	13.7

CETA, as reauthorized in 1978, and implementing regulations, provide a strengthened focus on the employment problems of older workers. Title III specifically provides that the Secretary of Labor shall insure that prime sponsors' plans provide the details of the specific services to be provided to individuals who are experiencing severe handicaps in obtaining employment, including those who are 55 years of age and older. Title III provides broad authority for research and training policies and programs to focus on providing older workers a more equitable share of employment and training resources to reflect their importance in the labor force.

The current CETA regulations are designed to enhance the effectiveness of CETA programs. Major emphases include targeting services to persons most in need and providing equitable services to significant segments of the eligible population (age, race, sex and national origin groups); ensuring comprehensive planning and delivery through coordination of the various employment and training activities; focusing on the transition of participants into unsubsidized employment; and providing for improved management control to ensure the integrity and efficiency of the program and to prevent program fraud and abuse.

CETA—National Programs

On April 1, 1977, the Department of Labor provided the Administration on Aging with CETA discretionary funds to continue 15 grants for older worker employment projects which were originally authorized under title X of the Public Works and Economic Development Act. These projects were later administered and funded by the Employment and Training Administration through direct grants.

During 1978, as many as 5,300 persons were employed in the program. However, the Department has encouraged a gradual reduction in the number of enrollees through a transfer of enrollees into title V of the Older Americans Act or into unsubsidized jobs. Currently, about 1,700 persons are working in the program. The remaining participants who do not transfer into other jobs or programs will be supported until September 30, 1981, after which time the availability of funding is uncertain. The Employment and Training Administration has budgeted $5.7 million for this purpose.

Employment Services to Older Workers

BACKGROUND

Within the broad framework of the Wagner-Peyser Act of 1933, as amended, which established the Federal-State employment service system, the State em-

ployment service agencies provide intensive counseling, assessment, job development, placement and referral to training and social services to meet the employment-related needs of middle-aged and older jobseekers.

The ultimate objective of these services is to minimize the duration of unemployment experienced by men and women who lose their jobs when in their mid-forties or later years, and to assist all middle-aged and older workers in obtaining and remaining in employment which utilizes their highest skills.

Although the unemployment rate for middle-aged and older workers is lower than for the younger age groups, the duration of unemployment experienced by men and women who lose their jobs when in their mid-forties or later tends to increase. The Age Discrimination in Employment Act of 1967, as amended, recognizes this trend in its coverage of most workers who are at least 40 years of age but less than 70. For purposes of recordkeeping and statistical reporting, the employment service uses age 45 as a reference point for the term "older workers."

FISCAL YEAR 1980 ACCOMPLISHMENTS

In fiscal 1980, the State employment services placed 355,171 individuals age 45 and over in jobs. This reflects the placement of more than half of the older workers referred by State employment service offices to job openings as well as the placement of nearly 18 percent of all new and renewal applicants age 45 and over. This placement figure also represents an increase in fiscal 1980 in the number of older workers for whom job development contacts were made. Over 14 percent of the older workers were placed as a result of job development contacts.

The following table, "Employment Services for Older Workers," provides comparative data on public employment services to jobseekers age 45 and over, 55 and over, and to all applicants regardless of age.

A total of 103,862 veterans age 45 and over were placed in jobs by the State employment services in fiscal 1980.

The employment services in Arkansas, Illinois, Massachusetts, and Virginia augmented their staff with specially trained low-income retired men and women who work on a half-time basis providing intensive job development and community outreach services for applicants age 55 and over. Similar services are also provided by the Missouri, Ohio, and New Jersey State employment services.

EMPLOYMENT SERVICES FOR OLDER WORKERS, FISCAL YEAR 1980

[Numbers in thousands, except percents]

55 employment services for older workers	Fiscal year 1980 (all fund sources)			Change from 1 yr ago [1] (percent)		
	Total	Age 45 and over	Age 55 and over	Total	Age 45 and over	Age 55 and over
New applicants and renewals	17,882.1	2,255.6	867.5	16.7	15.8	6.5
Individuals referred to job openings	7,719.7	755.8	291.5	−4.2	−1.6	.63
As percent of new applicants and renewals	43.2	33.5	33.6	(52.5)	(39.4)	(35.6)
Individuals placed in jobs	4,014.6	355.2	139.3	−10.1	−7.4	−3.8
As percent of individuals referred to job openings	52.0	46.9	47.8	(55.6)	(50.1)	(51.0)
As percent of new applicants and renewals	22.5	15.7	16.1	(29.2)	(19.7)	(18.1)
Individuals counseled	1,106.3	127.7	45.4	4.3	.71	−.9
As percent of new applicants and renewals	6.2	5.7	5.2	(6.9)	(6.5)	(5.6)
Individuals placed after counseled	273.4	24.3	8.5	−8.7	−9.8	−2.0
As percent of individuals counseled	24.7	19.0	18.7	(28.2)	(21.2)	(20.0)
As percent of new applicants renewals	1.5	1.1	1.0	(1.9)	(1.4)	(1.1)
Individuals placed as a result of job development	520.7	51.4	19.7	−11.6	−9.5	−7.2
As percent of new applicants and renewals	2.9	2.8	2.3	(3.8)	(2.9)	(2.6)
Individuals for whom job development contact made	1,858.0	264.9	103.9	7.0	8.9	9.9
As percent of new applicants and renewals	10.4	11.7	12.0	(11.2)	(12.4)	(11.5)
Individuals tested	826.7	60.5	16.7	.74	7.2	17.7
As percent of new applicants and renewals	4.6	2.7	1.9	(5.3)	(7.9)	(1.9)
Individuals referred to training	331.7	20.7	6.5	13.5	−.42	−3.5
As percent of new applicants	1.9	.9	.7	(1.9)	(1.1)	(.9)
Individuals referred to supportive services	1,413.0	203.8	81.5	26.5	30.5	34.1
As percent of new applicants and renewals	7.9	9.0	9.4	(7.3)	(8.0)	(7.5)

[1] Fiscal year 1979 percentages shown in parentheses for comparison.

Source: Office of Program Review, U.S. Employment Service.

State employment services participated in the annual observance of National Employ the Older Worker Week to foster public awareness of the benefits of hiring older workers and to emphasize year-round public employment services to older jobseekers.

A staff member of the U.S. Employment Service served on the Interdepartmental Task Force on Information and Referral created by the Cabinet-level Committee on Aging established under the Older Americans Comprehensive Service Amendments of 1973 (Public Law 93–29). The task force is concerned with implementation of the interdepartmental agreement on information and referral for older people signed by the Employment and Training Administration and 13 other Federal departments and agencies on December 21, 1974.

FISCAL YEAR 1981 INITIATIVES

(A) Provision of promotional and technical support for State employment service participation in the 1981 observance of National Employ the Older Worker Week.

(B) Continued involvement in the Interdepartmental Task Force on Information and Referral through increased emphasis on information and referral services in programs funded under the Comprehensive Employment and Training Act and title V (senior community service employment program) of the Older Americans Act, as amended.

(C) Initial and refresher training of new and onboard local office staff by all State employment services as needed in techniques of counseling, placing, and providing other basic and support services for older jobseekers.

(D) Continued promotion of public service employment cooperation with State and area agencies on aging and other organizations concerned with employment of older people.

RESEARCH AND DEVELOPMENT

The Employment and Training Administration's Office of Research and Development conducts a program of research, experimental and demonstration projects to improve and/or develop new employment, training and income maintenance programs, policies and initiatives. The program includes institutional grants to enable universities to strengthen their capability to conduct research and to train specialists in the employment and training field, as well as grants to support doctoral dissertation research and post-doctoral studies to develop new approaches to solve employment and training problems or to contribute to policy formulation. Many projects focus on the needs of specific target groups such as older workers, minority group members, offenders, veterans, women and youth. Some projects concerned with the employment-related problems of older workers are cited below.

A. Recently Completed Projects

1. Social Security and the Labor Supply of Older Men

The major objective of this study was to estimate the effects of social security and the associated earnings test on the retirement rates of men over 62. An analysis of National Longitudinal Survey's data (described below, under ongoing projects) indicated that changes in the earnings test between 1970 and 1974 had no measurable effect on retirement behavior. The study results also suggest that eliminating the earnings test will not increase labor supply but will increase the cost to the government of Social Security pensions.

2. Research and Development Strategy on the Employment-Related Problems of Older Workers

This study, completed in 1978, includes a systematic examination of all relevant older worker data, a review and evaluation of ongoing older worker programs, and an analysis of older worker policy issues and priorities. A major objective was to identify knowledge gaps and innovative programmatic approaches which might be addressed in research and development projects as a basis for improving programs and policies directed towards the employment-related problems of older persons. The study is expected to provide guidance for older worker research and development projects over the next several years.

3. The Preretirement Years: A Longitudinal Study of the Labor Market Experience of Men

This study probes the relationship of factors influencing the work behavior and experience of men aged 45 to 59 in 1966. The data were provided by the National Longitudinal Surveys (described below, under ongoing projects). The chief finding of this study was that pension coverage and tenure inhibited job changes by older workers. This study also found that health limitations caused lower earnings and labor force participation rates.

4. Program Participation of Elderly Hispanic Americans

A survey was conducted of 600 elderly Hispanic Americans in Riverside County, Calif., to study their participation in employment and training programs under the Comprehensive Employment and Training Act and the Older Americans Act. The major findings of the survey are that elderly Hispanic Americans have a low participation rate in these programs and that their knowledge or awareness of the programs is minimal. It has been recommended that programs should be developed which are aimed specifically at the Hispanic elderly and are staffed with bilingual-bicultural personnel.

5. National Program for Selected Population Segments (NPSPS)

One of the target groups of this project was older workers. In two areas this project trained older persons as homemaker or health aides to assist other elderly persons confined to their homes. Unexpectedly, many trainees qualified for nurse's aide or orderly certificates as a result of their training. Many took full-time jobs in hospitals and nursing homes in addition to working in private homes. In two other areas, the project offered more general counseling and placement assistance for elderly persons who may have been forced into early retirement. In another area, the NPSPS project for older workers coordinated existing services for the elderly and provided them with information concerning these services. The project paid the wages of 21 older worker coordinators who provided information and referral services for other elderly persons in the community.

6. Demonstration of Development and Testing of Job Sharing (Project JOIN)

A project to develop and test job sharing in the Wisconsin civil service system for persons wanting to return to work part time, for persons planning to retire, and for full-time employed persons who prefer to work part time. The study was designed to measure the productivity of those in conventional work situations and to measure the impact of creating less than full-time jobs on the balance of the work unit in which persons sharing jobs are located. The study findings indicate that job sharing can be implemented successfully, and can result in benefits to the employing organization as well as to the workers.

7. Paper on Socioeconomic Policies and Programs for the Elderly

In response to a request from the Organization for Economic Cooperation and Development a paper was prepared on socioeconomic policies and programs for the elderly. The paper describes and analyzes policy options and related programs, with emphasis placed on employment and related social programs and policies conducive to the labor market participation and social and community involvement of the elderly.

8. Utilization of Retired Teachers as a Supplemental Educational Resource

A study was undertaken to determine the feasibility of using retired teachers to make a significant impact on the solution of educational problems in the District of Columbia through the exercise of their lifetime skills, without undercutting the incomes or ambitions of younger teachers. The results indicate that a demonstration "emeritus teachers" project can be undertaken in the District of Columbia with a good chance of success. Such a demonstration project is underway.

9. Labor Supply Function for Older Males (Doctoral Dissertation Grant, Cornell University)

This study investigated the determinants of pension supply by firms and pension demands by workers. The dissertation offers some support for the contention that "quality regulation" of pension plans may result in the dissolution of some existing plans and hinder the establishment of new plans. It argues

that, for a variety of reasons, the Employee Retirement Income Security Act may lead to a reduction in the pension coverage of American workers.

10. Determinants of Age of Retirement and Patterns of Labor Supply (Doctoral Dissertation Grant, University of Wisconsin)

This study provides added information on the factors influencing the retirement decisions of older workers, with the analysis focused on patterns of labor supply before and after retirement and on age at retirement.

B. Ongoing Projects

1. National Longitudinal Surveys (NLS) of Labor Force Behavior

A study of the relationships of factors influencing the labor force behavior and work experience of four groups: men aged 45–59 in 1966; women 30–44 in 1967; and men (1966) and women (1968), 14–24. The study focuses on the interaction among economic, sociological and psychological variables that permit some members of a given age-education-occupation group to have satisfactory work experiences while others do not, and entails several consecutive surveys of each group. Interviews were initiated in the years cited above and repeated at various time intervals through 1980. In 1979, a new youth cohort of 13,000 men and women aged 14–21, with over-representation of blacks, Hispanics, and poor whites, was added to the NLS. Current plans are to collect additional data on the initial four groups through 1983 and on the new youth cohort through 1984.

2. Demonstration of Development and Testing of Alternative Employment Patterns for Older Workers

A project to develop and test a variety of employment options in the Wisconsin State civil service for persons approaching retirement age (55) and for those who have already retired but would like to reenter the work force in an option other than the traditional 5-day, 40-hour work week. Options include various part-time and full-time work schedules. Analyses will be conducted with respect to factors such as the effects on income, job satisfaction, morale, health and productivity; and comparisons of job option participants and a matched standard work-week group. A major objective is to develop a prototype preretirement employment policy for the State of Wisconsin with the model structured so that its components could be used by other State and local governments.

3. Postretirement Work Experience of Nonsupervisory Personnel

A study to determine to what extent and under what conditions persons receiving private pension benefits continue to engage in paid employment. The study focuses on nonsupervisory personnel from three large companies, which provides a data base suitable for comparison with an earlier study of professional and managerial personnel from the same firms.

4. Retired Teachers as Tutors

A project to demonstrate and assess the effectiveness of utilizing the services of retired teachers as volunteers in a program to improve the reading and math skills of elementary school pupils in the District of Columbia. The project is designed to determine the degree to which retired teachers gain satisfaction and a sense of accomplishment by utilizing their lifetime skills, as well as to measure the effectiveness of tutoring in improving the performance of students who need remedial assistance.

5. Early Retirement and the Labor Market Dynamics of Older Workers (Doctoral Dissertation Grant, Yale University

A study of early retirement and its effects, with the objective of developing information on unemployment compensation, social security, and other retirement areas.

C. Contemplated Projects

Consideration is being given to projects concerned with tapered or phased retirement, employment-related problems of minority older workers, factors associated with continued employment versus withdrawal from the labor force, employment needs of retired workers, relationships between age and employment, ways to increase the labor force participation of "discouraged" older workers out of work, and the occupational capabilities of middle-aged and older workers.

Other Programs for Older Workers

RURAL TRANSPORTATION INITIATIVE

This interagency program is intended to enhance the access of people in non-urbanized areas to health care and social services, as well as to shopping, education, recreation, other public services and employment, by encouraging the maintenance, development, and use of encouraging the maintenance, development, and use of coordinated transporation services. The program specifically focuses on assuring that necessary transportation resources are available in the context of ongoing programs, removing administrative barriers to coordination of services as fully and expeditiously as possible, and providing technical assistance and support to State and local officials in the development and evaluation of such services. Participants in the implementing interagency agreement include the Departments of Labor; Transportation; Health, Education, and Welfare (now HHS); and Agriculture; and the Community Services Administration.

The Department of Labor is providing funding to train and employ workers such as drivers, dispatchers, and mechanics for jobs in public transportation systems in the 14 demonstration States. Grants totaling approximately $4.7 million in CETA title III discretionary funds were awarded to five of the national nonprofit organizations that sponsor title V senior community service employment programs under the Older Americans Act. The programs are being run in accordance with SCSEP regulations and persons hired must meet the SCSEP eligibility criteria.

SUBSCRIPTIONS

For over 10 years the Employment and Training Administration has been purchasing a bulk 12-month subscription to "Aging and Work," a quarterly journal published by the National Council on Aging. Through this subscription the Employment and Training Administration provides copies of the journal to CETA prime sponsors, the local offices of State employment security agencies, and State and area agencies on aging.

PROJECTS FOR OLDER WORKERS

CETA section 308 authorizes programs to facilitate increased labor force participation of low-income persons age 55 and over.

Pursuant to the mandate of section 308 of CETA, the Department of Labor awarded a total of $2 million to four national nonprofit organizations to develop and administer innovative and replicable job training programs for low-income persons 55 years of age or older. The program's intent is to provide low-income, unemployed or underemployed older workers with skills needed to obtain permanent unsubsidized employment or training to improve skill levels and career opportunities, as well as address specific needs of individuals who have not been in the labor force for a number of years.

WEATHERIZATION

The Department of Labor's major involvement in weatherization dates back to an interagency agreement signed in 1977 between Labor, the Federal Energy Administration (now the Department of Energy), and the Community Services Administration (CSA). The weatherization programs assist low-income families and individuals, particularly the elderly and the handicapped. The Department, through CETA prime sponsors, provides CETA workers to install insulation and related materials.

In fiscal 1979, funds for weatherization program materials and administration were consolidated in one appropriation for the Department of Energy (DOE). DOE was to make grants to State energy offices or State economic opportunity offices. These State agencies were, in turn, to subgrant funds to local community action agencies (CAA's) to operate weatherization programs. CAA's were to use DOE funds for materials and project supervision and to negotiate agreements with CETA prime sponsors for installation laborers. Further, the 1978 CETA amendments included several new provisions to enhance CETA participation in weatherization projects and activities.

In addition to the major emphasis placed on weatherization under CETA public service employment programs, other CETA programs have also carried

out weatherization and related energy conservation activities. Under the older worker program, a number of projects have been launched which provide weatherization services in cooperation with various other agencies including the Department of Housing and Urban Development, CSA and the Administration on Aging. Because workers shift among activities in older worker projects, a precise count of the numbers of workers involved in weatherization activities is not available. However, it is estimated that between 1,500 and 2,000 older workers are engaged in housing rehabilitation and weatherization activities on homes of older persons. A substantial number of title V workers (approximately 3,000) are also engaged in weatherization and home rehabilitation projects.

Summary of Activity of Pension and Welfare Benefit Programs Affecting Aging

The Office of Pension and Welfare Benefit Programs (PWBP), an organization within the Department of Labor (DOL), administers title I of the Employee Retirement Income Security Act of 1974 (ERISA). The purpose of ERISA is to protect retirees who are receiving benefits from private sector pension plans and welfare plans, workers who participate in private pension and welfare plans and the beneficiaries of both retirees and active participants—to see that workers are not required to satisfy unreasonable age and service requirements before becoming eligible for pension plan participation and vesting benefits; to see that the money will be there to pay pension benefits when they are due; to see that plans and plan funds are managed prudently; to see that retirees and workers are supplied with the information needed by them regarding their plans; to see that spouses of retirees are given protection; and to see that the benefits of retirees and workers are protected if the plan should terminate.

SUMMARY OF PWBP ACTIVITY

DOL is given the following responsibilities under ERISA:

A. Enforcement

PWBP is responsible for enforcing provisions of ERISA, with the greatest emphasis being placed on obtaining compliance with the fiduciary provisions. These provisions require, among other things, that plan trustees and administrators shall perform their plan duties solely in the interest of participants and beneficiaries. Investigations are conducted and where violations are found, the Secretary of Labor may file a civil action to recover plan assets or remove those persons from their position of trust, among other remedies. The Secretary also may intervene on behalf of any retirees, active plan participants or their beneficiaries who allege that a violation of fiduciary responsibilities has occurred in the management of a plan's financial affairs. Where violations are discovered, PWBP's general priorities are the following: Move quickly to prevent any future loss of assets; recover assets that were lost; and, where appropriate, remove the trustees responsible for the loss.

Strengthening the compliance program was the major priority for PWBP in 1980. As part of this effort, a number of program improvements were implemented in 1980, which included efforts to continue improving targeting methods, closely monitoring and directing field activities, and providing additional specific guidelines to the field regarding our compliance strategy.

The program improvements implemented during 1980 were part of PWBP's effort to shift to an almost total emphasis on conducting fiduciary investigations, which protect and recover plan assets in the event of misuse. This is critical to insuring that funds are available to pay promised benefits from pension and welfare plans. As a result, 1,455 fiduciary cases were closed during this fiscal year.

B. Reporting and Disclosure

ERISA obligates plan administrators to furnish to participants and beneficiaries certain information about plan operations and finances. Such information shall include a copy of the summary plan description, summary annual report and individual benefit statements. Plans must also make available to them on request certain other plan documents, including the latest annual report, bargaining agreement and trust agreement.

In addition, ERISA requires plan administrators to file certain reports with the Department of Labor Internal Revenue Service (IRS) and Pension Benefit Guaranty Corporation (PBGC). Reports which must be filed with DOL include: the annual report (the Form 5500 series), and the summary plan description, a booklet which plans provide to participants and beneficiaries explaining plan benefits. These reports and other documents are maintained in a disclosure room for public examination. Copies of the reports are available for a small fee. The Department also accepts telephone and mail requests for copies of the reports. Requests should be directed to: Department of Labor, PWBP Public Disclosure, Room N–4677, 200 Constitution Avenue N.W., Washington, D.C. 20216. The telephone number is (202) 523–8773.

C. Public Education and Information

The Office of Communications and Public Services (OCPS) has primary responsibility for implementing PWBP's public information program. It serves as a liaison with the public on ERISA-related issues and responds to their requests for information about the pension and welfare field. OCPS publishes literature and audio visual materials which explain in some depth provisions of ERISA, procedures for plans to effect compliance with the act, and the rights and protections afforded participants and beneficiaries under the law. In addition, it provides speakers on various topics affecting the pension and welfare field, and serves as a contact point for the media on all questions pertaining to ERISA.

During 1980, the National and field office staff of PWBP responded to 134,000 inquiries from plan participants, beneficiaries and other persons interested in the administration of plans. In fiscal year 1980, OCPS also distributed 660,000 copies of its publications explaining provisions of ERISA. Among the publications disseminated, the following are designed exclusively to assist the public in understanding the law and how their pension plans operate:

—What You Should Know About the Pension and Welfare Law (English and Spanish versions).
—Know Your Pension Plan.
—How to File a Claim for Benefits.
—Often Asked Questions About ERISA.

Further information about any of these services may be obtained by contacting the: Department of Labor, PWBP, OCPS, Room N–4659, 200 Constitution Avenue NW., Washington, D.C. 20216. The telephone number is (202) 523–8921.

D. Research and Development

PWBP 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.

During 1980, the following studies relating to pension plans and retirement were initiated:

(1) A study to analyze and test a comprehensive theory of why business firms offer pensions.

(2) A study of the relationship between expected and actual labor supply resources of older workers.

(3) A study to design and estimate a model of a worker's retirement decision.

(4) A study to analyze the effects of pensions on wage levels, and saving and retirement decisions.

(5) A study to determine the implications of ERISA funding requirements on firm behavior, workers and the stock market.

(6) A study of the financial incentives for early and disability retirement.

(7) A study to determine the effects of pensions and social security on the age of retirement.

Employment Standards Administration Programs

On July 1, 1979, the Equal Employment Opportunity Commission (EEOC) assumed enforcement responsibilities previously carried out by the Department of Labor under the Age Discrimination in Employment Act of 1967 (ADEA), as amended, with respect to protection against age discrimination in private sector and State and local government employment. (The EEOC had already assumed

responsibility on January 1, 1979, for ADEA enforcement in the Federal sector, for which the Civil Service Commission previously had jurisdiction.) Under Reorganization Plan No. 1 of 1978, which affected these transfers, the Department of Labor continues to be responsible for research (including studying the effects of the 1978 ADEA amendments) and for educational and informational activities under the ADEA relating to the expansion of employment opportunities for older persons.

In 1979, the Department awarded research contracts to enable the Secretary to fully implement the congressional directive in section 5 of the ADEA that calls for an appropriate study of institutional and other arrangements giving rise to involuntary retirement. The 1978 amendments to the act stipulated that the section 5 study include: (1) an examination of the effect on private sector and non-Federal public employment of raising the upper age limit from age 65 to 70, (2) determination of the feasibility of raising or eliminating the current (age 70) upper age limit, and (3) examination of the effects of the exemptions allowing mandatory retirement at ages 65 through 69 to tenured teaching personnel in institutions of higher education and of certain executive employees.

The research contracts awarded to assist the Department in meeting the section 5 study requirements will provide information on these and other issues related to involuntary retirement and the effect of raising the age at which mandatory retirement is allowed. Data on employment and retirement behavior of older persons are being analyzed to assess the impact of mandatory retirement on older workers and others in the labor force, including younger workers and minorities. A survey is being conducted to examine institutional settings and factors leading to mandatory retirement, the reasons for the establishment of mandatory retirement age standards and attitudes and perceptions regarding mandatory retirement. Responses of firms and employees to the change in the legally permissible mandatory retirement age under the ADEA have been investigated, including information concerning employer retirement, pension and personnel policies, and union retirement policies. Also, the effects of the executive employee exemption are being studied, and work under the contract focuses exclusively on investigating the effects of the temporary exemption for tenured teaching personnel in institutions of higher education. Smaller studies are also being conducted on the bona fide occupational qualification exemption, characteristics of older workers, and developments in employment opportunities for older workers. The results of the research are being utilized by the Department of Labor in developing its report on involuntary retirement for submission to Congress and the President.

ITEM 11. DEPARTMENT OF STATE

DECEMBER 19, 1980.

DEAR MR. CHAIRMAN: In response to the letter of October 30 from you and Senator Domenici to Secretary Muskie, we are pleased to supply the following information concerning activity related to the elderly.

In our letter of October 29, 1979, we mentioned the Supreme Court decision which upheld the constitutionality of age 60 as the mandatory retirement age for members of the Foreign Service. Since that time, the Congress, in passing the Foreign Service Act of 1980 (Public Law 96-465), raised the mandatory retirement age to 65 for members of the Foreign Service.

Other involvement in matters pertaining to the elderly during fiscal year 1980 except for the ongoing activities described in our letter of October 29, 1979, were limited to those United Nations initiatives with which the United States was closely identified. Most significant were the following:

—In December 1979, the United Nations General Assembly adopted resolution 34/153, a follow-on to resolution A/33/382 on which we commented in our report for fiscal year 1979. Most notably, resolution 34/153 urged full participation by all governments in the World Assembly on the Elderly, and requested the concerned specialized agencies of the United Nations system to give attention to the major issues concerning the aging.

—In May 1980, the Economic and Social Council in an effort to strengthen the United Nations planning mechanism for the Assembly, recommended to the General Assembly that there be a full-time Secretary General for the

World Assembly on the Elderly; that an Advisory Committee for the World Assembly composed of 23-member states be created and meet in early 1981; and that the World Assembly take place in Vienna, Austria, the last 2 weeks of August 1982. (The United States was appointed as 1 of the 23-member states on the Advisory Committee.)

—The first meeting of the 23-nation Advisory Committee will be expected to actually draft the conference agenda for approval by the General Assembly in the fall of 1981.

—On November 5, 1980, the United States presented a check for $250,000 to the Secretary General as a contribution to the World Assembly. The United States was the first Nation to contribute money to that voluntary fund, thereby highlighting U.S. interest in the Assembly.

—A United Nations World Conference on the United Nations Decade for Women dealing with equality, development, and peace, was held in Copenhagen, Denmark, in August 1980. The U.S. delegation to that meeting was strongly supportive of a draft resolution entitled "Elderly Women and Economic Security." This resolution was finally adopted by consensus by the conference. The resolution requested member states: (1) To insure that women are included in the planning process for and are appointed as members of their delegations to the World Assembly on the Elderly; (2) to give special attention to the problems that elderly women face in their societies; and (3) to collect data on elderly women for use by the World Assembly on the Aging.

—In June 1980, the International Labor Organization held its 66th Session in Geneva, Switzerland. One of the subjects on the agenda was a proposed recommendation which would insure that older workers would not be discriminated against. The U.S. delegation was fully supportive of this recommendation which was adopted by the conference.

Thank you for the opportunity to contribute to this year's committee report on the aging.

Sincerely,

J. BRIAN ATWOOD,
Assistant Secretary for Congressional Relations.

ITEM 12. DEPARTMENT OF TRANSPORTATION

JANUARY 26, 1981.

DEAR MR. CHAIRMAN: I am pleased to forward to you the enclosed report which summarizes significant actions taken by this Department during the past year to improve transportation facilities and services for older Americans. Additional information will be submitted subsequently regarding the Urban Mass Transportation Administration's actions. This report is being forwarded to you in response to your letters of October 30 and November 26, 1980, to former Secretary of Transportation, Neil Goldschmidt, requesting information for part 2 of the committee's annual report, "Developments in Aging."

If we can assist you further, please let us know.

Sincerely,

CHARLES SWINBURN,
Deputy Assistant Secretary for Policy and International Affairs.

Enclosure.

SUMMARY OF ACTIVITIES TO IMPROVE TRANSPORTATION SERVICES FOR THE ELDERLY [1]

INTRODUCTION

The following is a summary of significant actions taken by the U.S. Department of Transportation during 1980 to improve transportation for elderly persons.[2] The information included in the report was furnished by the Office of the

[1] Prepared for the U.S. Senate Special Committee on Aging—January 1981.

[2] Many of the activities highlighted in this report are directed toward the handicapped. However, more than one-third of the elderly are handicapped and will benefit from these activities.

Secretary and by the following operating elements of the Department: Federal Aviation Administration (FAA), Federal Highway Administration (FHWA), Urban Mass Transportation Administration (UMTA), and National Highway Traffic Safety Administration (NHtSA). Additional information regarding UMTA actions will be submitted subsequently.

REGULATIONS

Federal Aviation Administration.—On November 13, 1980, the Federal Aviation Administration issued a notice of proposed rulemaking that would allow blind passengers to keep their canes with them while on board air carrier aircraft. The comment period for this notice closed on January 12, 1981.

Federal Highway Administration.—Under DOT's section 504 regulation, existing safety rest area facilities on the Interstate Highway System are required to be accessible to and usable by the physically handicapped, including wheelchair users, within 3 years of the effective date of the regulation (July 2, 1979). The States were requested to survey their Interstate rest areas to determine which did not meet the applicable ANSI standards and to develop a schedule for their modification to make them accessible. FHWA will continue to monitor the States' efforts to assure compliance with the ANSI standards and the States' schedules.

FHWA, in cooperation with UMTA, continued monitoring the activities of metropolitan planning organizations in meeting the elderly and handicapped "special efforts" requirements in planning transportation facilities, as set forth in regulations governing transportation for elderly and handicapped persons.

FHWA continued to monitor State compliance with section 402(b)(1)(f) of title 23, U.S.C., which provides for curb cuts at newly constructed pedestrian crosswalks, and the FHWA requirement that all new facilities on Federal-aid highways be designed to accommodate handicapped persons.

Federal Railroad Administration.—In mid-1980, Amtrak submitted to FRA its transition plan for compliance with the Department's regulation implementing section 504 of the Rehabilitation Act of 1973. The plan sets forth the various modifications necessary to make Amtrak's passenger railroad stations, vehicles, and services accessible to handicapped persons over the next 10 years. Amtrak's Board of Directors recently approved the expenditure of $2.9 million for accessibility improvements to 18 of the 23 stations scheduled for retrofit in 1981.

POLICIES AND GUIDELINES

Federal Aviation Administration.—FAA continues to work with the Air Transport Association in developing uniform procedures among airlines for transporting elderly and disabled persons. The background gained from this effort was used during 1980 to assist Civil Aeronautics Board personnel in preparing their rule implementing section 504 of the Rehabilitation Act of 1973. The CAB has indicated that the final rule will be issued in early 1981.

Investigators of aircraft accidents are continuing to feed information into FAA's Civil Aeromedical Institute computer bank on the human factors aspects of aircraft accidents and incidents. This information should prove useful to the FAA and the airline industry in the identification of special problems that are likely to be experienced by elderly and disabled persons during airline accidents.

Federal Highway Administration.—In 1979 the FHWA entered into an agreement with the Architectural and Transportation Barriers Compliance Board (A. & T.B.C.B.) to facilitate continued progress in making Federal-aid pedestrian underpasses and overpasses accessible to handicapped persons. Under that agreement, almost all States completed in 1980 an inventory of their pedestrian underpasses and overpasses constructed since 1969 with Federal-aid highway funds, to determine which facilities do not meet section 5.1 of the ANSI standards. FHWA urged States to develop a schedule for modifications of inaccessible facilities to make them accessible to handicapped persons. FHWA reviewed the results of the inventories and those schedules which had been developed by States, conducted other field reviews to further emphasize the need to construct facilities to accommodate handicapped persons and to urge States to complete their inventories.

The FHWA's rural public transportation program under section 18 of the Urban Mass Transportation Act, of 1964, as amended, has increased public transportation service in nonurbanized areas. The program has benefited the elderly both directly and indirectly. Section 18 projects are required to be coordinated with other federally funded systems, including special systems for the elderly.

To improve this coordination, FHWA issued a paper in February, issued guidelines on joint coordination with the Department of Health and Human Services in April, and issued further guidelines on coordination to its field staff.

Federal Railroad Administration.—Throughout fiscal year 1980, Amtrak continued its systemwide policy of offering a 25-percent fare discount on all one-way tickets valued above $40 to all elderly passengers.

CAPITAL ASSISTANCE

Federal Aviation Administration.—FAA obligated $1 million to its two local airports for modifications to improve access to these facilities by elderly and disabled travelers. The amount available is $550,000 for Washington National Airport and $450,000 for Dulles International Airport.

The modifications which are underway or which have been completed include: (1) Increasing the number of parking spaces for elderly and handicapped persons, (2) lowering curbs at crosswalks, (3) installation of ramps for persons who cannot use stairs, (4) installation of amplified telephones for use by persons with hearing impairments, (5) assisting with installations of TELEX for use by persons who are totally deaf, (6) provision of private toilet facilites for persons who require the assistance of attendants, and (7) placing into service a lift-equipped van for use by persons traveling between the terminal and the Metrorail station at National Airport.

Under FAA's airport development aid program, Federal and State funds in excess of $263 million have been obligated by airport operators for improving terminal facilities. A condition for accepting these grants is that improvements must incorporate the requirements of the ANSI standards.

Federal Highway Administration.—The relatively new section 18 program provided assistance for project administration, capital assistance, and operating assistance for public transportation service in nonurbanized areas. About $57 million were obligated for such activities in fiscal year 1980. This funding helped start new transportation systems and expanded others that directly benefited the elderly.

INFORMATION DISSEMINATION

Office of the Secretary.—The Department's technology sharing program finalized a summary report entitled "Transportation for the Elderly and Handicapped: Programs and Problems II." This report, which will be distributed widely early during 1981, is a companion document to an earlier literature capsule and a report on transportation programs disseminated previously through technology sharing. Other reports being finalized at DOT's Transportation Systems Center for the technology sharing program include a state-of-the-art report on small buses and overview of wheelchair restraint devices.

Technology sharing reprinted several reports during 1980 related to the topic and made them available to State and local government users: (1) "Coordination of Transportation by Human Service Agencies: An Interorganizational Perspective," January 1980. (2) "Transportation Options for the Mobility Disadvantaged in Rural Georgia," May 1979. (3) "Planning and Coordination Manual for Elderly and Handicapped Transportation Services," January 1979. Other reports relating to rural and small urban transportation were also reprinted.

Federal Aviation Administration.—FAA has distributed a 25-minute slide presentation with cassette sound track to all FAA regional offices which illustrates some of the problems disabled persons experience in traveling through airports. This audio visual presentation, released in mid-1980, assists aviation personnel in understanding problems disabled persons experience using airport terminal facilities, and solutions to these problems.

During 1980, FAA, in cooperation with the Airport Operators Council International and the Architectural and Transportation Barriers Compliance Board, completed the second printing of the third edition of "Access Travel: Airports." This guide lists 70 design features, facilities, and services available to elderly and disabled travelers at 282 airports terminals in 40 countries. Single, free copies can be obtained by writing to: Access America, Washington, D.C. 20201.

WORKSHOPS AND CONFERENCES

Office of the Secretary.—The Department served as a cosponsor of the National Miniconference on Transportation for the Elderly, endorsed by the White House Conference on Aging. The material from this session is being used to develop a

technical resource document on solutions to the transportation problems of the elderly. The report, which will be distributed through the Department's technology sharing program, should be available in mid-1981.

Federal Aviation Administration.—FAA continues to conduct cabin safety workshops for airline industry personnel. During each 3-day workshop, emphasis is given to procedures for assisting elderly and disabled persons under emergency conditions. During 1980, these workshops were attended by union and management personnel, emergency procedures instructors, engineers, pilots, and technical experts representing 22 U.S. airlines, 3 foreign airlines, and Transport Canada. A total of 92 persons attended the 12 workshops held in 1980 including a special workshop held for safety representatives from the Airline Pilots Association.

Federal Highway Administration.—Under the sponsorship of FHWA's National Highway Institute (NHI), four different training courses were conducted in 1980 that included discussions of transportation problems of elderly and handicapped persons. These courses were presented for a combined total of 35 presentations. The courses were "Relocation Assistance Advisory Services," "Pedestrian and Bicycle Consideration in Urban Areas—An Overview," "Improving the Effectiveness of Public Hearings and Meetings," and "Safety Design and Operational Practices for Streets and Highways." In addition, NHI had four other courses under development for presentation in fiscal year 1981.

Urban Mass Transportation Administration.—A grant was made to Florida State University to assist in a White House Miniconference on Aging in the area of transportation. The proceedings of this conference will be used by the delegates at the 1981 White House Conference on Aging.

RESEARCH COMPLETED

National Highway Traffic Safety Administration.—The feasibility of developing a medical condition data collection system was the subject of a final report of an epidemiological study dealing with the relationship of medical conditions and driving. Because the incidence of medical conditions is much higher in older people, the study population consisted of a significant number of elderly drivers.

RESEARCH ONGOING

Office of the Secretary.—In January 1980, a study was initiated to assess progress and problems by mass transit recipients in complying with the requirements of the Department's regulation implementing section 504 of the Rehabilitation Act of 1973. Through site visits and interviews with local officials, transit operators and handicapped persons in 16 U.S. cities which have bus and/or rail transit systems, contractors examined, in particular, the process at the local level of developing transition plans for accessibility under the regulation, and the nature, status, and anticipated funding levels of proposed accessibility improvements. A final report on the study will be available early in 1981.

Federal Aviation Administration.—During fiscal year 1980, FAA designated $25,000 for the development of three projects to aid the elderly or disabled air traveler. These projects are: (a) The development of a specification for a vertical lifting device to transfer elderly and disabled persons from ground level to the aircraft passenger door, (b) an analysis of the types of assistance that must be provided to elderly persons and different classes of disabled persons, and (c) the development of performance specifications for teletypewriter equipment (TTY), airport terminal information, and directory assistance (visual and aural).

FAA's Civil Aeromedical Institute is currently analyzing biomedical factors associated with the successful escape of passengers and crewmembers and the lessons learned from accidents where escape has been either marginal or successful. Special emphasis is being given to the escape problems of handicapped travelers and the improvements in the state-of-art proposed by government and industry. Results of biomedical and engineering research on the escape problem will be published and applied to improvements in both escape systems hardware and evacuation procedures.

National Highway Traffic Safety Administration.—NHTSA awarded a contract to the National Public Services Research Institute and Texas A. & M. University to conduct an extensive evaluation of the National Retired Teachers Association/American Association of Retired Persons (NRTA/AARP) older driver training

program. This program consists of a defensive driving course (DDC) originally designed by the National Safety Council for commercial drivers and modified by NRTA/AARP for the elderly driver. With a membership of 12 million and over 27,000 DDC graduates, this program provides a unique opportunity for collecting data on the particular driving problems of the elderly driver and learning what NHTSA can do to eliminate them. The final report for this project is expected to become available in July 1981.

Supported by a grant from NHTSA, Dunlap & Associates is conducting a study to investigate road accident risk levels for heart attack victims. NHTSA anticipates that this effort will provide guidelines for similar work on other medical conditions such as diabetes mellitus, seizure disorder, and glaucoma.

NHTSA is field testing three driver's manuals for novice, experienced, and older drivers in the State of Nebraska. The test involves one experimental group who will receive the new manual appropriate to his/her driving experience and age, and two control groups. (One group will receive the current State driver's manual and the other will receive no manuals at all.) NHTSA hopes this test will show an accident reduction rate as a result of presenting more relevant information to the driving applicant. If it does, NHTSA will have found a virtually no-cost countermeasure, since States routinely distribute manuals to driver license applicants.

Urban Mass Transportation Administration.—A grant was made to Dayton, Ohio, to test several methods of collecting data on the geographic distribution of elderly and handicapped persons. The results of these tests will be disseminated to metropolitan planning organizations and transit authorities in 1981.

A grant was made to Norfolk, Va., to document a unique planning process developed by that city's metropolitan planning organization and the United Way. This process provides for the utilization of taxis and social service agencies in providing transportation for elderly and handicapped persons.

Two cities, Pittsburgh, Pa. and Phoenix, Ariz., will test a previously developed manual on phasing full-size accessible buses into regular transit service. Such things as disruption of service and maximum benefits to handicapped persons will receive particular attention.

Jointly with the Department of Health and Human Services, a state-of-the-art report was developed on training handicapped persons to use transit.

DEMONSTRATIONS

Office of the Secretary.—FHWA and UMTA, with OST technical support and monitorship, are supporting a six-State demonstration on simplification of billing and accounting requirements for social service and public bus systems. The States involved are South Carolina, North Carolina, Michigan, Massachusetts, Iowa, and Arkansas. The Department of Health and Human Services (HHS) is also supporting the project.

Federal Highway Administration.—The 4-year pedestrian safety demonstration project is continuing in the Commonwealth of Puerto Rico. This project specifically recognizes that older persons are overrepresented in pedestrian fatality statistics, and will include an evaluation of measures to enhance the safety of older pedestrians. A study entitled "Priority Accessible Networks" is validating a user's manual of the same title. This manual is designed to offer guidance to local persons involved in developing a transportation network for elderly and handicapped pedestrians. Details on the design of individual elements of such networks are also included.

FHWA is also sponsoring a demonstration in Vermont to improve coordination between nonurbanized public, social service, and intercity bus transportation.

Urban Mass Transportation Administration.—UMTA amended and extended grants which support the Lawrence, Mass., user subsidy and the Pittsburgh, Pa., transportation brokerage demonstrations.

A cooperative agreement with the Department of Health and Human Services will result in a study of insurance problems of social service agency transportation providers.

The following is a list of relevant new demonstration grants made:

—Chico, Calif., for a user subsidy demonstration.

—San Diego, Calif., to plan a social service coordination demonstration.

—Pasadena, Calif., to plan a brokerage paratransit system.

ITEM 13. DEPARTMENT OF THE TREASURY

JANUARY 15, 1981.

DEAR LAWTON: In response to your and Senator Domenici's request, I am pleased to submit the Treasury's report on activities during 1980 which affected the aged. I hope this information will be useful both to the committee and to others concerned with the welfare of older Americans.

Best wishes.

Sincerely,

G. WILLIAM MILLER, *Secretary.*

Enclosure.

TREASURY ACTIVITIES IN 1980 AFFECTING THE AGED

The Treasury Department recognizes the importance and special concerns of older Americans, a group comprising a growing proportion of the population.

In the area of economic policy, the Treasury has been involved in the development and implementation of administration policies to fight inflation, which strikes particularly hard at retired persons living on fixed income. The Secretary, as managing trustee of the social security trust funds, is also concerned with preserving the financial soundness of social security, a major source of income to persons over the age 65.

The agency of the Treasury with whom the greatest number of older Americans have contact is the Internal Revenue Service (IRS). Special activities of the IRS directed at helping persons age 65 and over are detailed in the next section. Activities of other Treasury agencies which affect older Americans are summarized in the last section of the report.

INTERNAL REVENUE SERVICE ACTIVITIES AFFECTING THE AGED

The Internal Revenue Service places considerable emphasis on informing older Americans of their tax rights and responsibilities. IRS also continues to make a special effort to inform these individuals who, because of immobility, impaired health, or any of several other factors, may miss out on some tax benefits to which they are entitled unless IRS reaches them directly.

During 1980, IRS expanded assistance to older Americans through the tax counseling for the elderly (TCE) program. Training for TCE volunteers emphasized tax problems of the elderly. Lessons included information on tax credits for the elderly, estimated tax payments, and pension income.

In addition, IRS issued a number of informational materials targeted towards older Americans. Those materials had the following themes:

—Single taxpayers aged 65 and over are not required to file a Federal income tax return unless their income for the year was $4,300 or more (as contrasted with $3,300 or more for a single taxpayer under age 65). Married taxpayers who could file a joint return are not required to file unless their joint income for the year was $6,400 or more, if one of the spouses was 65 or over, or $7,400 or more if both were 65 or over. This is because all taxpayers age 65 or over get an extra personal exemption of $1,000. (See Publication 554 for further information.)

—The special tax credit for the elderly enables persons over 65, and also persons under 65 who had pension or annuity income from a public retirement system, to reduce their taxes by as much as $375 if single, or $562.50 if married filing a joint return. (See Publication 524.)

—The entire gain on the sale of a house before July 27, 1978 can be excluded from income if the selling price is $35,000 or less. For selling prices above $35,000, a part of the gain is excludable. For houses sold after July 26, 1978, those age 55 and over are allowed a once-in-a-lifetime exclusion of up to $100,000 of gain on the sale. (See Publication 523.)

—Much of the income received in retirement years is free from Federal income tax. This includes social security payments, railroad retirement benefits, payments from a general welfare fund, and payments for blindness. (See Publications 567 and 575.)

—Retirees with taxable pension income can avoid paying estimated tax or receiving a large tax bill at the end of the year by filing Form W–4P authorizing the payer of the pension to withhold taxes from the pension payments.

—Tax issues of particular interest to handicapped and disabled people are covered in a new pamphlet, Publication 907.

All publications are available free of charge at IRS offices. They are also used extensively in taxpayer education programs, often in cooperation with organizations especially interested in problems of retired people. In addition, IRS personnel provide such services as free tax information by mail, free telephone assistance, walk-in service at many IRS offices, and temporary offices during the filing season.

To communicate tax information of interest to the elderly, the IRS used the print and broadcast media, specialized newsletters, and organizations serving older Americans:

—To publicize the new tax counseling for the elderly (TCE) program, in which nonprofit organizations provide free tax information and assistance to individuals age 60 and over, the IRS produced a 12½-minute film, "A Right Good Thing." The film, which describes tax situations, frequently experienced by the elderly and depicts how the older taxpayer can get assistance at a local TCE site, is available free of charge to any interested group or organization.

—Also, to publicize TCE and other tax benefits for the elderly, two filing-season TV and three radio spots were produced as well as a drop-in ad for distribution to magazines, and a taxpayer information materials (TIM) package containing featurettes, news releases, newsletter items, a question and answer column, a live copy radio spot and a 2-minute radio program.

—Two filmed television public service announcements (PSA) were produced and were sent to each of the three major networks and approximately 1,000 television stations nationwide. Statistics from Broadcast Advertisers Reports, a firm which tracks the play of commercials and PSA's, indicate that these "Benefits for Older Americans" PSA's were used extensively.

—Three recorded radio PSA's were sent to the major networks and to about 6,700 local radio stations. Live copy radio material provided to these outlets was also widely used.

—Materials for the print media were provided to newspapers, periodicals and newsletters nationwide. Print materials also were sent to senior citizen and retirement organizations such as the American Association of Retired Persons, National Council of Senior Citizens, National Retired Teachers Association, and to State offices of services for the aging. A newspaper supplement with an article geared toward older Americans was sent to 4,500 local newspapers.

—Our inspectors made speeches to senior citizens groups to warn them of fraudulent schemes to victimize the elderly, including methods used by unscrupulous tax preparers. During fiscal year 1980, inspectors arrested an individual who posed as an IRS employee to obtain money and property from senior citizens.

The IRS assisted various governmental agencies in their administration of the Age Discrimination in Employment Act as it pertains to employee retirement plans. These agencies include the Department of Labor, the Pension Benefit Guaranty Corporation, and the Equal Employment Opportunity Commission.

Regulations and Rulings Activities

During 1980 proposed regulations under IRC section 37 were issued relating to the income tax credit for the elderly (2–27–80). Final regulations are expected to be adopted by the end of 1980. Also, final rules were adopted relating to tax counseling for the elderly (1–29–80).

In 1980, the IRS published the following revenue rulings generally affecting senior citizens:

(1) Rev. Rul. 80–45, 1980–8 I.R.B. 7, holds that unreimbursed expenses for transportation, paper and pencils, newspaper advertising, and similar items incurred by volunteers in connection with their participation in the volunteer income tax assistance (VITA) program are deductible under section 170 of the Code.

(2) Rev. Rul. 80–172, 1980–27 I.R.B. 7, holds that a taxpayer who otherwise meets the requirements of section 121 of the code may make the election to exclude gain on the sale of a personal residence if the ownership and use tests are met, even though the tests are not met simultaneously.

(3) Rev. Rul. 80–248, 1980–37 I.R.B. 10, pertains to interests on "reverse mortgage loans." The primary purpose of such loans is to enable elderly persons with limited income to remain in their homes. The ruling holds that interest which is added monthly to the outstanding loan balance as it accrues is neither includible in a cash method lender's gross income nor deductible by a cash method borrower at the time it is added.

(4) Rev. Rul. 80–249, 1980–37 I.R.B. 11, holds that, where a taxpayer who realized a gain on the sale of a principal residence elected to exclude the gain under section 121 of the code and elected to use the installment method of reporting income from the sale, in determining the amount of each installment payment that is reportable under the installment method of accounting, gross profit in the formula provided in section 453(a)(1) is the amount of the gain that is not excludable from gross income.

(5) Rev. Rul. 80–325, 1980–59 I.R.B. 6, supersedes Rev. Rul. 63–167, 63–168, and 63–169, relating to the effect of community property laws on the computation of retirement income credit for a social security beneficiary, a civil service retiree, and an armed forces retiree, with respect to the tax credit for the elderly in the case of a joint return filed for a taxable year beginning after December 31, 1977, because section 37(e)(8) of the code, which applies to taxable years beginning after December 31, 1977, provides that section 37(e) applies without regard to community property laws in the case of a joint return.

(6) Rev. Rul. 80–340, 1980–50 I.R.B. 8, holds that the extra cost of a specially equipped television set that provides deaf individuals with a visual display of the audio portion of television programs and the cost of an adaptor for a conventional television set that performs the same function are medical expenses.

The following rulings pertain to employee retirement plans:

(1) Rev. Rul. 80–27, 1980–1 C.B. 85, holds that retirement benefits being paid to a retiree can, by court order, be reallocated and paid as alimony or support to the retiree's spouse, former spouse, or dependent children without adversely affecting the tax qualified status of the plan. This has the effect of enforced sharing of retirement incomes with spouses that otherwise might not be able to provide for themselves. The elderly are particularly vulnerable when there is a family separation and withdrawal of financial support by the working or retired spouse. Consequently, this ruling is of considerable significance to them.

(2) Rev. Rul. 80–128, 1980–1 C.B. 86, provides that an employee of two corporate employers, whose separate qualified plans were funded by contributions to a single trust, may terminate employment with one of the employers and receive a lump-sum distribution. This holding has particular relevance to the aged because they are susceptible to physical impairments that eventually discourage continued multiple employment but would likely have an immediate need for supplemental income prior to the time of full retirement.

(3) Rev. Proc. 80–17, 1980–1 C.B. 621, sets out rules of procedures for sponsors of prototype simplified employee pensions (SEP). SEP's were made available in 1979 to encourage retirement contributions by employers for the benefit of their employees. Prototype SEP's will be reviewed by the Service to ensure technical accuracy. Diversity among prototype SEP's will provide a wide selection of statutorily allowable features. Unlike individual retirement accounts, SEP's have a much higher contribution limitation ($7,500 versus $1,500), and are available for employees over age 70½. The impact of these kinds of easily administered and inexpensive retirement programs should be to increase the level of retirement funds available to senior citizens.

(4) Rev. Rul. 80–122, 1980–1 C.B. 84, adds a measure of flexibility for plans which provide that benefit payments may be suspended for a period during which a former retiree returns to work. This could also benefit the employee who may thus be able either to increase the ultimate retirement benefit or prolong the benefit payments. Validation of this kind of plan provision may also have the effect of encouraging companies to rehire former employees who find employment preferable to retirement.

(5) Notice 80–7, 1980–1 C.B. 578, makes procedures available to salvage plans that do not meet the requirements for tax qualified status. In order to obtain full reinstatement, such plans must provide contributions and benefits (to all those who would have been eligible if the plan had conformed to the requirements from the beginning) at levels required by the code. Because this program will potentially impact on about 30,000 plans, it will have the effect of increasing retirement incomes for substantial numbers of present and future older citizens.

(6) Rev. Rul. 80–276, 1980–42 IRB 6, provides reassurances that profit-sharing plans may continue to provide that participants can receive distribution of benefits at a stated normal retirement age of less than 65 years, even if the participant does not actually retire. The result is that the employee of such a plan can have a more gradual retirement transition.

Forms Activities for the Elderly

A highlight has been added to the 1980 packages and instructions for Forms 1040 and 1040A to alert retirees that they may need to make estimated tax payments and thereby avoid any penalties for underestimation of estimated tax.

The instructions for Form W–4P, Annuitant's Request for Federal Income Tax Withholding, have been revised to caution taxpayers that they may be subject to estimated tax penalties if not enough tax is withheld or paid by estimated tax on taxable pensions and annuities.

OTHER TREASURY ACTIVITIES AFFECTING OLDER AMERICANS

Other agencies of the Treasury may have an impact upon the aged as part of their specific functions. Developments during 1980 include:

—The Treasury supported legislation to phase out Regulation Q, an interest rate ceiling on deposits in financial institutions. While large depositors can achieve near-market interest rates by purchasing money market certificates ($10,000 minimum denomination), small depositors, often the elderly, are limited to a 5¼ percent passbook interest rate (5½ percent for depositors at thrift institutions). Small depositors are likely to receive more equitable interest rates by phasing out Regulation Q. The President signed this legislation (Depository Institutions Deregulation and Monetary Control Act) on March 31, 1980.

—The Treasury continued its expansion of the direct deposit program for Federal recurring payments. This program offers an added measure of convenience and security to many people, including retirees, who depend on regular Government checks by permitting direct deposits into a personal checking or savings account. The service was implemented in 1975 and now includes social security benefit, supplemental security income, civil service retirement, railroad retirement, Veterans Administration compensation and pension payments, and certain Federal salary payments. As of December 1980 over 12.6 million recipients have enrolled in the program, representing over 28.6 percent of total recipients. Since 1977, a nationwide educational campaign has been underway to inform recipients about the advantages of the program. Treasury's goal is to have 55 percent of all eligibile recipients enrolled in the program by 1985 and 80 percent by 1990.

—The Treasury also continued to protect elderly recipients of Government payments through the vigilance of the Secret Service. During fiscal year 1980, the Service closed 15,407 social security check forgery cases and 5,581 supplemental security income forgery cases. Most of these checks were issued to retirees. Approximately 64 percent of the checks were cleared, that is, the identity of the forger discovered.

Finally, the Department of the Treasury makes every attempt to participate in the governmentwide effort to end discrimination against particular groups, including the aged, in employment and in the accessibility of public information and facilities:

—Throughout the Department's facilities, architectural modifications and new buildings include ramps, security bars in restrooms, and other aids to insure that Treasury facilities are usable by all individuals, including the elderly handicapped.

—In employment, Treasury Offices and Bureaus have implemented a part-time employment program (PTEP) as a result of Public Law 93–437 (October 10, 1978). Implementation of the program includes a particular focus on special interest groups such as organizations of older people. The PTEP is a viable and effective vehicle through which retirees and the elderly can obtain meaningful and valuable employment. The employment of the elderly benefits both the individual by supplementing his or her financial intake and the agency by the addition of productive employees to the regular work force.

—A retirement planning seminar was presented to approximately 550 Treasury employees in the Washington, D.C., metropolitan area. The seminar, con-

sisting of three 4-hour sessions, was designed to assist employees in pre- and postretirement financial, housing, health, and life pursuit planning. Similar seminars are offered by the Philadephia Mint and will be available throughout the Bureau of the Mint in succeeding fiscal years.

Office of Revenue Sharing Activities Affecting the Aged

General revenue sharing provisions affecting the aged

The general revenue sharing program is a direct general fiscal assistance program that provides funds to State and local governments. No application is required of State and local jurisdictions to receive these moneys, although a statement of assurance of compliance with the revenue sharing law is required. Therefore, revenue sharing is described best as an entitlement program.

Congress created the program in 1972 with the intent of sharing Federal income tax with State and local governments. Legislative provisions of the program indicate an intent to disburse these funds with minimum restrictions on the use of funds and allow maximum flexibility by State and local officials in determining how they spend the money.

The State and Local Fiscal Assistance Act of 1972 (Public Law 95–512) was authorized for a period of 5 years to end in December 1976. However, the program was extended first under the 1976 amendments (Public Law 94–488) through September 30, 1980, and extended a second time in December 1980 under Public Law 96–604 through September 30, 1983. For the respective periods, a total of $74 billion will be distributed to State and local jurisdictions based on a formula prescribed by the Revenue Sharing Act.

Originally, State and local governments were required to use the funds in priority categories contained in the act. Under the 1976 amendments, the funds may be used for any purpose which is a legal use of the jurisdiction's own funds under State and local law. Thus, recipients are to this extent free to use shared revenues for expenditures of benefit to the aged.

Extension of the program in 1976 brought a number of substantive changes from the original act, which became effective January 1, 1977, and remain primarily intact under the 1980 amendments. Among the 1976 amendments are the following changes which could be viewed as affecting elderly persons. Specifically, the 1976 amendments:

—Strengthened the nondiscrimination requirements to include specific protection against age discrimination. This provision, which became effective July 1, 1979, does not apply to employment discrimination.

—Provided for special public participation requirements relative to the participation of citizens in the decisions on expenditure of GRS funds and encouraged recipient governments to include senior citizens in this process.

—Repealed the provisions which restricted the use of funds to certain priority expenditure categories. Eliminated the prohibition against the use of revenue sharing funds as local matching money for Federal grants.

The removal of the prohibition against using GRS funds as matching money for Federal grants may have increased the availability of funds for use in the social services areas.

GRS contributions to aged Americans are likely to be found primarily in the areas of public participation and nondiscrimination. Activities in these areas which may increase the accessibility and accountability of governments to the aged as a special class are:

—Publication of the proposed age and handicapped discrimination regulations in December 1979.

—Publication in January 1981 of the final regulations with respect to a qualified handicapped individual. These regulations address service delivery, employment, and accessibility of programs to the handicapped.

—The delay in publication of ORS's final age discrimination regulations is due to OMB's failure to approve the recordkeeping requirements as set by HHS's governmentwide regulations. Nonetheless, ORS is currently enforcing the age discrimination regulations of 1975 by authority of 45 CFR, part 90, pending OMB approval of its own regulations.

—Participation by ORS in two major workshops on sec. 504 of the Rehabilitation Act of 1973. These workshops were sponsored by the National League of

Cities and the U.S. Conference of Mayors, and provided an opportunity for the Office of Revenue Sharing to inform mayors, city managers, and other city officials about the handicapped provisions of the Revenue Sharing law.

The Office of Revenue Sharing continues to conduct outreach activities to groups requesting assistance in program interpretation. It also follows up on all complaints filed with it.

HIGHLIGHTS OF 1980

A considerable effort was expended during the fiscal year on trial computer runs and other activities concerned with the renewal of general revenue sharing. Testimony was offered before both Houses of Congress and substantial materials were supplied to them. At the end of the fiscal year, the Congress was still considering renewal.

During fiscal 1980, increased emphasis was placed on followup reviews of State audit agencies whose performance had been determined to be unacceptable. By the end of the year all of the State audit agencies had either achieved an acceptable status or the recipients involved had arranged to have their audits performed by independent public accountants. By the end of fiscal 1980, 19,554 audit reports had been submitted to the Office of Revenue Sharing or to appropriate State audit agencies.

The number of civil rights complaints continued to increase during this fiscal year, with 1,236 cases carried over into fiscal 1981.

More than 200 public participation complaints were received in fiscal 1980; 199 cases were closed during the year.

Public Participation

The 1976 amendments to the Revenue Sharing Act require each State and local government to conduct two public hearings prior to appropriating revenue sharing funds. The function of the hearings is to provide the public with the opportunity to suggest possible uses for the funds and to comment on uses proposed by elected officials. Public notice of the hearings and the availability for public inspection of budget documents and revenue sharing use reports are integral to this process.

Investigations were undertaken of more than 200 recipient governments to assure compliance with the public participation requirements; 199 cases were closed during the fiscal year. Direction was provided to those jurisdictions which failed to comply in order to enable them to take voluntary corrective action. The compliance efforts of five jurisdictions were reviewed following completion of the initial investigation to provide technical assistance where needed.

Outreach activities were carried out to advise members of nationwide community interest organizations of the opportunities for public participation in the revenue sharing program. The public participation staff participated in the national conventions of seven community interest organizations. The operations of the Office of Revenue Sharing were described at the conventions and public participation publications were distributed.

Technical Assistance to Recipient Governments

The Office of Revenue Sharing provides information and technical assistance concerning the program to State and local governments receiving general revenue sharing funds.

Technical assistance was provided to recipients through more than 2,800 letters in response to written requests for specific information and guidance. In addition, thousands of telephone contacts were made with recipient governments, various organizations, and others interested in the revenue sharing program. Eight technical papers have been prepared on various aspects of the program.

The Office has established a network of about 600 liaisons within the 50 States. Over 70 technical assistance workshops were conducted during the year for the benefit of recipient governments, in cooperation with these liaisons and other cosponsors.

Quarterly, each of the more than 39,000 recipient governments was sent an informational letter to help them comply with public participation and other requirements of the program.

Civil and Human Rights

Section 122 of the Revenue Sharing Act provides that: "No person in the United States shall, on the grounds of race, color, national origin, or sex, be excluded from participation in, be denied the benefit of, or be subjected to discrimination under any program or activity of a State government or unit of local government, which government or unit receives funds * * *. Any prohibition against discrimination on the basis of age under the Age Discrimination Act of 1975 or with respect to an otherwise qualified handicapped individual as provided * * * shall also apply to any such program or activity. Any prohibition against discrimination on the basis of religion, or any exemption from such prohibition, as provided * * * shall also apply to any such program or activity."

Although the Civil Rights staff is small, it has investigated a significant number of complaints, many of which have been closed through negotiation and voluntary compliance. In those instances where recipient jurisdictions have been reluctant to take the necessary steps to comply with civil rights requirements, ORS has initiated action requiring them to do so.

Shown below is a table that demonstrates the growth of the activities of the Civil Rights Division.

DISCRIMINATION COMPLAINTS

Year	Received	Discrimination/ findings	Closed	Carried over
1972	2	0	0	2
1973	27	1	2	27
1974	75	14	26	76
1975	213	8	29	260
1976	229	7	71	418
1977	276	125	142	552
1978	306	156	184	674
1979	330	179	228	776
1980	677	151	217	1,236

The Office continued to work in a cooperative effort with several Federal agencies to help resolve discrimination complaints and to assist in conducting field investigation. The Office is attempting to renegotiate cooperative agreements with the Federal agencies with which it had shared agreements under the 1972 Revenue Sharing Act.

Preparation of a more extensive civil rights compliance manual for processing complaints is in progress and should be completed in fiscal 1981.

Audit Procedures

The 1976 amendments to the Revenue Sharing Act require each recipient government receiving $25,000 or more annually in revenue sharing entitlements to have an independent audit of its financial statements in accordance with generally accepted auditing standards, not less often than once every 3 years, to determine compliance with the act. This requires a financial audit of all funds and a compliance audit of revenue sharing and antirecession fiscal assistance funds. The audit requirements are applicable to about 11,000 of the nearly 38,000 revenue sharing recipients. At the end of the 1980 fiscal year 64 percent of the recipient governments subject to the audit requirements had fully complied. Table 1 shows the status of all governments which must be audited. All but 5 percent of these governments filed audit reports or acceptable audit plans with the Office of Revenue Sharing by the end of the fiscal year.

There are 63 State audit agencies involved in auditing State and local governments (some States have a separate audit agency responsible for auditing the State accounts and another agency responsible for local governments.) ORS reviewed the professional practices of all State audit agencies in previous fiscal years and found 20 of the agencies to be performing unacceptable audits for revenue sharing purposes. During the 1980 fiscal year, emphasis was placed on performing followup reviews of the unacceptable agencies to determine whether progress had been made in correcting the deficiencies.

In addition to the reviews of State audit agencies described above, the fiscal year's major emphasis was placed on the review of audit reports submitted by recipient governments. By the close of the fiscal year, 19,550 audit reports had been submitted to the Office of Revenue Sharing or to State audit agencies by 9,627 recipient governments. (In many instances a government is required to submit more than one report in order to cover "all of its funds" as required by the act.) Of the reports submitted, 13,735 were received in 1980 with approximately one-half of them being submitted directly to ORS. The reports reviewed by ORS and State audit agencies during the current fiscal year resulted in 5,413 governments satisfying the audit requirements during fiscal 1980.

TABLE I.—GENERAL REVENUE SHARING AUDIT REPORTS STATUS RECAP, SEPT. 30, 1980

Status category	Number of governments	Percent
1. Total governments subject to audit	10,946	100
2. Fully acceptable	6,956	64
3. Partially acceptable [1]	1,209	11
4. Unacceptable	109	1
5. Unauditable	14	
6. Not reviewed [2]	1,339	12
7. Governments filing audit reports (total lines 2 through 6)	9,627	88
8. Audit plan filed [3]	783	7
9. Total (lines 7 and 8)	10,410	95
10. Delinquent governments [4]	536	5
11. Total (lines 9 and 10)	10,946	100

[1] Governments that have filed either a financial or compliance report that has been accepted; second report pending. Also includes governments with partial audit submissions.
[2] Governments that have submitted reports to State audit agencies or ORS and the reports have not been reviewed as of the report date.
[3] Governments that have not filed audit reports but have filed acceptable plans for submitting the report.
[4] Governments that failed to respond to the audit requirement or responded by filing plans and then failed to meet the plan dates.

TABLE II.—OFFICE OF REVENUE SHARING, AUDIT DIVISION WORK MEASURES, THROUGH SEPT. 30, 1980

Noncompliance cases	Fiscal year— Through 1976	1977	1978	1979	1980	Cumulative through 1980
Revenue sharing:						
Balance beginning of period		265	390	178	102	
Cases opened	779	495	364	183	111	1,932
Total	779	760	754	361	213	1,932
Cases closed	514	370	576	259	126	1,845
Balance end of period	265	390	178	102	87	87
Antirecession:						
Balance beginning of period				16	39	
Cases opened		4	35	69	39	147
Total		4	35	85	78	147
Cases closed		4	19	46	49	118
Balance end of period		0	16	39	29	29

Copies of audit reports must be submitted to ORS if they disclose violations of Revenue Sharing or Antirecession Fiscal Assistance Acts and regulations. Copies of audit reports issued by independent public accountants (IPA's) for which a State auditor has no legal responsibility must also be furnished to IRS. State auditors provide ORS with a quarterly report listing audit reports

which they issue or receive for review from IPA's that do not contain violations of the Revenue Sharing or Antirecession Fiscal Assistance Acts or regulations. These reports are kept on file by the State auditors for review by the Audit Division as a part of the periodic reviews made of State auditors' technical performance.

In fiscal 1980, 111 noncompliance cases were opened of which 98 resulted from findings contained in audit reports. Cases closed totaled 126. Thus, open cases were reduced from 102 to 87 or a decrease of 15 during the year. As of September 30, 1980, there were only 17 cases that had been open for a year or more. See table II for a summary of noncompliance case activity.

The Audit Division also responded to 4,207 requests from IPA's for confirmation of entitlement fund payments.

Legal Issues

In fiscal year 1980, the Chief Counsel for the Office of Revenue Sharing (ORS) represented the Director and the Office in the Federal court systems and at administrative hearings; negotiated and supervised the execution of compliance agreements; drafted legislation and administrative regulations for implementation of handicap discrimination requirements; and continued to provide daily legal counsel to the Director and the Divisions of the ORS on a variety of issues.

On July 10, 1980, in *Board of Supervisors of Henrico County* v. *Blumenthal* (CA 79–1788), the Fourth Circuit Court of Appeals reversed a lower court ruling, and held that the ORS procedure of computing adjusted taxes was lawful in that it was reasonably related to the purposes of the Revenue Sharing Act. The court held that the ORS was under no obligation to revise its bookkeeping system to make accommodations for individual recipient governments. A petition for rehearing was denied by the court.

The Chief Counsel is providing legal representation in several cases in U.S. district court in which the ORS is a defendant.

In addition to litigation in the Federal courts, the Office of the Chief Counsel has prosecuted cases on the administrative hearing level. The majority of these concern civil rights violations under the act. In *ORS* v. *Borough of Haledon, N.J.*, the Director has for the first time appealed an administrative law judge's finding of no sex discrimination to the Secretary of the Treasury.

During this fiscal year, the Office of the Chief Counsel has assumed responsibility for prosecuting civil rights cases arising from holdings by State or Federal judges, in which jurisdictions have unlawfully discriminated. The Office has pursued these actions, issuing numerous notices of noncompliance and suspending funds where no compliance was obtained.

The Chief Counsel drafted regulations under the act which for the first time include age and handicap discrimination. Proposed legislation to extend the revenue sharing program and the antirecession fiscal assistance program was also drafted on behalf of the Secretary.

Data Acquisition and Analysis

The Office of Revenue Sharing has evaluated the effects of proposed formula changes on the distribution of general revenue sharing funds. This information has assisted the Department of the Treasury and the appropriate congressional committees in developing proposed changes in the General Revenue Sharing Act.

The Office of Revenue Sharing began planning with the Bureau of the Census to obtain population estimates for Indian tribes and Alaskan Native villages. The results of the 1980 census should permit the development of population counts for Indian tribes and Alaskan Native villages. It is expected that population estimates as of July 1, 1981, for Indian tribes and Alaskan Native villages as well as for all other recipient governments will be prepared by the Census Bureau for future entitlement periods.

The accuracy of the individual data factors used in the computation of entitlements is of major importance. These data factors—per capita income, adjusted tax collections, population, and intergovernmental transfer revenues—are obtained from several sources, including the Bureau of the Census, the Bureau of Economic Analysis, the Bureau of Indian Affairs, and the Internal Revenue

Service. In recognition of the importance of accurate data upon the equity of funding under the program, the Office of Revenue Sharing has traditionally placed major emphasis upon efforts to insure their validity.

In past years, the Office has conducted a data improvement program whereby all eligible recipient governments are advised of the individual data factors to be used in the computation of their allocations for the forthcoming entitlement period. Each government was asked to examine its data factors based upon established data definitions, and to propose corrections if appropriate. Typically, several thousand revisions may result from a single data improvement program.

Under normal circumstances, such a program would have taken place in the spring of 1980, for a not-yet authorized entitlement period 12. However, due to the uncertainties of renewal, plans for a full-scale data improvement program were postponed until legislative changes resulting from renewal could be evaluated and conveyed to all recipient governments.

At the beginning of fiscal year 1980, approximately 2,000 governments had failed to provide essential data to the Bureau of the Census relating to adjusted taxes and intergovernmental transfer revenues despite several collection attempts. With the Office of Revenue Sharing assuming responsibility for their collection at that point, reports were obtained from more than 1,200 previous nonrespondents in time for inclusion in the final 11th period allocations. Also, challenges submitted in response to that period's data improvement program were accepted through the end of fiscal year 1980, as provided by statute. Since the beginning of fiscal year 1980, approximately 200 such challenges were received and acted upon by the Office.

In preparation for a possible renewal of the revenue sharing program in essentially its present form, the Office obtained updated data factors. These data consist of population estimates relating to July 1, 1978; estimates of per capita income for calendar year 1977, and adjusted taxes and intergovernmental transfers amounts relating to the local government fiscal year which ended between July 1, 1978, and June 30, 1979. These data have been subjected to rigorous analysis within the Office of Revenue Sharing and the Bureau of the Census, and are expected to be used in a data improvement program for entitlement period 12.

Uses of Funds

The State and Local Fiscal Assistance Act of 1972, as amended, and regulations promulgated under title II of the Public Works Employment Act of 1976, as amended (Antirecession Fiscal Assistance), require each State and local government which receives funds to supply information on its annual fiscal transactions, including data on the expenditure of funds received through either of these programs. A report has been published on the data submitted by the State and local governments entitled, "Expenditures of General Revenue Sharing and Antirecession Fiscal Assistance Funds 1977–1978." It presents the data aggregated by type of government. In addition, individual government data are presented for all States, for the 63 largest counties, and for the 46 largest muncipalities.

The following table summarizes the reported expenditures of GRS money by State and local governments for 1977–78 by functional categories, as reported by these governments to the Bureau of the Census. These reports provide only a limited basis for making judgments about the impact of shared revenues since displacement effects are not fully revealed.

The total revenue sharing expenditures of over $6.5 billion in 1977–78, represent expenditures reported by more than 38,000 State and local governments. According to reported data, over 22 percent of shared revenue spent during the period went into public safety activities such as fire and police protection services. The next category on which most revenue sharing funds were reported to have been expended is education which accounted for over half of all revenue sharing expenditures by State governments in 1977–78. In general, the reported expenditure patterns by functional categories have remained the same as those of previous periods.

Of the total amount of revenue sharing expenditures, about 75 percent was reported as being used to augment and maintain current expenditures, while 23 percent were reported as devoted to capital outlay. The remainder of less than 2 percent was reported as used for debt redemption.

TABLE B.—EXPENDITURE OF GRS FUNDS BY FUNCTION: 1977-78

[Dollar amounts in thousands]

Function	GRS	
	Amount	Percent
Total	$6,682,324	100.0
Correction	173,266	2.6
Education	1,230,911	18.4
Finance and general administration	274,845	4.1
Fire protection	507,614	7.6
Health	426,956	6.4
Highways	849,855	12.7
Hospitals	204,379	3.1
Interest on general debt	112,335	1.7
Parks and recreation	257,655	3.9
Police protection	956,338	14.3
Public welfare	223,628	3.3
Redemption of debt	110,266	1.7
Sanitation other than sewerage	275,495	4.1
Sewerage	79,453	1.2
Utility systems	67,300	1.0
All other	932,028	13.9

The Revenue Sharing Organization

The staff is organized into nine functional units, as follows:

(1) Administrative services staff—Coordinates personnel, daily financial operations, central services, and other internal administrative functions of the Office.

(2) Planning and coordination staff—Accomplishes special research projects at the request of the Director; manages the program planning system, and coordinates budgetary matters.

(3) Data and Demography Division—Responsible for acquisition of current and accurate data used to compute allocations of funds; conducts data improvement program.

(4) Systems and Operations Division—Computes allocations of funds; writes payment vouchers; completes all associated accounting; develops management information systems; issues and processes required reports; produces computer-generated communications and publications and carries out allocation trials related to policy development.

(5) Audit Division—Reviews the practice and audits made by State audit agencies, certified public accountants, and other public accountants; follows up on audit compliance situations.

(6) Civil Rights Division—Responsible for insuring compliance with the civil rights provisions of revenue sharing and antirecession law; conducts investigations of allegations of noncompliance; and cooperates with other Federal agencies, and State governments.

(7) Intergovernmental Relations and Technical Assistance Division—Provides technical advice and assistance to States and local governments; maintains liaison with public interest groups; and through a separate branch enforces the public participation provision of the Revenue Sharing Act, as amended.

(8) Public affairs staff—Provides information about general revenue sharing to the public, the media, citizens' groups, other Federal agencies, and the Congress.

(9) Chief Counsel—Interprets the law; issues opinion letters, prepares regulations; represents the Office of Revenue Sharing in all legal matters concerning the general revenue sharing and antirecession fiscal assistance programs.

At the end of the fiscal year, the Office of Revenue Sharing employed approximately 150 permanent employees and operated at a cost of about $6,469,048.

January 8, 1980

The first payment of revenue sharing entitlement period 11 funds was made to 35,034 State and local governments. A total of $1.7 billion was paid.

April 7, 1980

The second quarterly payment of entitlement period 11 revenue sharing funds was issued to 36,428 State and local governments. A total of $1.7 billion was paid.

July 8, 1980

The third quarterly payment of revenue sharing funds for the 11th entitlement period was issued to 36,511 units of State and local governments. A total of $1.7 billion was paid.

October 7, 1980

The fourth quarterly payment of revenue sharing entitlement period 11 was issued to 36,857 State and local governments. A total of $1.7 billion was paid.

TRUST FUND STATUS

State and Local Fiscal Assistance Trust Fund

The State and Local Fiscal Assistance Act of 1972 (Public Law 92–512) established in the Treasury of the United States a trust fund to be used only for payments to States and local governments as provided in the act. The 1976 amendment (Public Law 94–488) to the original act of 1972 extended the general revenue sharing program from January 1, 1977, through September 30, 1980. The original act appropriated to the trust fund approximately $30.2 billion to be distributed in seven periods. The amendments extending the general revenue sharing program provide, within specified maximum limits, for the determination of entitlement period appropriations beginning with period 8 by the use of a statutory formula. Funds appropriated for distribution by the original and amended act (periods 1–7 and 8–11 respectively) are as follows:

	Start	End	Amount
Entitlement period (EP):			
1–7	January 1972	December 1976	$30,212,500,000
8	January 1977	September 1977	4,987,500,000
9	October 1977	September 1978	6,850,000,000
10	October 1978	September 1979	6,850,000,000
11	October 1979	September 1980	6,850,000,000

In addition to the above, amounts are appropriated for "noncontiguous States adjustments" ($42.3 million for EP 1–11) which are available for allocation to Alaska and Hawaii under prescribed conditions. These amounts are distributed only to the extent required pursuant to section 106(c) of the act as amended, and any unused amounts must be returned from the trust fund to the general fund of the Treasury.

To insure the integrity of the trust fund and to eliminate the prospect of recurring computations of entitlements of all 39,000 governments for prior entitlement periods, the Office of Revenue Sharing has established obligated adjustment reserves. During the seven periods covered by the original act of 1972, a national reserve was established and amounts added thereto on the basis of one-half of 1 percent (0.5 percent) of appropriations, exclusive of noncontiguous States adjustment funds, for entitlement periods 1 thru 5. No funds were retained for addition to this reserve in entitlement period 6 or 7. Beginning with

entitlement period 8 separate reserve funds were established for each State as required by the 1976 amendments extending the original act. Reserves for each State were thus established and amounts added thereto on the basis of one-half of 1 percent (0.5 percent) of each State's respective portion of the appropriation, exclusive of noncontiguous States adjustment funds, for entitlement periods 8, 9, and 11. No funds were retained for addition to State reserves in entitlement period 10.

The respective cumulative amounts in national and State reserves are available to the Secretary of the Treasury to satisfy legitimate claims against the trust fund for prior entitlement periods. The amounts retained in the trust fund as obligated adjustment reserves will be reduced whenever the Secretary determines that such amounts are adequate and exceed the foreseeable liabilities against the trust fund. The reduction will be made by paying the excess amount to recipients as part of a regular or special distribution.

FINANCIAL HIGHLIGHTS

[In millions of dollars]

	Inception through Sept. 30, 1980 (EP 1–11)	Oct. 1, 1979 through Sept. 30, 1980 (EP–11)
For the period:		
Cash available	55,792	8,651
Payments to recipients	53,955	6,829
Returned to Treasury	15	
At period end:		
Cash distributable (net payables)	1,710	1,710
Obligated adjustment reserves:		
National reserve	22	22
State reserves (total)	90	90
Cash balance	1,822	1,822
Other:		
Appropriations received	55,792	6,855
Reserve funds utilized:		
Reserve funds allocated for period adjustments	34	2
Special distribution of excess funds from national reserve	50	

STATE AND LOCAL FISCAL ASSISTANCE TRUST FUND, STATEMENT OF FINANCIAL POSITION, SEPT. 30, 1980

Assets:	
Cash balance with U.S. Treasury	$1,821,889,203
Accounts receivable	40,269
Total	1,821,929,472
Liabilities and fund balance:	
Accounts payable:	
Current	1,705,511,455
Deferred (note 1)	4,658,469
Total liabilities	1,710,169,924
General fund: Obligated adjustment reserves (note 6)	111,759,548
Noncontiguous States adjustment fund: Funds not allocable—to be returned to General fund of the Treasury	
Total fund balance	111,759,548
Total	1,821,929,472

The accompanying notes which follow "Analysis of Changes in Fund Balance," are an integral part of this statement.

STATE AND LOCAL FISCAL ASSISTANCE TRUST FUND

	Inception through Sept. 30, 1980 (EP 1-11)	Oct. 1, 1979 through Sept. 30, 1980 (EP-11)
SUMMARY OF CHANGES IN CASH BALANCE		
Cash balance beginning of period		$1,795,800,120
Transferred into trust fund	$55,792,257,000	6,854,924,000
Total cash available	55,792,257,000	8,650,724,120
Less:		
Entitlements paid	53,954,958,208	6,828,834,676
Returned to general fund of the Treasury: Noncontiguous States adjustments not allocable (note 2)	15,409,589	241
Total reductions	53,970,367,797	6,828,834,917
Cash balance end of period	1,821,889,203	1,821,889,203
Analysis of ending cash balance:		
Reserves for obligation adjustment (note 6)	111,759,548	111,759,548
Noncontiguous States adjustments funds		
Available for distribution (note 3)	1,710,129,655	1,710,129,655
Cash balance end of period	1,821,889,203	1,821,889,203
SUMMARY OF CHANGES IN FUND BALANCE		
Fund balance beginning of period		79,543,660
Transferred into trust fund	55,792,257,000	6,854,924,000
Total funds available	55,792,257,000	6,934,467,660
Less:		
Allocations made to recipients (note 4)	55,665,087,863	6,822,707,871
Returned to general fund of the Treasury: Noncontiguous States adjustment funds not allocable (note 2)	15,409,589	241
Total reductions	55,680,497,452	6,822,708,112
Fund balance end of period	111,759,548	111,759,548
Analysis of ending fund balance:		
Reserves for obligation adjustments (note 6)	111,759,548	111,759,548
Noncontiguous States adjustment funds: Funds not allocable—to be returned to Treasury		
Fund balance end of period	111,759,548	111,759,548
ANALYSIS OF CHANGES IN FUND BALANCE		
General funds:		
Balance beginning of period		79,543,660
Transferred into trust fund	55,750,000,000	6,850,000,000
Total available	55,750,000,000	6,929,543,660
Allocations made to recipients (note 4)	55,638,240,452	6,817,784,112
Funds not required—returned to general fund of the Treasury		
Total reductions	55,638,240,452	6,817,748,112
Obligated adjustment reserve (note 6):		
Balance beginning of period		79,543,606
Add tion to reserve	196,125,076	34,250,015
Adjustments (note 5)	(50,000,007)	
Reserve funds allocated for prior period adjustments	(34,365,521)	(2,034,127)
Balance in reserve end of period	111,759,543	111,759,548
Balance end of period	111,759,548	111,759,548
Noncontiguous States adjustment funds:		
Balance beginning of period		
Transferred into trust fund	42,257,000	4,924,000
Total available	42,257,000	4,924,000
Allocations made to recipients	26,847,411	4,923,759
Funds not allocable—returned to general fund of the Treasury (note 2)	15,409,589	241
Total reductions	42,257,000	4,924,000
Balance end of period		
Fund balance end of period	111,759,548	111,759,548

The accompanying notes which follow are an integral part of this statement.

Note 1. Accounts payable—deferred.—Amounts shown as deferred were previously eligible for payment but such payments were delayed due to court order or failure of recipients to file required assurances, certifications and reports or for other status reasons such as those resulting from jurisdictional changes (annexations, disincorporations, etc.) in process.

Note 2. Funds not allocable.—$241 in noncontiguous States adjustment fund appropriations received for EP 11 were determined "not allocable" and returned to the general fund of the Treasury in December 1979. These funds exceeded the maximum amounts permitted for use by the 1976 amendments (Public Law 94-488) to the original act.

Note 3. Available for distribution.—The total available for distribution excludes any moneys due the fund but not as yet returned by recipients. It corresponds to the net amount payable (total payables less receivables) to recipients. The amount available Sept. 30, 1980, includes approximately $1.7 billion disbursed to recipients Oct. 7, 1980, as the last quarterly payment of entitlement period 11.

Note 4. Allocations made to recipients.—Includes funds allocated from the obligated reserve for entitlement period adjustments and special distributions of excess reserve funds.

Note 5. Reserve adjustments.—A computer distribution of $50,000,007 in national reserve funds, accumulated during entitlement periods 1 through 7, was made in September 1977 for payment to recipients with their regular Oct. 7, 1977, payment (last payment of entitlement period 8). These funds were determined to be in excess of identified or foreseeable liabilities against the trust fund relating to entitlement periods 1 thorugh 7. The distribution approved by the Secretary was made to recipients on the basis of their entitlement period 8 computer allocations and applied as an adjustment to entitlement period 7 computer allocations.

Note 6. Obligated adjustment reserves:

National reserve.—All funds in this account were obtained from appropriations authorized by the State and Local Fiscal Assistance Act of 1972 (Public Law 92-512). Reserves were established and amounts added thereto on the basis of one-half of 1 percent (0.5 percent) of the appropriations, exclusive of noncontiguous States adjustment funds, for entitlement periods 1 through 5, plus variances totaling $43 due to rounding in the final allocation process for entitlement periods 1 through 7. No funds were retained for addition to the reserve from entitlement period 6 or 7 appropriations since the reserve fund balance at the beginning of those periods was determined to be sufficient. A total of $102,687,543 was set aside in this reserve during entitlement periods 1 through 7. All allocations from the reserve for entitlement period adjustments through entitlement period 7 (Dec. 31, 1976) were made from this national reserve account. The balance in this account on Dec. 31, 1976, was $73,200,089.

Amounts remaining in the national reserve account on January 1, 1977, are available to satisfy legitimate claims (allocation adjustment increases) against the trust fund relating to entitlement periods 1 through 7 and, when determined excess to identified or anticipated needs, are available for general distribution to recipient governments. During entitlement periods 8 through 11, a total of $877,313 of the January 1, 1977, balance was used for adjustments to entitlement periods 1 through 7. In addition, $50,000,007 determined excess (note 5), was allocated for distribution to recipient governments in entitlement period 8, leaving a balance of $22,322,769 in the national reserve on September 30, 1980.

State reserves.—The eighth period in the revenue sharing program was the first period authorized by the 1976 amendments (Public Law 94-488) to the State and Local Fiscal Assistance Act of 1972 (Public Law 92-512). These amendments required the establishment of separate reserve funds for each State beginning with entitlement period 8 (January 1, 1977). State reserves were therefore established and amounts added thereto on the basis of one-half of 1 percent (0.5 percent) of each State's respective portion of the total appropriation, exclusive of the noncontiguous States adjustment funds, for entitlement periods 8, 9, and 11, plus variances totaling $33 due to rounding in the allocation process for periods 8 through 11. On this basis a total of $93,437,533 was set aside in respective State reserve accounts for those entitlement periods. $4,000,754 of the amount set aside was subsequently used for adjustment of allocations during entitlement periods 8 through 11 leaving a balance of $89,436,779 in State reserves on September 30, 1980.

Reserve Composition and Activity

The following table shows the composition of total reserves and respective national and summarized State reserve account activity:

	National reserve	Summarized State reserves	Total reserves
Entitlement period 11:			
Balance beginning of period	$22,335,384	$57,208,276	$79,543,660
Additions		34,250,015	34,250,015
Adjustments			
Reserve funds allocated for period adjustments	(12,615)	(2,021,512)	(2,034,127)
Balance end of period	22,322,769	89,436,779	111,759,548
Program inception through Sept. 30, 1980 (end EP 11):			
Balance beginning of period			
Additions	102,687,543	93,437,533	196,125,076
Adjustments (note 5)	(50,000,007)		(50,000,007)
Reserve funds allocated for period adjustments	(30,364,767)	(4,000,754)	(34,365,521)
Balance end of period	22,322,769	89,436,779	111,759,548

FUND STATUS

Antirecession Fiscal Assistance Fund

The Public Works Employment Act of 1976 (Title II, Public Law 94-369) established an antirecession fiscal assistance fund in the U.S. Department of the Treasury to provide financial aid to State and local governments during sustained periods of high unemployment. The fund could be used only for payments to State and local governments as provided in the act. The 1977 amendments (Title VI, Public Law 95-30) to the act of 1976 (effective July 1, 1977) extended the

antirecession program through September 30, 1978, and authorized payments to territorial governments. The original act appropriated $1.25 billion to the fund for five calendar quarters beginning July 1, 1976. Additional appropriations of $632,500,000 and $1,400,000,000 were received in May 1977 and October 1977 respectively. These funds were available for use as required under the amended program. Total appropriations received funded the program for nine calendar quarters (July 1, 1976, through September 30, 1978).

The original act of 1976 and the 1977 amendments to that act provide for the use of a formula based upon national unemployment rate data to determine the amount of the appropriation available for distribution each quarter. Quarterly amounts authorized and available for distribution in the nine periods covered by the original and amended act are as follows:

	Start—	End—	Amount
Quarter period:			
1	July 1976	September 1976	$312, 500, 000
2	October 1976	December 1976	250, 000, 000
3	January 1977	March 1977	312 500. 000
4	April 1977	June 1977	312, 500, 000
5	July 1977	September 1977	520, 150, 000
6	October 1977	December 1977	429, 250, 000
7	January 1978	March 1978	398, 950, 000
8	April 1978	June 1978	308, 050, 000
9	July 1978	September 1978	186, 850, 000

The first disbursements under the original act were made in November 1976 and included payments for quarters 1 and 2 (July 1–December 31, 1976).

To eliminate the prospect of recurring computations of allocations of all recipient governments when adjustments to individual allocations are required and to insure the integrity of the fund, the Office of Revenue Sharing has established adjustment reserves. Beginning with period 5 reserves were maintained in three separate accounts. One account each for States, local governments, and territories. Amounts were retained for addition to reserves on the basis of one-half of 1 percent (0.5 percent) of the funds available for distribution each quarter for periods 1 through 6 and 8 (territorial reserves only). No funds were retained for addition to reserves in periods 7 and 9. Allocations waived by governments were also deposited in reserve accounts upon their return to the fund.

Cumulative balances in respective reserve accounts are available to the Secretary of the Treasury to satisfy legitimate claims against the fund. The amount retained in the fund as adjustment reserves are reduced whenever the Secretary determines that such amounts are in excess of identified or foreseeable liabilities against the fund. The reductions are made by paying the excess amount to recipients as part of a regular or special distribution.

The statements following show: The cumulative results of financial operations from inception through September 30, 1980; results of operations for the 1-year period (October 1, 1979 through September 30, 1980); and the status of the fund as of September 30, 1980. There were no disbursements made from the fund during the fiscal year ended September 30, 1980.

ANTIRECESSION FISCAL ASSISTANCE FUND

FINANCIAL HIGHLIGHTS

	Inception through Sept. 30, 1980	Oct. 1, 1979 through Sept. 30, 1980
For the period:		
Cash available	$3, 282, 500, 000	$2, 223, 566
Payments to recipient (returns)	3, 028, 525, 762	(672)
Funds not allocable, returned to general fund of Treasury	251, 750, 672	672
At period end:		
Cash distributable (net payables)	2, 223, 566	2, 223, 566
Adjustment reserves:		
State reserve		
Local reserve		
Territorial reserve		
Cash balance	2, 223, 566	2, 223, 566
Other:		
Reserve funds utilized:		
Allocated for period adjustments	1, 201, 353	
Special distributions from reserves	11, 745, 184	2, 223, 566

ANTIRECESSION FISCAL ASSISTANCE FUND

STATEMENT OF FINANCIAL POSITION, SEPT. 30, 1980

	Amount
Assets:	
Cash balance with U.S. Treasury	$2,223,566
Accounts receivable	
Total	2,223,566
Liabilities and fund balance:	
Accounts payable:	
Current	
Deferred (note 1)	2,223,566
Adjustment reserves (note 4)	
Total	2,223,566

Note: The accompanying notes which follow "Summary of Changes in Fund Balance," are an integral part of this statement.

ANTIRECESSION FISCAL ASSISTANCE FUND

	Inception through Sept. 30, 1980	Oct. 1, 1979 through Sept. 30, 1980
SUMMARY OF CHANGES IN CASH BALANCE		
Cash balance beginning of period		$2,223,566
Transferred into fund	$3,282,500,000	
Total cash available	3,282,500,000	2,223,566
Less:		
Payments to recipients (returns)	3,028,525,762	(672)
Funds not allocable—returned to the general fund of the Treasury	211,705,672	672
Total reductions	3,280,276,434	
Cash balance end of period	2,223,566	2,223,566
Analysis of ending cash balance:		
Adjustment reserves (note 4)		
Available for distribution (note 2)	2,223,566	2,223,566
Cash balance end of period	2,223,566	2,223,566
SUMMARY OF CHANGES IN FUND BALANCE		
Fund balance beginning of period		
Transferred into trust fund	3,282,500,000	
Total funds available	3,282,500,000	
Less:		
Net allocations made to recipients (note 3)	3,030,749,328	(672)
Funds not allocable—returned to the general fund of the Treasury	251,750,672	672
Total reductions	3,282,500,000	
Fund balance end of period		

The accompanying notes which follow " Summary of Changes in Fund Balance," are an integral part of this statement.

Note 1. Accounts payable—deferred.—Amounts shown as deferred payables resulted from a special computer allocation distribution of adjustment reserve funds ($695,664, $1,491,401, and $36,501 from State, local, and territorial reserves, respectively) to recipient governments in the last quarter of fiscal year 1979 (note 4). Disbursement of these funds is being delayed to have funds available to pay any necessary adjustments should such arise as the result of pending litigation such as "Board of Supervisors of Henrico County, Va. v. W. Michael Blumenthal, et al." This case concerns the treatment of county highway funds with respect to the derivation of adjusted taxes in the revenue sharing allocation formula. The district court decided the case adversely to ORS. The Fourth Circuit Court of Appeals reversed the district court's decision on July 10, 1980. A petition for rehearing was denied on Sept. 16, 1980. Accordingly, the ORS expects to be able to make a final distribution of the above-mentioned funds to eligible recipients in the near future. The ORS will delay the redistribution only until the time period for further appeal to the Supreme Court has expired, or until the Supreme Court has ruled on any such appeal.

Note 2. Available for distribution.—The total available for distribution excludes any moneys due the fund but not as yet returned by recipients. It corresponds to the net amount payable (total payables less receivables) to recipeints.

Note 3. Allocations made to recipients.—Includes amounts allocated from adjustment reserves.

Note 4. Adjustment reserves.—A special computer distribution (allocation) of $694,664, $1, 491,401, and $36,501 from State, local, and territorial reserves respectively, was made in September 1979 (see note 1). The distribution was made to eligible recipients on the basis of the governments' fractional share of the total quarter 9 allocation, including subsequent adjustments thereto, of record as of the distribution date. Governments that were not eligible to receive an allocation for quarter 9, or who voluntarily or constructively waived their entitlement for that period, did not share in the distribution.

ITEM 14. ACTION

JANUARY 15, 1981.

DEAR MR. CHAIRMAN: I am pleased to submit current information on ACTION's programs for "Developments in Aging," the annual report of the Senate Special Committee on Aging.

The dedicated service by approximately 291,0000 volunteers age 60 or over in ACTION programs is significant evidence that older persons can be a part of the solution rather than a part of the problem. Of the 269,000 RSVP volunteers serving in March 1980, 39.8 percent were age 60–69, 45.3 were between 70–79, 10. 6 percent were between age 80–84, and 4.3 percent were age 85 and over. These volunteers contributed approximately 54 million hours of service worth an estimated $167 million based on a minimum wage rate of $3.10 an hour. In SCP and FGP, where volunteers serve 20 hours each week, approximately 21,000 seniors were serving in March 1980 and 13 percent of them were age 80 and over. Last year's activities in connection with the 15th anniversary of the foster grandparent program revealed there were 98 foster grandparents who had been serving with their local projects since their inception. All of these older American volunteer programs are authorized under title II of the Domestic Service Act of 1973, as amended.

The volunteers in service to America (VISTA) program under title I continues to tap the wealth of knowledge and skills of older Americans. Approximately 15 percent of the VISTA volunteers are themselves age 55 or older. Approximately 22 percent of all VISTA projects are specifically designed to assist in the solution of poverty and poverty-related problems of older people.

Other programs under title I include a community energy project in one city where over 200 households of elderly residents benefited from the energy conservation efforts, and 20 other communities have joined in similar efforts. The 25 State Offices of Voluntary Citizen Participation, many funded by ACTION are presently involved in efforts to encourage the growth of older American volunteer programs in their States.

The enclosed statements summarize ACTION's major older American volunteer activities during the past year.

Sincerely,

SAM BROWN, *Director.*

Enclosures.

OLDER AMERICAN VOLUNTEER PROGRAMS

The older American volunteer programs provide an opportunity for persons over 60 to apply their time and energy to unmet community and individual needs. The programs have the dual yield of improving the well being of both those volunteers who are serving and those who are served. There are no educational or experience requirements for enrollment; participation in the foster grandparent and senior companion programs is limited to persons whose income is not more than 125 percent of the poverty line established by the Economic Opportunity Act of 1964, as amended annually. They receive a stipend of $40 for a 20-hour week. The stipend is not considered income for tax purposes nor does it affect eligibility for other Federal or State programs. Retired senior volunteer program volunteers receive no stipend.

All volunteers serve under the sponsorship of local organizations. Categorical grants are awarded by ACTION to private, nonprofit organizations and public agencies which recruit, train, place, and support volunteers. Day-to-day supervision is provided by volunteer stations which are public or private agencies and organizations such as proprietary health care organizations, hospitals, day care centers, units of local governments, and community action programs. ACTION field staff provides technical assistance to sponsors and training for project staff. Funding is shared between the sponsor and ACTION.

ACTION is committed to the principle that the satisfaction of each volunteer is a direct result of her or his involvement in activities which will improve the lives of others and enrich their own. OAVP seeks to:

(1) Encourage the recognition of older persons as a solution to problems rather than as a problem.

(2) Influence OAVP projects to develop program activities which include advocacy, self-reliance, and mobilization of local resources to meet local needs.

(3) Coordinate OAVP program activities with other ACTION programs including VISTA and Peace Corps.

(4) Encourage volunteer assignments in RSVP and FGP which increase cross-generational contacts.

(5) Encourage increased State and/or local funding of OAVP and OAVP-type projects.

The OAVP program concept has been greatly expanded by the use of State and local moneys to create non-ACTION OAVP-type projects or to supplement existing ACTION projects. More than 30 States and local governments are providing approximately $15 million for this purpose. These moneys are in addition to the required local matching funds provided by all project sponsors. Since most State and local projects wish to be identified with one of the respective OAVP program titles, they have entered into written memoranda of understanding with ACTION. These memoranda allow the local projects to use the generic Federal program name and make the volunteers serving in these projects eligible for the income disregard provision of ACTION legislation with respect to foster grandparent and senior companion programs. Project staff participate in ACTION training activities, receive program assistance materials and utilize the technical expertise of ACTION staff.

OAVP has made a special effort to encourage members of minority groups to participate as volunteers and sponsors in all three programs. More than 17 percent of RSVP volunteers, 40 percent of foster grandparents and 37 percent of senior companions were minorities in fiscal year 1980. Continued emphasis has been placed on recruiting males, elderly persons, and the handicapped.

Volunteer totals and funding for fiscal year 1980 was:	*Millions*
RSVP (269,000 volunteers)	$26.2
FGP (17,370 volunteers)	46.9
SCP (3,820 volunteers)	10.2
Total OAVP (290,000 volunteers)	83.3

Improved cooperation with other agencies that deliver social services is a major OAVP objective. A summary of existing interagency agreements includes:

Agency	*Purpose*
Administration on Aging (AoA), title III.	To have at least one ACTION OAVP project in each AoA service area.
(Title VII is merged under title III)	To assign senior volunteers to assist in achieving the purpose of the title III nutrition program.
	To provide opportunities for seniors to serve children as well as other seniors in public schools.
State agencies on aging agreements with each ACTON State program office.	To promote use of ACTION full- and part-time volunteers to serve in State AoA programs.
ED, Office of Education, right to read (RTR).	To assign senior volunteers to assist with literacy programs sponsored by RTR.
Department of Commerce, National Fire Prevention and Control Administration.	To engage senior volunteers in a public education program to reduce fire loss in their communities.
ED, Bureau of Education for the Handicapped.	To utilize senior volunteers in public awareness and advocacy activities to promote community responsiveness to the requirement of the act.
DOT, Urban Mass Transportation with Administration on Aging (title III at HHS).	To assist in identification of transportation services for lonely and isolated elderly persons.
HUD, Public Housing Administration	To develop a mutual benefit program where senior volunteers can be recruited from public housing where they live to help satisfy the basic human needs of other public housing residents of all ages.

Agency	*Purpose*
HHS, Administration for Children, Youth and Families (ACYF).	To coordinate more use of foster grandparents and RSVP volunteers with ACYF programs for children who are abused and neglected, or in danger of being separated from families, or are in need of foster care and adoption, or who are classified as status offenders. runaway youth, and teenagers facing special problems.

RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)

The retired senior volunteer program was established to provide a variety of opportunities for persons aged 60 and over to participate more fully in the life of their community through significant volunteer service. Through RSVP, over a quarter million older Americans are making significant contributions toward solving some of the pressing problems of their communities. In turn, the program enables the elderly to find the dignity and usefulness they seek.

RSVP was originally authorized in 1969 and funded in 1971. In July, 1971, it was transferred to ACTION.

As an inherently local program, each RSVP project is locally planned, operated and administered, and supported on a cost sharing basis. The non-Federal support of the budget may not be less than 10 percent during the first year. Grantees are expected to increase the local share of the project costs by 10 percent each year and to assume a minimum of 30 percent financial responsibility at the beginning of third year and each year thereafter. Exceptions to this requirement may be granted by ACTION in individual cases of demonstrated need.

A person, 60 years of age or over, is eligible to join the program. There are no income, education or experience requirements to becoming an RSVP volunteer. Orientation, in-service instruction and recognition are provided for the volunteer. Volunteers serve without compensation, but transportation assistance is provided between their homes and volunteer assignments when needed. Accident, personal liability, and when appropriate, excess auto liability insurance are also provided.

Too often older citizens have been regarded as a problem. The retired senior volunteer program sees them as a resource capable of improving community life. They serve in hospitals, schools, courts, crisis centers and other similar agencies, assisting clients of all ages. They are involved in projects dealing with health care delivery, energy conservation, operation of food co-ops, and fixed income counseling. Numerous examples illustrate the value of the contributions of RSVP volunteers to their communities.

Aware of the need for low cost food in their area, a group of RSVP volunteers in Cazenovia, N.Y., established and are now operating a successful food co-op serving low income and home-bound elderly in their community. These volunteers are involved in every aspect of management of the cooperative. They purchase, package and deliver food items to their clients.

In Detroit, Mich., about 100 volunteers have been trained to conduct house to house energy audits and to educate citizens on how to conserve energy.

In Brockton, Mass., a number of volunteers are assigned to a local probate court to help protect the rights of children from broken homes and provide the emotional support they desperately need. One volunteer speaking of the reward he gets from providing this service states, "There's plenty of reward. Its the feeling that you're doing something worthwhile . . . that you give the love to the children."

Over the years, several experimental efforts involving existing projects have been implemented to ensure the development of more innovative service opportunities for volunteers now serving in the program.

In 1978, 113 test components were given technical assistance and some additional funding to develop volunteer services in the areas of: advocacy, deinstitutionalization, criminal justice, housing/food and energy conservation. A year after it was initiated, close to 2,000 volunteers became involved in this nationwide effort.

In 1979, 10 RSVP projects were given additional funds and training to establish components in Fixed Income Consumer Counseling (FICC) that would recruit and train volunteers to assist persons on fixed incomes in areas such as: health and nutrition, crime and victimization, banking, and financing, rebate programs, legal aid and other services.

With funding support and technical assistance provided by a cooperating private agency, 22 RSVP projects started work in 1980 to establish test components with volunteers who will provide community support services to hardcore unemployable youths between the ages of 16 and 21. In early 1981, RSVP will embark on a cooperative effort with the senior companion program to test the feasibility of involving RSVP volunteers in the provision of long term care services to homebound elderly people.

Since 1971, the retired senior volunteer program has experienced considerable growth. In 1972, with a budget of $15 million, there were 84 RSVP projects and 1,816 senior volunteers. By the end of fiscal year 1980, with a budget of $26.2 million, there were 707 federally funded projects and approximately 269,000 senior volunteers participating nationwide. There are RSVP projects currently operating in all 50 States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. Many States have appropriated over $2 million in support of program activities.

In 1980, RSVP volunteers contributed approximately 54 million hours of service worth an estimated $167 million based on a minimum wage rate of $3.10 an hour.

Older Americans serving as RSVP volunteers, have, through their achievements, earned the respect and support of their own communities, the aging network and professional gerontologists. They have not only proved to be formidable advocates of their own interests, but remain independent and productive contributors of services to their communities rather than just recipients.

Foster Grandparent Program (FGP)

The foster grandparent program (FGP) was originally developed as a cooperative effort between the Office of Economic Opportunity and the Department of Health, Education, and Welfare. It was given a legislative base in 1969 and transferred to the Administration on Aging in HEW. In July 1971, the program was transferred to ACTION.

The FGP enables low-income persons aged 60 or over to remain active in their community through person-to-person service to children with special or exceptional needs in health, education, welfare, and related settings. The foster grandparents derive a renewed sense of dignity and self-worth from their special service roles. In addition to a stipend, they receive additional tangible benefits in the form of transportation to and from their volunteer station, a noon meal on the days (usually 5 days per week) they serve, accident and liability insurance, and an annual physical examination.

Children are assigned foster grandparents on the basis of their potential for improvement in personal or social adjustment, skill development and for deinstitutionalization. In the latter case, foster grandparents will follow deinstitutionalized children needing continuing attention to their own homes when possible and approved. Initial assignments of foster grandparents are also made in cases where they can have the greatest impact in the delay or prevention of institutionalization of children living in a home environment.

Foster grandparents give attention and affection to the children to whom they are assigned. Ideally, the volunteers spend 2 hours with each of two children on a daily basis. Some group settings are not permissive of a strict one-on-one assignment basis. In these cases, foster grandparents may serve several children as long as the setting is conducive to the establishment of person-to-person relationships among the volunteers and the children they serve. The program provides social, psychological, and educational benefits to children with developmental disabilities and related special needs. The foster grandparents simultaneously benefit from alleviation of some of the consequences of poverty and loneliness. Their psychological outlook and physical health are improved. The mutually benefiting relationship also has a notably positive effect on the children's development and the outlook of their families. The program provides a degree of protection of human rights of both "grandparent" and "grandchild," ensuring that each group is dealt with fairly and humanely.

Foster grandparents are provided orientation prior to assignment to individual children. Subsequently they are provided monthly in-service training. They function as stipend volunteers and are not in the regular work force. Their activities are limited to those which would not supplant the hiring of or result in the displacement of employed workers, or impair existing contracts for service. Foster grandparents may not provide physical therapy, babysitting service, housecleaning service, or other services normally performed by volunteer station staff to the children they serve. Foster grandparents are expected to accept supervision of volunteer station and project staff. Appropriate volunteer grievance and appeal procedures are the responsibility of the individual project sponsors.

Project staff are employees of the project sponsor; they are not employees of the Federal Government. ACTION requires concurrence in the selection of project directors.

The project director, on behalf of the sponsor, recruits, trains, and exercises general supervision over the volunteers. This person also develops memoranda of understanding with volunteer stations where volunteers are to be placed. He/she also ensures that foster grandparents are assigned to children with demonstrated special needs.

Project sponsors, in accepting ACTION grants to operate foster grandparents projects, agree to abide by agency regulations and policies. ACTION, in turn, provides training and technical assistance to sponsors and project staff, and promotes cooperation and coordination with other Federal, State, and local entities concerned with the needs of low-income elderly and children with special needs, including transportation needs.

The foster grandparent addresses the most pressing basic human needs, both in seeking the poorest of the poor to serve as foster grandparents, and in the selection of individual children the volunteers serve.

During the entirety of fiscal year 1980, the program operated under authority of a continuing resolution at a level of $46.9 million. At year's end there were 17,370 funded foster grandparents serving approximately 51,000 children. There are 208 (federally funded) projects with at least one project in each State; Puerto Rico, the Virgin Islands, and the District of Columbia. Additionally, more than 30 States have now appropriated varying sums to expand foster grandparent opportunities and services. Michigan presently leads the way in this regard with 8 nonfederally funded projects in operation, providing approximately 360 additional low-income elderly residents the opportunity to serve in and benefit from the program.

The stipend was increased effective November 3, 1979 from $1.60 per hour to $2 per hour.

Senior Companion Program (SCP)

The senior companion program offers volunteer opportunities to adults, age 60 and older, who have annual incomes which fall below the poverty guideline. The senior companions (volunteers) provide personal assistance and companionship to primarily older adults in an effort to support them in achieving their highest level of independent living.

The senior companion program has grown from 18 pilot projects and 1,000 senior companions in fiscal year 1974 to 62 projects and approximately 3,820 senior companions as of December 1980. The operating budget in fiscal year 1980 was $10.2 million.

The senior companion program provides a visible demonstration that older persons can perform a critical role in contributing to the solution of problems that affect them. SCP fosters independence and enhances the self-esteem of the senior companions by engaging them in activities which improve the lives of individuals and communities.

An SCP volunteer in Michigan had been hospitalized seven times over a period of 20 years in a State institution for the mentally ill. The volunteer had experienced periods of severe depression and isolation prior to becoming a senior companion. Since joining the program in 1975, the volunteer has not been hospitalized and has become increasingly independent and satisfied with life.

SCP assists in meeting the long-term care needs of moderately and generally impaired adults, focusing on older adults whose physical, mental and emotional impairments put them at risk of inappropriate or unnecessary institutionalization. Senior companions are placed at or through volunteer stations, which are

direct health care providers, social service agencies, and Federal and State long-term care networks.

In Indianapolis, a senior companion noticed her client seemed disoriented, and she watched her closely. She eventually discovered the client was taking 23 different prescription drugs—from several doctors, of course; one not knowing she was going to another—she made a list of the drugs, with the doctor's names and the pharmacy. With the help of the project director, she made the doctors and the pharmacists aware of the situation and the client was put under the care of one doctor.

Approximately 80 percent of the senior companions are assigned to assist older persons to remain in their own places of residence.

The senior companions also assist clients in patient-release programs in acute care hospitals, mental health, and other long-term care facilities to make the transition and adjustment to living in less restrictive settings.

In all placements, the senior companions serve as advocates by linking clients to appropriate services and assuring that they receive benefits to which they are entitled.

Senior companions receive a stipend for their service. They are also provided or reimbursed for transportation and meals for days of service, orientation or training. Volunteers are covered by accident and liability insurance and receive annual physical examinations. Senior companions are also provided an orientation and regularly scheduled in-service instruction.

During 1980, eight test projects were initiated. The new concepts incorporated into the project design included: (1) the integration of senior companions into a plan of care developed by community organizations with the capacity to coordinate the health and social needs of clients served; (2) enrichment of volunteer training; (3) increasing the role of the senior companion, clients, and other older low-income persons in the advisory council; (4) strengthening of volunteer station roles and responsibilities; and (5) expansion of senior companion program services to special at-risk populations, the mentally impaired, the aging, those with substance abuse problems, and patients from acute care hospitals.

Office of Voluntary Citizen Participation

The Office of Voluntary Citizen Participation (OVCP), in its effort to develop ties between Federal and private sector voluntary efforts, has supported many projects for and involving older Americans. It has accomplished this through awarding of grants to local projects, emphasizing the role of older citizens in its special projects, informing the State Offices of Voluntary Citizen Participation about older American programs, and working with the older American volunteer programs to inform the S/OVCP's of their accomplishments and potential.

The minigrant program provides small grants, not to exceed $5,000 each, for local communities or $10,000 for statewide projects, to private voluntary organizations for support of ongoing volunteer efforts, and for use as seed money to establish volunteer programs. Of the 105 minigrants awarded in fiscal year 1980, seven were for projects for older Americans or to organizations of senior citizens. For example, the National Indian Council on Aging in Albuquerque, N. Mex., developed a project to recruit older Americans as volunteers to work with their Indian peers in developing such life skills as budgeting money. Fifty volunteers are participating in this project.

The support service assistance program provides grants averaging $35,000 for technical assistance, training and materials development to private voluntary organizations to support volunteer efforts or programs. Of the 14 grants awarded in fiscal year 1980, one grant was awarded for an older American project: the Older Women's League Educational Fund. A preconference to the 1981 White House Conference on Aging was held in Des Moines, Iowa. The monies provided scholarships for 16 volunteers to attend the conference where proposals were developed and contacts made among 400 conferees in preparation for the 1981 White House Conference on Aging. Besides ACTION, the Administration on Aging, the Department of Labor/Women's Bureau and the International Paper Corporation funded this project.

The community energy project (CEP) offers technical assistance and information to communities across the U.S. to initiate short-term energy conservation

campaigns involving citizens helping themselves and their neighbors to apply low cost/no cost techniques to save energy. There are presently 20 communities receiving intensive technical assistance (site visits) besides the numerous communities who have heard of the success of the program and called or written for assistance. The project has emphasized the plight of low income and the elderly during fuel shortages and the means to incorporate these two groups into the program. For example, due to the active participation of social service agencies in Fitchburg, Mass., including the Council on Aging, the project was able to contact elderly residents who normally may have not received the information. Caseworkers of one agency took application forms for weatherization materials to shut-ins who were visited on a weekly basis. Many of these individuals received materials free of charge.

The project concentrated its crew assistance effort on the elderly. Crews of high school students, college students, and other citizens volunteered to weatherstrip doors, caulk windows and insulate hot water heaters in homes of residents who were unable to do their own work. Over 200 households of elderly residents received this service. With hypothermia threatening older people more than ever during the energy crisis, this weatherization effort in Fitchburg was crucial, both to protect the health of the elderly and to help them save money. Since the winter of 1979, 20 other communities have joined in similar community energy conservation efforts. All projects have emphasized services to the elderly.

In order to present the 25 State Offices of Voluntary Citizen Participation (S/OVCP's) with ideas on how they can encourage the growth of the older American volunteer program in their States, a packet was designed in conjunction with the older American volunteer program staff which includes information on replication of models and how to identify potential State funding sources. This has been sent to all offices. These offices are in an ideal situation to support the growth of the older American programs. The S/OVCP's provide daily contact, coordination and cooperation with the leadership of private voluntary organizations and the public voluntary action efforts in the State. They are integral parts of the State government and have established relations with departments of aging and State legislatures.

Volunteers in Service to America (VISTA)

Since the creation of VISTA in 1964, VISTA volunteers have, in a myriad of individual situations, amplified the opportunities offered by government programs so that they work as originally intended and enable low-income people to increase their capacity to deal with poverty problems. VISTA's have, for example, helped poor people revitalize decaying urban neighborhoods, focused attention of medically underserved areas, helped low-income groups to organize and develop consumer and farmers' cooperatives, and advocated for the rights of disabled persons. Continuously throughout its history, VISTA volunteers have also worked to assure older Americans the emotional, physical, and financial security they deserve.

ACTION legislation requires that VISTA encourage "fullest participation of older persons and older person membership groups as volunteers and participant agencies. . . . "

An October, 1980 survey revealed that over one-quarter of the total 4,375 VISTA volunteers are serving people 60 years of age and over. Fifteen percent of VISTA volunteers are themselves 55 years or older including 113 who are over 70. They are assigned to over 20 community based organizations around the country, often working in their own communities.

VISTA's are helping to coordinate senior companionship and recreation programs at local community centers as well as working with meals-on-wheels and the Federal food stamp program to guarantee adequate food and nutritional education to seniors who are homebound. They have helped low-income seniors receive FHA grants for indoor plumbing, weatherization, and home rehabilitation, and have worked to set up food and health cooperatives and rural transportation systems to serve the elderly.

Typical is the Colorado Congress of Senior Organizations, a joint VISTA–RSVP project, whose volunteers have organized a rural transportation system serving the elderly in every county in that State.

Another example is the Energy Extension Services in Michigan (EES). Through their effort, 13 VISTA's, working with the area agencies on aging and with

RSVP volunteers, have coordinated energy audits and weatherization efforts on a statewide basis.

In conjunction with an RSVP program in upstate New York, a VISTA volunteer works with handicapped elderly people who still want to work but are isolated due to their handicap. The volunteer with the support of local agencies and businesses, has established a variety of volunteer positions for their elderly clients.

In addition, the volunteers organized a committee of interested elderly people to study the problem of architectural barriers. They published a list of agencies, businesses, restaurants, and other services that were accessible to handicapped persons.

More specific examples of VISTA serving older Americans follows:

Citizen Advocates for Better Care, Leominster, Mass.—Under a national VISTA grant to the National Citizens Coalition for Nursing Home Reform, four VISTA volunteers are working on behalf of nursing home residents in the Leominster-Fitchburg area. Two of the VISTA's make daily visits to area nursing homes and serve as local ombudsmen working to resolve any complaints the residents have. The two VISTA's also assist in coordinating the visits of the citizens who volunteer their time to visit specific homes on a regular basis.

A third volunteer, a retired businessman, has assisted the group with publicity and fund raising. The higher profile of the group in the community has boosted its membership and increased the number of citizens who volunteer their time to the group. This volunteer also regularly visits the area nursing homes to deal specifically with the special problems of male residents. A fourth volunteer provides the group with research on nursing home issues. Largely through the efforts of this volunteer, CABC has received a major grant from the area agency on aging and was asked to be a part of the State ombudsman network to assist groups in other areas of the State with training on nursing home issues.

Grey Law, Los Angeles, Calif.—Along with providing legal services for the elderly, Grey Law is involved in projects relating to senior citizens problems of a nonlegal nature. In Los Angeles, a particularly outstanding problem facing seniors and one which VISTA is confronting, is housing. VISTA's have been instrumental in establishing a housing coalition which has sought to include the vast number of Los Angeles housing and tenants rights organizations into one unified and effective body. In addition to getting the coalition off the ground, VISTA's are performing an essential communication function, contacting the various groups in the Los Angeles area in attempt to provide information about the new organization and encouraging widespread participation in the coalition.

In addition to these and other programming efforts, VISTA has linked with ACTION's older American volunteer programs in implementing two White House on Aging miniconferences.

University Year for ACTION and Older Americans

University Year for ACTION (UYA) volunteers work in programs which directly or indirectly benefit senior citizens in a variety of localities. UYA volunteer activity which is primarily focused on seniors includes somewhat isolated activity such as the volunteer working on feeding and nutrition problems of the elderly in Tchula, Miss., to longer programs such as a senior citizens folkcraft cooperative located elsewhere in the rural South.

In addition, there is a large-scale UYA program with the University of Georgia's Gerontology Center in Athens. There, approximately 20 volunteers work with low-income elderly on such issues and concerns as consumer education, therapeutic services, counseling and advocacy for the handicapped.

ITEM 15. CIVIL AERONAUTICS BOARD

January 12, 1981.

Dear Mr. Chairman: You asked for information on our initiatives and programs that had either a direct or indirect impact on the elderly during 1980. This information is to be included in the annual report, "Developments in Aging."

Last year we reported that airlines had been allowed to offer special discounts to the elderly on an unrestricted reserved-seat basis but that none had

chosen to do so. In 1980, at least two airlines, Air Florida and Wright Air Lines, offered unrestricted discount fares for senior citizens. About 10 other carriers continue to offer standby fares for the elderly. Under these fares, reservations can be made only 1 day in advance.

On April 10, 1980, the Board approved a final rule to prohibit discrimination against air travelers on the basis of age. This rule is required by the Age Discrimination Act of 1975, which exempts discounts for the elderly from the general prohibition against age discrimination. The rule incorporates that exception. This act requires that the Board's age discrimination rule be submitted to the Department of Health, Education, and Welfare (now Health and Human Services) for review. Our rule was submitted to HHS last April and we are awaiting their approval.

In addition to prohibiting age discrimination in air transportation, the rule would require airlines to complete a written self-evaluation of compliance with the Age Discrimination Act, and when requested, provide the Board and the public with information, including the self-evaluations, to determine whether there has been a violation of the act's provision. The rule would also establish procedures for filing complaints alleging age discrimination by an airline. The rule would permit continued discounts for the elderly.

We believe that Board policy, combined with the major changes of the Airline Deregulation Act of 1978 and the International Air Transportation Competition Act of 1979, has created opportunities for new services and low fares. In recent months several new carriers have announced their intention to initiate low fare air service. These actions, as well as the increasingly competitive airline industry that reduced regulation has fostered, will benefit all air travelers, including elderly persons who may have previously found air transportation to be too costly.

I hope you find this information helpful.

Sincerely,

MARVIN S. COHEN, *Chairman.*

ITEM 16. COMMISSION ON CIVIL RIGHTS

DECEMBER 17, 1980.

DEAR MR. CHAIRMAN: The U.S. Commission on Civil Rights is pleased to respond to your request for a statement concerning our fiscal year 1980 activities affecting the interests of older persons.

If we can be of any further help on this or any other matter, please let me know.

Sincerely,

LOUIS NUNEZ, *Staff Director.*

Enclosure.

REPORT OF MAJOR ACTIONS OF THE U.S. COMMISSION ON CIVIL RIGHTS—FISCAL YEAR 1980

The U.S. Commission on Civil Rights is a temporary, bipartisan agency within the executive branch of the Federal Government, established by the Congress in 1957 and directed among other things, to study and collect information about legal developments relating to discrimination because of race, color, religion, sex, age, handicap, or national origin and to appraise Federal laws and policies with respect to discrimination or the denial of equal protection of the laws, and submit reports, findings, and recommendations to the President and the Congress.

Before October 1978, the Commission's jurisdiction over "age" and "age discrimination" matters was limited to a special short-term mandate of the Age Discrimination Act of 1975 (Public Law 94–135) that the Commission study and report on the nature, scope, and extent of age discrimination in federally assisted programs. The Civil Rights Commission Act of 1978 (Public Law 95–444), however, expanded the Commission"s general authority to include matters related to age discrimination.

In addition, the 1978 Amendments to the Older Americans Act (Public Law 95–478) directed the Commission to undertake a study of race and ethnic discrimination in federally assisted programs and activities for older persons, examining in particular employment, the award of contracts, and the delivery

of services. No funds have been appropriated by Congress to finance the costs of the study; however, because the directive was prompted in part by the findings of the Commission's 1977 age discrimination study, and because the Commission believed the results of such a study would be useful to the forthcoming White House Conference on Aging, the Commission decided to allocate a portion of its existing budget to initiate an effort that conformed essentially to the intent of Congress.

The plans for the study focus on an examination of programs authorized under title III of the Older Americans Act at the Federal, State, and local levels. The plans also provide for a review of employment at the Federal, State and local levels with respect to minorities and policies and practices related to the delivery of services and the award of grants and contracts as they relate to minorities. Research is being carried out in Washington, D.C., and in selected cities throughout the country. The Commission anticipates issuing its report early in fiscal year 1982.

In May 1980, the Chairman testified on behalf of the Commission before the Senate Special Committee on Aging with regard to "Aging and Mental Health: Overcoming Barriers to Service." The Commission endorsed the provisions of S. 1177, the Mental Health Systems Act, which included special provisions for providing mental health services to older persons. This support was consistent with the Commission's findings in the report of its age discrimination study that older persons were discriminated against because of their age in the community mental health centers program. The Commission subsequently wrote to the Senate Labor and Human Resources Committee urging retention of the special provisions in the bill ultimately to be considered by the full Senate.

In April 1980, the Commission convened a national consultation on "Civil Rights Issues in Physical Health Care Delivery." Specialists from the public and private sectors presented and responded to papers on health care financing and service delivery as they relate to civil rights concerns. Considerable attention was paid to the special problems faced by older persons in obtaining needed health services and in meeting increasing costs that are not satisfied by medicaid or medicare.

The Commission made extensive comments on regulations proposed by the Department of Health and Human Services to implement the 1978 Amendments to the Older Americans Act.

The Commission continued its monitoring and oversight of the implementation of the Age Discrimination Act of 1975, as amended. The Commission wrote to the heads of all Federal agencies subject to the act, urging prompt publication of proposed agency-specific rules as required under the act. The Commission is also monitoring enforcement of the Age Discrimination in Employment Act of 1967, as amended, which is administered by the Equal Employment Opportunity Commission pursuant to the President's Reorganization Plan No. 1 of 1978.

In its research projects and investigations, the Commission continues to take steps to include, where feasible, concerns related to the Commission's age jurisdiction. The Commission has also established ongoing liaison with specialists in aging from both the private and public sectors. The Commission has also expanded its library collection to include works related to "age" and "aging."

ITEM 17. COMMUNITY SERVICES ADMINISTRATION

FEBRUARY 4, 1981.

DEAR MR. CHAIRMAN: The Community Services Administration is pleased to respond to the committee's letter of October 30, 1980, requesting that CSA submit a report on the Agency's activities and programs for the low-income senior adults.

Our report is for fiscal year 1980, as was requested, and includes information on the senior opportunities and services (SOS) program, as well as all of CSA's programs that provided services and assistance in urban and rural areas of our country, where otherwise the services are either inadequate or nonexistent.

The changed format includes narrative program descriptions that detail in some depth and length the catalytic and generative power of SOS grants. Included also, are descriptions of SOS funded research and demonstration grants; description of other CSA programs; activities of CSA's headquarters and regional

staffs involvement in community or local forums, State conferences and miniconferences preparatory to the planned White House Conference on Aging (WHCoA) to be convened in Washington, D.C., November 30 to December 4, 1981.

CSA jointly funded with AoA the WHCoA miniconference on energy, convened by the American Association of Retired Persons; the WHCoA six regional miniconferences on the rural elderly, jointly funded by nine agencies and convened by Green Thumb, Inc. CSA singly funded two regional WHCoA low-income elderly conferences, convened by the National Community Action Agency Executive Director's Association (NCAAEDA).

Thank you for the opportunity you have provided CSA to submit information for part 2 of the committee's annual report, "Developments in Aging: 1980."

Sincerely,

WILLIAM W. ALLISON, *Acting Director.*

Enclosure.

SERVICES PROVIDED TO THE ELDERLY POOR DURING FISCAL YEAR 1979 THROUGH PROGRAMS FUNDED BY THE COMMUNITY SERVICES ADMINISTRATION

LEGISLATIVE MANDATE

The Economic Opportunity Act of 1964, as amended, charges the Community Services Administration with the following responsibilities to aid the low income poor:

(1) To identify the needs of poor persons over 60 years old.

(2) To meet identified needs in one or more of the following areas: (a) development and provision of new employment and volunteer services; (b) effective referral to existing health, welfare, employment, housing, legal, consumer, transportation, education, and recreational and other services; (c) stimulation and creation of additional services and programs to remedy gaps and deficiencies in presently existing services and programs; (d) modification of existing procedures, eligibility requirements and program structures to facilitate the greater use of, and participation in, public services by the older poor; (e) development of all season recreation and service centers controlled by older persons themselves, and other activities and services needed to meet the requirements of the elderly poor or to assure them greater self sufficiency.

(3) To make maximum use of the services of other Federal agencies, particularly the Administration on Aging of the Department of Health and Human Services.

(4) To seek sponsorship of programs funded under titles III and V of the Older Americans Act of 1965 as amended.

(5) To develop and carry out pilot projects which aid elderly persons to achieve greater self sufficiency.

(6) To serve the elderly poor in all other components of the Community Services Administration programs.

(7) To plan for the participation of the poor in programs funded under the Economic Opportunity Act; to continuously review programs to insure that the needs of the elderly poor are taken into consideration; to maintain interagency liaison with the objective of a coordinated national approach to the elderly poor, and to determine the need for new programs and recommend legislation to Congress.

DEMOGRAPHIC TRENDS

The number and percentage of persons over 60 since the turn of the century, paralleling improvement in life expectancy and reductions in the birth rate: In 1900, 1 person in 25 was over 60 years old. In 1978, slightly more than 1 person in 10 in a national population of 220 million was over 60 years old. By 2030, the Census Bureau projects that almost 1 person in 6 will be over age 60. The number of elderly people who are poor or near poor has been reduced in the last decade, based on 1978 census data. In 1978, there were 4.8 million older persons in poverty and an additional 3 million older persons with incomes less than 125 percent over poverty thresholds.

Because of the gap in life expectancy between men and women, a high proportion of the elderly poor are females living alone; 40.6 percent of women over age 75 lived alone. The proportion of the elderly poor that is extremely old (age 85 or older) is rising. In 1975, 37.4 percent of the elderly were age 75 or older compared to 29 percent in 1900 and 33.7 percent in 1960.

Economic and Social Trends Affecting the Elderly Poor

There are a number of trends, both positive and negative that have recently affected the quality of life for the elderly poor. Some of the *positive trends* have been:

—Extension of mandatory retirement to age 70. Elderly persons seeking paid employment to supplement retirement income or wishing to continue in their jobs are protected by antidiscrimination laws.

—Increased Federal regulation of private pensions. Enactment of ERISA greatly increased accountability of private sector employers for adequately funding benefits, created mandatory vesting rights for employees and increased portability of pensions.

—Improvements in medical care are increasing life expectancy, thereby the number of citizens who enjoy good health to older ages is increasing.

—Increased tendency to index the level of Federal transfer payments to increases in the cost of living has slowed the erosionary effect of inflation on benefits.

—Laws regarding public accommodation for the physically handicapped have increased access of the elderly to public transportation and public buildings.

—Discounts for senior citizens for transportation, prescription drugs, cultural events, personal services and entertainment are a growing trend.

—Increased provision by Congress of transfer programs and social services programs designed to serve the elderly poor.

—Emphasis on the problems of the elderly by the President. Former President Carter has called for a decennial White House Conference on Aging in 1981.

Some of the *negative trends* have been the acceleration of:

—Increase cost of health care. The cost of physicians' services, hospital care, nursing home care, and day care facilities is increasing. The deficit between medicare benefits, insurance, and the cost of medical care is increasing.

—Increased cost of energy for heating, cooling and cooking. The elderly have been disproportionately affected because many live alone or with a spouse in older, poorly insulated homes, much too large for one or two persons. The aged are more vulnerable to the effects of excessive heat and cold than other adults.

—Increased property taxes. Many of the elderly are forced to sell their homes to pay delinquent taxes. These homes are frequently the owner's only substantial financial asset.

—Rental costs, where there are no rental cost ceilings, are forcing the low income elderly to move to poorer housing accommodations.

—Food costs are increasing relative to other costs. In 1980, increases in the cost of food accounted for slightly less than half of the double digit increase in the cost of living index.

—Failure of private pensions to keep pace with inflation because benefits are paid at a fixed rate, not indexed to living costs.

—Rising fear of physical assault, theft, con games and living in unsafe neighborhoods. In 1975, at least one third of the older population had at some time experienced criminal victimization.

—Fewer opportunities for the elderly to live with children or younger relatives. Currently, the average U.S. family moves every three years, frequently to a different area. Decline of extended families increases the cost of living for the elderly, increases social isolation, and decreases the family support needed for independent living.

—Decline in financial support from children. Increased living costs have created circumstances where two incomes are necessary to support a nuclear family.

—Increases in rental costs are forcing the elderly poor to cut back on food and medical care and/or to move to inadequate housing.

—High rates of conversion of rentals to condominiums are resulting in the elderly poor people being uprooted from long established living patterns. Frequently those affected are unable to find adequate housing they can afford.

—Decline in the number of public transportation routes, particularly in rural areas is affecting the ability of the elderly to get to markets and needed services.

—Increased costs are preventing the elderly from buying the clothing and household furnishings they need for warmth. The cost of shoes has doubled in the last two years. The elderly poor are unable to afford enough clothing to enable them to layer several garments for protection against the cold.

COMMUNITY SERVICES ADMINISTRATION PROGRAMS

CSA funds programs assisting low income older persons through section 221, local initiative funding of community action agencies, section 222, special programs and assistance and section 232, research and demonstration programs. CSA grantees, particularly community action agencies and national grantees funded to provide backup assistance in specialized areas, act as a network that links together and focuses on the needs of the elderly poor, and garners assistance from Federal, State, and local government and voluntary sources.

The major CSA programs providing assistance to the elderly poor are local initiative programs, senior opportunities and services programs, community food and nutrition programs.

Generally, programs designed to meet the needs of the elderly poor in local communities, whether by advocacy, better integration of services at the State level and at the point of delivery, or by direct services, are funded and administered by regional office. Programs which advocate for the interests of the elderly as they are affected by national policies, most programs which test new approaches to serving the elderly poor, and programs which provide specialized support to regionally funded programs are funded and monitored by the CSA national office.

SENIOR OPPORTUNITIES AND SERVICES PROGRAMS

Senior opportunities and services programs was authorized by the 1967 amendments to the Economic Opportunity Act. The program was intended to provide assistance for meeting those problems of the elderly poor that could not be met by CSA programs serving all age groups. In 1979, CSA revised its priorities and funding policies for SOS programs to assist the increasing numbers of vulnerable and frail, elderly poor persons to remain in their homes and avoid institutionalization; to assist the elderly poor to organize and advocate for their own interests; to strengthen the capability of grantees of the Community Services Administration in planning and programing; and to help the elderly avoid criminal victimization. The policy areas adopted were: outreach and follow-through, access and advocacy, innovative programing and integrated services, income maintenance and employment, elderly victimization, independent living, nutrition, transportation, and age discrimination. The new CSA policies are equally enforceable on all grants made by headquarters and regional offices. (See attachment A for the SOS policy statement for 1980.) In 1979, CSA also changed its program reporting to yield information on unduplicated numbers of beneficiaries in each policy area. The new reporting system, the Interim Data Highlight, began in the last quarter of 1979. The 1980 annual report reflects additional programmatic information collected under the new system. Currently available data on beneficiaries by our two major SOS policy areas is summarized in attachment B.

Funding of Headquarters and Regional grantees during fiscal year 1980 is summarized in attachment C.

Independent Living

The greatest emphasis in SOS programs nationwide has been to provide a variety of types of assistance designed to prevent unnecessary institutionalization of older people, and to assist them to continue to lead full lives.

Senior opportunities and services programs and community action agencies' activities help elderly poor people apply for property tax rebates, appeal rises in assessments, repair homes, qualify for weatherization programs, qualify for assistance in paying utility bills, lower fuel bills by practicing simple, but effective energy conservation tactics and receiving food, clothing, shelter and medical care in emergencies. Community action agencies and SOS projects find housing accommodations, stimulate construction of housing units for elderly poor people, and help them obtain homemaker services, visiting nurse services, and home delivered meals. CAA's and SOS projects sponsor immunization and health

screening clinics, health education classes for the elderly, and exercise programs. The agencies also operated community centers for low income elderly people where they do craft work, hold social activities, provide congregate meals, organize educational and cultural programs, plan outings, exchange services and share activities with children and teenagers. CAA and SOS volunteers telephone and visit homebound and isolated older people to provide companionship and information. Other SOS national and local priorities and policy statements are summarized in attachment A.

Independent Living—A Local Project

Project Involve, Inc., a delegate agency of the Community Relations-Social Development Commission (CRCSDC), the local community action agency, city and county of Milwaukee is a low-income senior adult program designed to provide neighborhood outreach, information, referral and followthrough and advocacy to bring community organizations together in a coordinated and comprehensive manner to confront and conduct activities for low-income senior adults.

Project Involve, Inc., received $184,000 in fiscal year 1980 from the SOS program funds. This funding generated $763,590 in additional monies from 12 additional Federal, State, county and city sources. Project Involve offers comprehensive services through five senior centers located in areas of high elderly concentration. The program provided 25 different types of services to more than 29,000 low-income seniors to enable them to continue to live independently with self-respect and dignity still intact.

The services provided to them included clothing, home-delivered meals, emergency food, employment, financial assistance, and counseling, food stamp assistance, friendly visitation, homemaker help, housing repair, legal aid, health care, consumer education and shopping assistance, social security and SSI eligibility aid, tax/rent relief assistance, telephone reassurance, emergency transportation, senior companions and outreach, information, referral and followup and other services. These comprehensive services enabled the program to serve 4,362 new unique persons who had not been assisted in prior years.

Innovative Programing and Integrated Services

CAA's have put together and are operating integrated services by combining categorical programs with SOS and local initiative funding, volunteer and fund raising efforts. CAA's are participating increasingly with area agencies on aging (AAA) in developing area plans, and as program operators. A common pattern is for a CAA to operate a congregate meals program funded from AoA, title III, bring people outreached by SOS staff to the meals by means of AoA, a Department of Transportation, or by an SOS funded program. Afterwards a crafts and social session organized by SOS staff, might be provided and held in a center funded by the Administration on Aging, HUD, a city or county. Another common pattern is for elderly shutins outreached by SOS staff to receive home delivered meals, homemaker services, comprehensive health care and other services such as legal counseling provided under an agreement with an area agency on aging (AAA), a city or county council on aging, or a city or county human services office.

A low-income elderly program participant may be living in a house that has been weatherized by a CAA program combining CETA title VI funds for labor costs, Department of Energy funds for materials and CSA funds for energy crisis assistance and administration. The resident may have also participated in a CSA funded energy conservation education program to increase the benefits from the investment in weatherizing the house.

At the national level, CSA's sponsorship of innovative programs focuses on projects designed to stimulate research and training of professionals and paraprofessionals to work with the elderly poor. Regionally funded programs stress innovative methods of integrating services and inventive types of services such as networks to barter services and home produced items.

Innovative Programing and Integrated Services: A City Program

In New York City, the Community Development Agency, New York City's community action agency, received in fiscal year 1980, $445,251 from the Community Services Administration's SOS program funds to develop and maintain 16 core services/information/access centers in 15 neighborhood development areas

as immediate response mechanisms to ongoing problems of the low-income senior adults and as bases for the development of new programing and comprehensive, integrated programs for this expanding segment of the city's population.

The SOS program funds generated another $2,649,000 in funding from other sources and enabled the centers and a network of subsites to assist or provide services for 681,232 low-income senior adults.

The three primary areas of service delivery were: nutrition (congregate and home delivered meals); information and referral including information dissemination and case advocacy in areas such as employment, entitlements, housing, etc.; and integrated general services including home care, counseling, social/cultural/recreational programs and group services.

One of the SOS projects, the Nutrition and Social Services Center, located in a United Methodist Church in the upper, westside of the city served its one millionth meal in July 1980. The Nutritional and Social Services Center serves congregate meals each day to an average of 450–500 seniors and its "meals-on-wheels" delivers nearly 100 meals each day to homebound seniors. Part-time staff and volunteers deliver these meals in compartmentalized, sanitized containers by means of small upright, two-wheeler carts that can be loaded with 6 to 8 hot meals and lifted aboard a bus or subway. This center serves a densely populated area of 10 square blocks comprised of old highrise apartment buildings largely occupied by single elderly individuals or couples.

Access and Advocacy

The senior opportunities and services (SOS) programs and community action agencies' activity help low-income older people qualify for food stamps, emergency energy assistance, social security benefits, SSI, veteran's benefits, medicare, homemaker services, visiting nurse services, and pensions. CAA's advocate on behalf of applicants with officials and represent applicants at fair hearings. Statewide federations of low-income senior programs in 11 States have combined with other SOS grantees and CAA's to organize groups and associations of low-income senior citizens and provide training in the legislative process to enable the low-income elderly to advocate effectively for their own interests.

Access and Advocacy: A Statewide Program

The Colorado Congress of Senior Organizations (CCSO), from the time of its initial funding, has had as its major foci the organization of low-income senior adults to advocate for themselves in order to change restrictive local and Colorado State laws and to assist these seniors to gain access to the services and entitlements for which they are eligible.

CCSO initiated and is a participant in a coalition between the Senior Edition, the Senior Lobby and the senior discount programs. Currently, CCSO is statewide federation of 52 organizations of older persons involved in training the elderly to be their own advocates and provide them with the Federal, State, and local entitlement program information. This has been accomplished through the development of a statewide legislative advocacy communication and training network.

In addition, CCSO administers an ombudsman and legal services program through a network of local advocates all around the State. Some of these are volunteers; some are senior aides; some are VISTA volunteers and a few others are paid staff. CCSO is developing linkages with national reform organizations, such as the Citizens Coalition for Nursing Home Reform.

During fiscal year 1980, CCSO targeted for special emphasis the needs of the Native Americans and Hispanics within the State. It sought to involve local groups of these minority and ethnic populations, as well as other seniors, in local forums that were held in nearly every community throughout the State in preparation for the October 1980, Governor's White House Conference on Aging. The CCSO director, the legislative liaison, and the former board chairperson were keynote speakers at the White House Conference on Aging-Colorado State Regional Conferences.

CCSO, the ACTION State office and the Colorado Agency on Aging have four interagency agreements through which they have combined nearly $1 million of grant funds from CSA/SOS. ACTION/VISTA and the Administration on Aging (AoA)/State agency on aging to make a major, concerted and comprehensive effort to assist the low-income senior adults in every area of the State. CCSO is the lead agency and will administer and monitor the grant programs.

Outreach, Information, Referral, and Followthrough

Outreach, information, referral and followthrough are the means used by local SOS programs to locate the elderly poor, to determine who needs which services, and to link the individual to the services provided by the CAA, the area agency on aging (AAA) local government, the voluntary sector and other available resources.

Volunteers and community aides, funded by section 221, local initiative funds, outreach elderly poor people, as well as SOS outreach workers who are funded specifically for this purpose. Providing coverage in rural areas is particularly difficult and expensive on a per contact basis because of the distance involved between each client and the relative lack of service delivery programs.

CSA stresses the importance of followthrough on outreach contacts, by not counting as beneficiaries in 1980, individuals who were contacted and assessed but did not receive any additional assistance. Other outreach methods used included community meetings, newsletters, and the development and distribution of directories of available services.

Outreach, Information, Referral and Followthrough: A Countywide Senior Program

The Division of Senior Programs of Tioga Opportunities Programs, Inc. (CAA) since its origin in 1968 with a $24,258 grant from CSA for a senior opportunities and services (SOS) program has grown from a small outreach (information and referral) service to a comprehensive, coordinated services delivery system for the elderly. The target group has been in the past, and continues to be, the low-income, frail older persons of Tioga County, N.Y. Since 1974, the dollars received from CSA for the senior opportunities and services program has remained at a level of $40,000. However, with ingenuity and creativity this money has generated several hundred thousands of dollars to implement new programs and fulfill many of the needs and concerns older people have living in a rural county, where public transportation does not exist. The total elderly population for the county in 1980 was 6,000 with 36 percent at or below the poverty level.

One of the first and still major needs the SOS program of TOP, Inc. began to address, after receiving the first SOS funding in 1968, was transportation. With the purchase of an eight-passenger station wagon, low-income older persons were transported to medical appointments and grocery shopping. Since that time, with the addition of new funding from the State office for the aging (title III–B) and Department of Transportation (UMTA 16(b) 2), the program now has four 12-passenger vans, one of which is equipped with an automatic wheelchair lift for handicapped persons. The vans are radio equipped and the demand response system is used for maximum efficiency in a rural area.

Persons 60-plus are transported to nutrition sites, doctor and medical appointments, social service agencies, shopping centers, banks and other necessary locations. Persons call the coordinator in their area 24 hours in advance, with the exception of the medical vans where calls are made directly to the office and a schedule for the driver is made. Persons are picked up at their door. A total of 18,680 one-way seat trips were provided in 1980.

In addition to transportation, outreach service was provided, starting in 1969 on a one-to-one basis where referrals were received.

In 1974, the title VII nutrition program was implemented with the county legislature designating Tioga Opportunities Program to administer the program. This nutrition program became a part of the division of senior programs, and four sites were opened in areas of Tioga County where the largest number of low-income elderly were located.

The number of congregate meals served in 1980 was 37,205 and 11,272 meals-on-wheels delivered to the homebound, frail and low-income elderly.

In 1975, the Tioga County Legislature by resolution designated T.O.P., Inc., through its division of senior programs to act on their behalf as the office for the aging to receive title III–B funding. This gave an expansion of services as well as adding the planning function to the division of senior programs. New sources of funding and innovative programs have resulted, as well as the integration of existing services and the tie-in with other social service agencies in the county—further coordinating and filling gaps in service.

The outreach component, which is still funded by CSA's senior opportunities and services program is the link that ties the program together. The outreach aides are the "eyes and ears" for the program and as such are able to obtain and

give information and referrals that are vital to meeting the grass roots needs of the elderly poor. Paraprofessionals employed by this program have had a minimum of 3 years training on-the-job including workshops on counseling techniques, college credit courses in psychology and sociology of the aged, summer seminars at local institutes and numerous conferences on aging. Among the many services this component provides are: Assistance in obtaining entitlements and other services, such as medicaid, medicare, food stamps, S.S.I., social security, VA pensions, legal, tax break, fuel programs, rent subsidy, FHA grants, public health nursing services, transportation, meals-on-wheels and companion-chore services. Assistance entails making application for those who are blind/disabled, accompanying them to various services as supporter and advocate and education to participants on eligibility for services.

Outreach aides work directly with hospitals, social workers on discharges, obtaining in-home services, consultation on prescription or over the counter drugs used by participant. Hygiene problems are dealt with when requested, assistance with phone calls is given for those who have visual or audio difficulties. Shopping for groceries, supplies, prescriptions, etc. is done by the outreach workers. Above and beyond the call of duty, they help hanging curtains, gluing furniture, finding homes for pets when requested and dealing with family problems. All these things may not seem important but help to keep the "human" aspect in the services and give peace of mind to the participants.

The outreach staff assist with health fairs, foot clinics, pap smear clinics, glaucoma clinics, sponsored by the division of senior programs. They do outstanding public relations in dealing with town and village officials as advocates for the elderly clientele. In addition, they help to train the student interns from Cornell University in the field work they are so adept in; 885 participants, 90 percent of whom were of limited, low-income were served by this program in 1980. Additionally, 180 participants were served by the two friendly visitors whose job it is to seek out the problems and refer them to the proper sources for solution. Categories of services addressed by the outreach staff and the number in each category follows:

Title IV–A, funding received through the State office for the aging helps to train staff, especially the 9 paraprofessionals to better serve the needs of low-income elderly persons.

Title V is available to the senior program through three sources: Twelve slots are allocated from Green Thumb, Inc.; five slots from Steuben County CAA, under a grant from National Council of Senior Citizens; and seven slots from the New York State Office for the Aging. Those employed are used primarily to supplement staffing of the division in the nutrition program, craft shop, office and friendly visiting services.

Student interns from Cornell and SUNY are assigned to the program during the school year for their practicuum experience. They are involved in learning how to tie in with the community and at the same time they are trained to assist in outreach work. The large print service directory is a product of student work. The program has one or two graduate students per semester for 2 days each, per week. The hours cost out at $10,416 per school year.

CETA personnel and social services work program enrollees are employed in the nutrition program as supplementary food service workers. Their time amounts to 5,630 hours costs out at $17,453 a year.

Recreation is another service that is vital and cost effective in allowing persons to remain independent and alleviate social isolation. Funding for this program is jointly provided through New York State. Recreation for the Elderly via the New York State Office for the Aging and individual municipalities (50 percent from each source). Work is done with groups of 10 or 12 persons in three areas of the county as well as at the nutrition sites where participation ranges from 8 to 15 persons per session. Bead work, macrame, chair caning, ceramics, needlepoint, bargello, oil painting, quilting, plaster craft, knitting projects, tole painting, pen and ink drawing and miscellaneous other craft are made. These skills are also taught to the elderly homebound, including special techniques for the blind and physically handicapped. The craft shop is the sales outlet for these crafts. The shop was opened 3 years ago and at the present time there are 50 low-income senior adults and homebound elderly who have their crafts sold in the shop.

A senior community services employment program employee manages the shop. Contributors therefore receive the full tagged price for their articles, giving a financial subsidy as well as a feeling of usefulness. Outreach workers pick up

articles for sale in the shop from the homebound. The end of the year inventory in 1979 was $3,061.85 and sales in 1980 amounted to $4,325.13.

Through a model project funded in 1979 from AoA, Washington, D.C., a companion-chore, minor repair project was implemented that served more than 150 elders 60 years and over. In 1980, funding was through the New York State community services program. The chore program, as it is now called assists elderly persons with household chores, who could not afford to hire help but who also are just over the medicaid guidelines. They are very needy in the sense that they do not qualify for any financial assistance, yet cannot pay the minimum wage for home help and are not physically able to do their housework. This program has been extremely helpful in contributing to independent living by seniors in their own home setting, where they are most comfortable and happy—a viable alternative to costly institutionalization.

A program made available in 1980, to Tioga County's elderly population, "free of charge" is the vial of life program. Cost of vials were contributed to Lourdes Hospital by a large industry and then made accessible to the elderly. In cooperation with the local Sheriff's Department, arrangements were made for laminated photos to be included in the vial for positive identification in case of fire. The vials were placed in the homes of 600 elderly persons so that in an emergency, when technicians respond to a call and find the elderly person unable to talk, the decal on the door signals them to look in the refrigerator under the top shelf where the vial is located and contains all relevant information: name and address, medications, nearest relative, etc. so that treatment can be properly administered. The dollar value of this service cannot be evaluated but it is a life-saving effort.

Health screenings are done periodically during the year as follows:

Blood pressure readings follow up through their individual physician monthly at four nutrition sites serving a total of 1,412 in 1980. Sixty volunteers contribute time is valued at $4,686.

Pap smears are done twice a year through the family planning clinic serving approximately 80 elderly persons each time. Two volunteers' time is valued at $45.

Foot clinics are also held at 6-month intervals serving 54 seniors each time using a volunteer professional podiatrist and six volunteers whose time is valued at $495.

A yearly health fair is held each May during senior citizens month with screenings in diabetes, hearing, glaucoma, demonstrations in CPR and other information provided through Public Health Nursing Services and the Arthritis Foundation as well as local hospitals.

Another service is sex counseling for the elderly who are beginning a second marriage.

The discount card program made up of 101 local merchants is one method used to alleviate financial stress for elderly living on limited incomes. The program is a four county effort and gives an average of 5–10 percent discount on goods at participating retail stores; 365 businesses in the four-county area participate and 2,422 Tioga County residents have signed up for the picture card at a one time fee of $3.50. Applications are processed for Golden Park Passes available through the New York State Department of Parks and Recreation enabling persons 62 and over to enter any New York State Park free.

In addition to the services discussed above, provided directly by the division of senior programs, other services for the elderly have been generated by advocacy on the part of staff and the elderly themselves. One such program is the two new senior housing complexes located in Owego and Waverly with 32 and 35 units respectively; 84 persons aged 62 and over reside in these units which are subsidized so that renters pay no more than one-quarter of their income for rent and utilities.

The social and physical environment is such that residents feel very much at home. Both 2-bedroom and 1-bedroom apartments are available, but there is a long waiting list at each site.

Rent subsidy is available to 69 low-income elderly in private apartments, homes and mobile units, paying no more than one-quarter of their income for rent and utilities and funded by HUD and DHCR through Tioga Opportunities Program, Inc. Housing Department. Section 8 moderate rehab program also provides rental assistance for low-income tenants, and provides for another 40 units, some of which are occupied by low-income elderly.

A food bank for the poor, including low-income senior adults, is under implementation through T.O.P.'s community food and nutrition program. They have established a tie-in with the Wayne County food bank which is part of a national network to salvage and distribute donated, nonperishable food. The food is trucked to Tioga County by coordination with the local Sheriff's Department where it will be picked up by volunteers from six church related food pantries. The pantries will stock food until requested by a needy household. The nutrition program for the elderly will also be a recipient of the donated food.

The weatherization program under T.O.P., Inc. has winterized 96 elderly homes to make possible independent living in their own homes.

Tying in with other community agencies on behalf of elderly persons and their special needs, are memberships of the director and planner-coordinator on the Public Health Nursing Service utilization and review committee and advisory board, the department of social services advisory board, Riverview Nursing Home consumer board, cancer task force and long-term care committees of New York-Penn Health Planning Agency. A Cornell University professor, Mark Zober, Ph. D., assisted in the evaluation instruments and data collection for the model project independence as well as assisting in a needs survey instrument for the senior citizens division's new area plan for 1981.

As the foregoing information attests, Tioga County Office for the Aging is dedicated to the philosophy of helping low-income senior adults maintain themselves in their own homes as long as possible. It is demonstrated through this agency's experiences in the field of aging that only by the development of a comprehensive network of services, the regular monitoring and evaluation of these services and ongoing program development can the low-income elderly receive the services they require. Paramount in this structure is the outreach component. Even an understaffed, underfunded outreach component can provide more than basic linkages between the elderly and appropriate services providers.

The final accomplishment of this goal of effective service delivery demands dedicated advocacy in the interest of the vulnerable low-income older person, matched by unceasing efforts to forge linkages with other service providers and benefit program administrators. How well and aggressively this has been done by Tioga Opportunities Program, Inc., is illustrated and the two succeeding pages that shows the services and other funds and funding sources generated by $40,000 of SOS program funds a year.

Nutrition and Transportation

Senior opportunities and services programs and community action agencies organize, sponsor, and supplement staffing for communal and home delivered meals provided under title III of the Older Americans Act. CAA's outreach participants, provide transportation to dining centers and provide social, educational, and cultural activities after the meal. CAA's have found ways to prepare meals on-site, economically, from fresh meat and produce. CAA's provide nutrition education to the elderly, and secure assistance for the elderly in preparing meals at home through homemaker programs and voluntary assistance. The agencies also help low-income elderly people qualify for food stamps, as well as assist low-income people to raise their own food and livestock, and hold workshops on food preservation.

Transportation, particularly in rural areas, is a crucial element in bringing the elderly to services, getting services to homebound elderly, and encouraging socialization. Senior opportunities and services programs and community action agencies use agency vehicles interchangeably to provide individual and group transportation to the elderly. CAA's administer grant from the Department of Transportation and other sources to operate scheduled transit and dial-a-ride systems.

CAA's assist elderly poor to use existing transit systems, and to advocate for new routes and favorable fare structures. Transportation is provided for grocery shopping, medical appointments, congregate meals, social activities, and visits to service providers.

Nutrition and Transportation: A Multicounty Rural SOS Program

The senior citizens' program has been operating since 1968, sponsored by Hill Country Community Action, San Saba, Tex. The program, at present, is operating in nine counties; Mason, Llano, San Saba, Mills, Lampasas, Milam, Bell, Hamilton, and Coryell, and received $81,000 in fiscal year 1980 SOS funds.

The program has been able to add a number of permanent facilities for activities in the past few years. At present, there are permanent facilities in Llano (2), Goldthwaite, Hamilton, Gatesville, Copperas Cove, Rockdale (2), Cameron, Killeen, Lampasas and Lometa. Plans have been completed for permanent centers for Hico, San Saba, and Mason. Activities are being held also in Belton, Mullin, Priddy, and Evant. Harvest House in Temple is the base for several programs.

The 21 senior centers have become a base for comprehensive services for the low-income elderly in these nine counties. Below is a brief explanation of each program that is operated in or from the centers that assisted 15,000 elderly poor in fiscal year 1980.

Title III–C—Nutrition.—Funded by the Governor's Committee on Aging, this program provided a hot, nutritious meal to 158,600 persons 60 years of age or over. In addition to the meal, the participants had the opportunity to join in social activities, crafts and educational programs. Many of them volunteered as helpers with all phases of this program funded in the amount of $284,885 in fiscal year 1980.

RSVP.—The retired senior volunteer program is funded by the ACTION agency, with HCCAA as sponsor. This program involved 667 older persons in volunteer work in stations such as senior centers, schools, hospitals, nutrition programs, etc. The purpose is to keep the older person in the mainstream of activities because they have much experience and wisdom to share with other elderly persons. The 189,485 hours of service was valued at $587,404 in fiscal year 1980.

Title III–B.—Funding for social services in the amount of $44,000 was received through a subcontract with the area agency on aging, as part of their funding from the Governor's Committee on Aging. These funds are combined with the basic SOS funding from the Community Services Administration. The combination of funds provides such things as center personnel, supplies, telephones and travel, to operate the centers. Social services, crafts, educational programs, information and referral services, home delivered meals and transportation services are also provided. There are many outlets for the elderly through the center concept.

VISTA.—Volunteers in Service to America, funded by ACTION, provides personnel to work in the centers, nutrition programs, transportation, weatherization and outreach.

Transportation.—Transportation for medical, nutrition and emergency assistance is provided through funds from title III; Department of Human Resources, and rehabilitation programs. Fourteen vans in eight counties provide much needed transportation to the elderly poor. The total transportation funds received in fiscal year 1980 was $160,000 and provided 134,789 one-way rides.

Community food and nutrition.—Funds received from Community Services Administration to provide food vouchers for participants in need of emergency-type assistance. This is a much needed program and requested by many of our local governments.

Energy crisis assistance program (ECAP).—Funded in the amount of $378,000 to provided assistance to the elderly and low income who needed help with payment of excessive fuel and electric bills. This program has been most effective during the winter of 1979–80, and it is expected to be repeated during the winter of 1980–81.

Home weatherization and SSI home repair program.—These programs are funded through the Department of Human Resources. The household must meet the income guidelines, and the funds can be used for weatherization as well as to install safety devices such as handrails, and repair parts of a home considered a health hazard. Neither weatherization nor the SSI home repair includes labor costs. This must be obtained by the family. In many instances, the program has had the use of a Green Thumb crew, and help from the CETA manpower program has been available.

All of these programs described are a part of the coordinated effort to provide comprehensive services to the elderly, using the SOS senior centers as the base or focal point. The total program is accomplished by utilizing a number of funding sources. as well as personnel provided by agencies such as Green Thumb, STEP, VISTA, and CETA manpower. The $81,000 of SOS funds provided the Hill Country was the catalytic funding that generated a total of $2,042,118 of additional funds from other Federal, State, and local resources.

Community Food and Nutrition

Examples of types of CFN programs and program elements with substantial participation of the elderly poor are:

(1) *Chore services.*—A worker comes into the home of the elderly to help with the preparation of meals and to perform other needed household tasks as required.

(2) *Home shopper.*—Elderly people who cannot get out, plan a grocery list with a home shopper who goes to the store to purchase items. The shopper will also plan meals with the elderly who are mobile, prepare shopping lists, and accompany them to the store for purchases. The salary of such "shoppers" is paid by CFN funds.

(3) *Transportation.*—Provided for volunteers to deliver home meals and to assist others to get to Federal nutrition program centers.

(4) *Pantry service.*—Serves as a mobile grocery store for the elderly, and delivers, commodities which the elderly run out of prior to the receipt of monthly checks and these commodities are sold at reduced cost. Food items are supplied by co-op stores and CFN funds pay for the truck driver. The truck routes include homes for the elderly, and apartments and projects where elderly people are congregated.

(5) *Farmer's markets.*—Located in city parking lots have reduced food costs for the urban elderly poor by eliminating the middle businessman.

(6) *Garden and livestock projects.*—CFN projects provide seeds, fertilizers, livestock, feed and information. CETA workers and youth programs participants help with the work that is too physically demanding for elderly participants.

Housing Programs

The CAA's, SOS Projects and other limited purpose agencies funded by CSA indicated in a recent survey that they place housing as a priority need of the elderly poor whom they are serving. With $20 million in local initiative funds and $6 million in 51 research and demonstration programs, grantees in rural areas and approximately 749 CAA's are using section 221, local initiative funds, to help the low income obtain better and more affordable housing.

Elderly persons, who as a group are the most desperately in need of housing assistance, are the greatest beneficiaries of the housing program. This is particularly true with the extensive work that is being done that predominately assist the low income elderly with rural home repair projects. Agency funding enables local organizations to help poor residents of the community qualify for Farmers Home Administration loans and HUD community development block grants. It also undertakes, often with CETA labor, the actual repair of the home. The elderly poor (over 60) especially benefit from this program as they may become eligible for an outright grant if their incomes are too low to qualify for the low interest (1 percent) FmHA home repair loan. There is a greater need for grants to the elderly under the 504 FmHA programs because a major segment of the poor receiving assistance in housing are elderly. CSA programs provide staff support for rural housing development and rehabilitation management of subsidized rental housing and senior citizens housing. During fiscal year 1980. CSA housing office initiated a new national housing program entitled "rural housing initiatives program" that has funded 24 State coalitions to assist the poor, including the elderly poor, to obtain decent housing and related social services, also to improve opportunities for the poor to be involved in mobilizing and channeling additional housing resources to their areas.

Energy Crisis Assistance

The steadily rising costs of the elements essential to life: food, shelter, and energy are recognized as primary to the erosion of the economic stability and advancement of all households, poor and rich alike. In particular, the escalation of energy costs has had all encompassing and dramatically negative, direct and indirect effects on the quality of life. However, in no other strata are the increases felt more keenly than in the community of the elderly poor. Living on fixed and sometimes subsistence level incomes; fighting at minimum, the increasing medical problems brought on by age; often isolated and generally living in the substandard shelter traditionally available and affordable to the poor, the elderly face energy related choices which literally mean life or death.

During the winter of 1979–80, CSA administered the energy crisis assistance program (ECAP). This program was designed to meet the emergency needs of the poor and near poor and gave priority to the elderly through mandating special outreach, accessibility and eligibility considerations. Just short of a million elderly headed households received energy bill paying and other services related to the alleviation of energy crisis conditions. But, in addition to achieving the goal, preliminary ECAP evaluation is indicating that many elderly persons who had never before participated in programs of this nature were identified, involved and provided other vitally needed services.

In the summer of 1980, the heat energy assistance program (HEAP) provided assistance to 161,489 low-income elderly persons affected by the prolonged heat wave. HEAP funds were used to provide transportation to heat relief centers, fans and other cooling devices and in life and health threatening situations, pay utility bills.

In the winter of 1980–81, CSA has funded a $3 million outreach program called project energycare, incorporating the facilities and expertise of various national, State and local aging groups under the coordination of the National called project energycare, incorporating the facilities and expertise of various Council of Senior Citizens. Project energycare is engaged in a massive outreach program geared to ensure low-income elderly exposure and participation in the low-income energy assistance program (LIEAP).

The philosophy of the program is to bring a medicare concept to the involvement of the elderly in energy programs and to further identify and provide other needed services.

The energy crisis intervention program (ECIP) for the 1980–81 program year is operating through the community action agency and SOS networks to provide access to energy related services, leadership in the furtherance of community mobilization, planning and educational activities, replacement or supplement of alternate energy services where appropriate and direct services in the form of goods or services where extreme crises conditions exist and all other sources of aid have been exhausted. ECIP is a crucial element in the total Federal energy program for this year in that it addresses all the energy related needs not addressed by bill payment, and attempts to move the low-income poor and elderly to lesser degrees of energy program reliance.

PILOT, RESEARCH AND DEMONSTRATION PROJECTS—ELDERLY CRIME PREVENTION AND ASSISTANCE PROJECTS

The crime prevention/victim assistance projects of the New York City Community Development Agency (CDA) and the Community Relations-Social Development Commission of Milwaukee County completed in the last quarter of fiscal year 1980 3 years of a highly successful experimental program that was first funded nearly 3 years ago.

The Milwaukee and New York City projects grew out of a conceptual idea generated and developed by program and research personnel of the CR–SDC, the public community action agency of Milwaukee city and county.

The CR–SDC executive director and two of his associate directors are to be commended for the vision, time and energy that went into developing new concepts and techniques of preventing the elderly from being victimized, and if the elderly poor are victimized, then providing them with many types of urgent and critical assistance.

The concept was developed in 1976 and early 1977 as a national elderly crime prevention and assistance program and in 1977 received funding totaling more than $1.6 million for three city projects by CSA and four city projects by the Administration on Aging that totaled more than $1.6 million. Additional funding in the amount of $400.000 was made to the National Council on Senior Citizens by the Law Enforcement Assistance Administration (LEAA) and Housing and Urban Development (HUD) for the coordination, technical assistance and long-term impact evaluation of the projects.

The Milwaukee project has sustained a steady growth during its years of CSA funding, which have totaled $700.000. During this third year, the Milwaukee CR–SDC elderly crime project has already involved more than 2.000 elderly and other interested Milwaukee citizens in influencing changes in public policies to prevent elderly victimization and provide protection to the elderly through

block-watch organizations and educational programs to help the elderly avoid being attacked on the streets or in their homes.

The projects during their third year have also assisted more than 500 elderly victims of crime in resolving the many associated problems resulting from their victimization. These included the replacement of personal articles one normally has in his wallet or in her purse as well as the replacement of stolen or destroyed household goods and the provision of temporary housing.

The project also sought to reduce household burglary by installing deadbolt locks on doors, securing ground level windows with a heavy duty, unbreakable plastic cover.

Much has been learned from Milwaukee crime prevention/victim assistance project (CP–VAP) and the New York City project that the CSA can disseminate to other CAA's and cities through the "how to" manuals designed by the projects on planning and startup strategies. Many of the projects' features will serve as models for future projects and will benefit other programs across the country.

The Milwaukee project has been so successful that its component parts have been spun off to other agencies and will no longer require Federal funding. The New York City project through a "no cost time extension" grant action is continuing its project operations through February 1981.

The National Council of Senior Citizens (NCSC) with a small CSA grant of approximately $49,000 has provided training sessions in elderly crime prevention and assistance in Baltimore, Richmond, and Norfolk to the CAA staffs, law enforcement officials and interested community groups to test the validity and utility of the training manuals developed by the Milwaukee and New York City projects, as well as the Criminal Justice and the Elderly (CJE) Department of the National Council of Senior Citizens.

These multiple training sessions in all three cities have been well attended, excellent training experiences for the local CAA staffs, etc. and enthusiastically received by the training participants.

This NCSC funding demonstrated that cities differing in size, cultural makeup, ethnic and racial backgrounds and economies can put into place, at relatively small costs, effective elderly crime prevention and assistance programs.

Comprehensive Home Care for Senior Adults: A City Area Project

A comprehensive care project for homebound senior adults, utilizing neighborhood churches as a primary resource was funded in fiscal year 1979 and began its initial efforts in the first quarter of fiscal year 1980. The project, begun by the West Philadelphia Fund for Human Development, Inc., has through the efforts of three congregations in the Cedar Park-Kingessing section of West Philadelphia and an interfaith coalition of four other congregations in the area, set out on an endeavor to prove that volunteers, particularly those available through local congregations can provide comprehensive care to home-bound low-income senior adults in this poverty area of Philadelphia.

It already has established a case for the premise that a small staff will discover in the network of people connected with local congregations ready-made resources for keeping senior adults out of nursing homes and involved with their peers and society around them.

Lay and professional volunteers have been coordinated in a comprehensive effort to deliver hot meals, do house repairs, negotiate with absentee landlords, design nutritional plans, provide meals and groceries-on-wheels, intervene in health emergencies, maintain a watch on continuing health problems and provide in-home cultural enrichment for home-bound senior adults.

In the first year of its operation, the project has expanded from 5 to 50 senior adults served and from three to seven congregations directly involved in providing assistance to them.

—The expanded project will serve a neighborhood of 15,000 people of whom 15 percent are over 65—2,200 (approximately); (a) 80 percent of whom are near or below the poverty guidelines—1,760; (b) 20 percent need comprehensive, in-home care to avoid institutionalization at some future time—350.

—Hypotheses being tested by the project: (1) Congregations of all faiths constitute an available resource for low-cost, comprehensive in-home care. (2) Volunteers, such as church members, work most effectively in their own neighborhood (parish). (3) Home-bound low-income senior adults are strengthened and their situation improved when the approach is compre-

hensive and every program is dealt with from every perspective. (4) Senior adults themselves can provide an important part of the comprehensive care delivery system. Involvement in the project gives seniors an opportunity to serve those they know best.

—Components of the project: (1) Legal rights and advocacy—volunteers have been trained to provide services in the areas of taxes, real estate, wills and estates and areas related to the special needs of low-income senior adults. (2) Nutrition and health—daily delivery of food, both meals-on-wheels and groceries-on-wheels. The delivery system also serves as a base for health monitoring and support. Volunteer professionals have concentrated on health education of lay volunteers and of the senior adults. Another emphasis has been on preventative measures and on making use of existing health care facilities. (3) Home and apartment repair and maintenance—a small corps of retired craftsmen has been formed; a revolving loan fund established for senior adults who were unable to secure home improvement loans from banks and grant funds made available to assist in repairs or necessary renovation. This program component has been made possible by a credit union being established and incorporated by the West Philadelphia Fund. (4) Cultural enrichment—volunteers trained in the use of cultural resources meaningful to home-bound senior adults provide them with desired reading materials in large print, recordings for the blind, and readings in braille for the deaf and blind.

A low-wattage UHF radio station license has been secured by the West Philadelphia Fund for Human Development and a broadcast room has been built and all necessary equipment supplied as a gift from a local radio station in Philadelphia. The station will broadcast 2 hours each morning and 2 hours in the early evening. One hour of the morning and one hour of the evening broadcast will be in Vietnamese to serve the nearly 4,000 South Vietnamese who have been located in the West Philadelphia area.

We feel that this project can demonstrate to city communities and to rural areas of our nation that strong, viable and continuing local congregations can form consortia to assist the low income senior adults to remain in their homes, apartments or other housing units and remain independent, retain their individuality, sense of community and self-worth.

The Intergenerational University Service-Learning Centers Project

The purpose of this CSA national demonstration project has been to demonstrate how the human resources of our nation's 3,200 institutions of higher education can be made more available to meet the needs of older persons, particularly those who are poor.

The project has been cooperatively funded since October 1, 1978 by the Community Services Administration, the Robert Wood Johnson Foundation and the seven participating educational institutions. The Robert Wood Johnson Foundation has provided $350,000 and CSA has provided nearly $500,000 to support 2 years of local demonstration activities in seven communities because of their interest in developing systems which increase access to and expand the range of health-related services to older persons. The seven institutions of higher education: Boston University, George Washington University, Hampton Institute, University of Georgia, CUE of Indianapolis, University of Denver and Oregon State University are participating to meet simultaneously the needs of older persons and the needs of the institutions themselves. NCOA is providing leadership to the project because of its expertise in and historical commitment to developing innovative programs and services which improve the quality of life for older persons.

In this project, the objectives of NCOA, the Robert Wood Johnson Foundation and the seven participating institutions complement and reinforce title II, section 222(a)(2), "senior opportunities and services" (SOS) program objectives of the Community Services Administration. Through title II, CSA manifests its commitment to the better focusing of all available resources to enable low-income persons to become self-sufficient.

The primary objective of the SOS program is to "identify and meet the needs of poor persons above the age of 60 in projects which serve or employ older persons as the predominant or exclusive beneficiary group." A basic operating tenet

of each local program is to identify and fill gaps in services to older persons, especially those who are poor, vulnerable and isolated.

As a result of CSA participation in the funding of this project, NCOA has taken and will continue to take active steps to assure CSA priorities are reflected in the operation of the local centers. These mutual concerns of both NCOA and CSA are:

(1) *Emphasis on expansion of services to the poor elderly.*—As a result of CSA cooperative funding, NCOA has required of the local participating institutions that at least 40 percent of the elderly served through the project fall within the poverty category. After 6 months of 1980, the campuses report that over 68 percent of the older persons served have been poor. Services to the low-income elderly will continue to be a primary emphasis of the local programs.

(2) *Emphasis on the development of jobs and career training opportunities for low-income students.*—Involving students in need of financial aid means developing programs capable of attracting or generating funds for student support. This has been and will continue to be a major focus of the NCOA technical assistance effort to the participating institutions.

(3) *Emphasis on the ways in which local CAA's can utilize university resources.*—The CAA's in each community have been involved in identifying needs and in the planning and development of the local demonstrations. CAA representatives are on the advisory committees of six communities (there is no CAA in Hampton, Va.). As a regular part of the site visit schedule, NCOA staff meet with regional and local CAA personnel to discuss cooperative ventures. NCOA has developed a model for a followup project which it hopes several CAA's will elect to initiate as a joint venture this year. This pattern of technical assistance and site visits continued during the second year of the project. During the second year, materials are being developed for dissemination to all CAA's about how they can tap into and utilize local college and university resources.

(4) *Focus by university faculty and students on the needs of the elderly poor.*—This project is expanding and improving opportunities for faculty and students to have needed experiences with elderly persons suffering from the effects of poverty. We are already seeing evidence of how these experiences are generating more community interest in the poor, especially the older poor. This may have the long-range effect of facilitating the redirection of some of the intellectual resources of the universities to seek solutions to the causes and social and economic costs of poverty in America.

(5) *Emphasis on the development of in-home, access and followup services for older persons.*—NCOA and the participating institutions are placing special emphasis on the development of service-learning projects which foster independent living of the elderly. Projects which are being planned or are underway include home-help and chore services, outreach, escort, counseling and advocacy, followup and hospital discharge planning. These foci are based on the recognition by NCOA, CSA and the local communities of the dire need to expand and improve services in these areas.

This report provides a summary of the major activities and accomplishments of the intergenerational service-learning project during the 7-month period from January 1, 1980 to August 1, 1980.

Overview of National Staff Activities

NCOA project staff has been proceeding with tasks and activities in accordance with the plan of operation in the most recent CSA highlights memorandum. Staff efforts have primarily concentrated on the following activities:

(1) Continued technical assistance, consultation, and oversight through periodic site visits, telephone, and mail as well as semiannual meetings of local project personnel.

(2) Evaluation and reporting carried out in accordance with the plan and documentation provided to CSA. Some modifications have been made in the evaluation strategy on the basis of recommendations by the Office of Policy, Plans, and Evaluation and the older Americans' office.

(3) Continued assistance to the seven local projects in identifying and soliciting local sources of funds to support various demonstration activities.

(4) Developed outlines of all final project publications. First drafts of selected chapters have been completed for some.

Summary of Local Campus Activities

During the first 7 months of 1980 for each of the seven participating institutions of higher education, over 569 students were involved in providing more than 42,000 hours of services to more than 12,000 older persons. Over 60 percent of the older persons served were poor, significantly exceeding the CSA contractual mandate—at least 40 percent of the persons served be poor.

Each of the seven campuses has developed, identified, and implemented feasible projects which have nationwide implications for colleges and universities. NCOA staff has worked extensively with each of the schools during this time to focus their efforts on the development, expansion, and strengthening of those projects which are most likely to become institutionalized and continued on a long-term basis.

Summary of Public Policy Initiative

A major accomplishment of the intergenerational service learning project during the past 6 months has been the effort to change public policy to enable colleges and universities across the country to replicate or adapt models developed from the demonstration project. Based on the knowledge gained during the first 14 months of the national demonstration, NCOA developed and proposed amendments to title IV–C of the 1980 Higher Education Act. These amendments are designed to provide both an incentive and a means for institutions of higher education to use college work-study students in community service-learning activities on behalf of low-income community residents. For every student who is employed in a qualifying experience, the school will be allowed to retain 2½ times the usual administrative cost allowance. Both legislative language and most of the committee report for these amendments, which are almost certain to be included in the final version of the bill approved by Congress, were written by NCOA project staff.[1] It should be noted that these amendments contribute to the general goals of CSA as well as the SOS program because it encourages the development of student-delivered services for low-income people of all ages. Although it is difficult to accurately predict the impact of a program where participation is voluntary, NCOA staff conservatively projects that by 1983 the amendment will result in a annual involvement of 245,000 students providing over 44,000,000 hours of service for or on behalf of low-income persons.

Plans for the Final Phase of the Demonstration Project

At present, the demonstration project is scheduled to end in July 1981. The Robert Wood Johnson Foundation, which has already provided $350,000 for support of campus activities, recently approved a supplemental grant of $70,000 to enable the campus programs to operate for a second full academic year until June 1981, and CSA provided a supplemental grant of $49,528. These supplemental grants were made in recognition of what the project has been able to accomplish to date and the following potential benefits to the overall demonstration by providing an additional 6 months of program operation:

(1) The findings of the program would be based on local programs which will have operated for 2 full academic years. Excellent progress has been achieved during the first full academic year of the project, but we believe that a second full academic year would yield considerably more exciting projects and results.

(2) National funding of the local programs would be terminated in the springtime and therefore be consistent with the academic budget cycles. This is likely to have a substantial impact on the ability of the local universities to institutionalize the model programs by having an opportunity to incorporate the programs into the normal budgeting process.

(3) NCOA staff could actively participate in the development of regulations relating to the new college work-study amendments and actively encourage utilization of new work-study opportunities at the demonstration sites and other universities nationwide. These efforts could have a critical impact on the extent to which colleges and universities ultimately participate in this new federally supported program. During this time, NCOA could also develop a special techni-

[1] NOTE: NCOA staff time directly related to this public policy initiative was *not* charged to the CSA-funded account.

cal assistance report aimed at enabling CAA agencies to take full advantage of the new legislation.

(4) NCOA and local universities could do a more complete and extensive dissemination of project findings to encourage project replication throughout the country. During this time, NCOA staff would develop and implement training programs for various conferences and prepare articles for appropriate professional journals. Details of the dissemination efforts will be developed in collaboration with CSA officials.

Health Advocacy for Older Adults: A University Project

The Institute of Gerontology, University of Michigan in Ann Arbor, Mich., was funded to demonstrate how CAA's, AAA's and other area agencies can be brought together to plan, coordinate, and implement health advocacy programs on behalf of the elderly poor. The project covers a four-county area in the State of Michigan: Oakland, Livingston, Jackson, and Washtenau.

The ultimate goal of the project is to improve access to and the quality of health care for the elderly poor residing in the community.

During the first year of operation the Institute of Gerontology researched, developed, and assembled components of the staff/student training program and compiled a training manual. Information includes: physical and psychological aspects of aging, interpersonal skills, advocacy methods, and evaluation instruments. Planned, scheduled, and implemented the staff/student training program. Conducted a health education workshop at the Willow Run Nutrition Site entitled: "Sleep Disorders of Older People and Relaxation Techniques." Researched and developed drafts of five additional pamphlets. Titles are: "Cardiovascular Disease," "The Normal Changes of Age," "Cancer," "Stroke," "You and Your Doctor."

Planned and conducted a peer counselor recruitment program in Jackson, Mich., with the Willow Run/Ypsilanti peer counselors as program presenters and role models. Commenced the peer counselor training in Jackson, developed guidelines for the peer counselor training programs.

The projects' major objectives during the first year were:

(1) Developing model training programs for peer advocates.

(2) Training a cadre of older people in the four-county area to act as peer advocates for the elderly poor in health-related situations.

(3) Developing models of survival education and health education workshops.

(4) Providing survival education to large groups of older people in nutrition and senior centers in a variety of substantive health and consumer issues, in order to make them better health consumers.

LOCAL INITIATIVE PROGRAMS

In fiscal year 1980, the Community Services Administration received $382 million of local initiative (LI) funds. Of this amount, $57 million, more than one-seventh of the total, was spent in the provision of services or assistance to low-income elderly. In fiscal year 1980, the 218 senior opportunities and services (SOS) program allocations totaled $9.2 million. These LI and SOS funds generated more than $450 million from HEW, HUD, USDA, DOL, and State and local sources for low-income elderly citizens. The above local initiative and SOS funds, totaling $66 million allocated by the agency to serve the low-income elderly, do not include other agency funds from the community food and nutrition, energy, rural housing, and the research and demonstration program funds. A considerable part of these funds went to serve the low-income elderly.

THE WHITE HOUSE CONFERENCE ON AGING ACTIVITIES

CSA headquarters and regional offices have adopted several strategies to assure that the special needs of the elderly poor are addressed in the White House Conference on Aging (WHCoA). The scope of our activities has extended to the local, State, regional, subnational, and national level. Whenever possible, CSA at the national, regional, State, and local levels have coalesced activities with other Federal, State, and local agencies whose programs also focus on the elderly. This has not only prevented duplication of effort, it has developed stronger ties where they might not have previously existed. Interagency coordination has

included the Department of Health and Human Services; the Administration on Aging, ACTION, and DOE at the national and regional levels, as well as area agencies on aging; RSVP; Foster Grandparents; and Green Thumb at the local level.

For example, a region VII ad hoc advisory committee appointed in July 1980, has guided regional WHCoA activities. This committee, chaired by a CAA executive director, includes representatives from CAA's, region VII CSA, HHS, AoA, and ACTION.

Region VII WHCoA activities which have been completed or which are planned for the near future include:

Community forums: Since September 1980, more than 5,000 citizens of region VII have participated in at least 285 community forums sponsored by community agencies in preparation for the 1981 White House Conference on Aging. At these meetings, the low income have specified needs and recommended strategies to submit to their State White House Conference on Aging.

These forums have adopted many forms. For example: In Iowa, a single meeting attracted 250. In Missouri, a CAA took its meetings to small towns and villages in order to reach residents who might be overlooked in countywide meeting. In Nebraska, a CAA cosponsored forums in unCAPed counties to widen the scope of elderly poor involvement.

Other major events including the elderly include:

Iowa Poor Persons Congress: This was funded by CSA and including elected representatives including elderly from all Iowa CAA's and SOS project. Over 300 persons attended on September 19, 20, and 21, 1980. Resolutions in the areas of health, transportation, housing, and energy, including elderly concerns, were formulated and opted.

Kansas families and poverty conference: This was also funded by CSA, and included representatives from all SOS projects and CAA's, most of whom were elderly. Between 200 and 300 attended on June 13, 14, and 15, 1980, and covered such subjects as health and nutrition, upward mobility, economics, and housing.

Nebraska Silver Haired Unicameral: On October 14–16, 1980, representatives elected by low-income seniors met in the State legislature (unicameral) and worked out positions and priorities on taxes, transportation, and other matters of interest to the elderly. These will be submitted to the legislature and their progress followed. This was funded by CSA.

NCAAEDA miniconference on poverty and the elderly: Two NCAAEDA sponsored miniconferences on poverty and the elderly were held during the month of January 1981. The first in Kansas City, Kans., January 13–15, 1981. This conference covered regions VI through X. Approximately 220 low income, elderly delegates from 23 States attended. The second conference was in Washington, D.C., January 25–27, 1981, covering regions I–V. Approximately 250 low-income elderly delegates from 23 States attended.

The delegates worked in small groups to refine issues and establish priorities. Each working group presented its recommendations to the full body during a general assembly on the last day.

These two conferences were officially approved by the White House Conference on Aging. The recommendations from the two miniconferences will be distributed to the conference technical committees, to State conference coordinators, to the 2,000 national conference delegates and to the Members of the U.S. Congress.

In conclusion, we believe that the WHCOA activities encouraged by the CSA headquarters office and fully supported by the regional CSA offices and the CAA network represent an outstanding effort—one which is characterized by a high level of interagency coordination and cooperation and, more importantly, by a genuine commitment to advocate the special needs of our elderly poor constituents.

POLICY ISSUES FOR THE ELDERLY POOR

Purpose

The purpose of this project was the development of a series of policy recommendations to be used by CSA in formulating program decisions relevant to the elderly population and for the White House Conference on Aging's technical committees and the 22 Mini-White House Conferences on Aging covened by special interest groups.

The high proportion of elderly citizens in this country who fall into low income categories requires that CSA develop policies addressing the special needs of the elderly be periodically updated. Demographic trends also necessitate further planning for the changing needs of successive aged cohorts.

In an effort to identify the most pressing issues as well as the long-term considerations for policy planning for the elderly the Policy Planning Division of OPPE initiated a three-stage project. Participation of gerontologists active in the field was emphasized to ensure broad, detailed, sophisticated and current analysis of policy-relevant issues.

Work Plan

The project focused on three objectives relevant to policy issues for the elderly poor:

(1) Solicitation, review and presentation of policy papers for the Gerontological Society.

(2) Compilation of a series of policy papers for the 1981 White House Conference on Aging.

(3) Development of a policy statement for CSA addressing the elderly poor.

To accomplish the work plan, CSA solicited papers from gerontologists across the Nation on specific topics under the category of "Policy Issues for the Elderly Poor." Authors were informed that the best of the papers would be presented at a symposium session at the Gerontological Society conference, and that cash honoraria would be awarded. In addition the papers will be included as part of a policy statement on the elderly poor to be sent to the White House Conference on Aging in 1981.

The papers were solicited with the help of the Gerontological Society. Abstracts for papers were requested through a special mailing sent to members of the society announcing a symposium on "Policy Issues for the Poor Elderly" sponsored by CSA at a scientific meeting of the society. Abstracts submitted to the society were reviewed, as per usual society procedure and all of the abstracts were then forwarded to CSA. They were reviewed against the criteria of relevance, policy orientation, comprehensiveness and analytic sophistication. Thirteen of the 96 abstracts were selected for further development as bases for CSA policy planning. The papers will be written by November 1, 1980 and submitted to CSA's older Americans program Office and OPPE.

Objective II

The papers will be compiled and abstracted to be submitted to the 1981 White House Conference on Aging.

Objective III

The papers will subsequently be used as the foundation for a policy statement on the elderly poor for use in program planning within CSA. The papers will be included in a package to be circulated throughout the CSA-CAA network for reference in programing for the 1980's.

In fiscal year 1980, 218 SOS headquarters and regional offices' funded grantees reported serving more than 2 million low-income senior adults. The data displayed in attachment B shows that many of those served received multiple assistance or participated in a number of activities provided by the SOS projects.

In addition to the number of low-income senior adults assisted by the SOS program, as reported elsewhere in this report, more than 1 million other seniors in low-income strata were assisted through the CAA's local initiative fundings and the special assistance programs of community food and nutrition, energy crisis assistance, housing, and research and demonstration.

ATTACHMENT A.—*Older poor persons policy statements*

I. GENERAL CSA OLDER POOR PERSONS POLICIES

CSA's policy on the older poor will focus on the goals of promoting the highest possible level of independent living, preventing or delaying institutionalization, providing supportive services especially for the functionally dependent, increasing the access of the elderly poor to services, and overcoming and eliminating discrimination on the basis of age.

II. SPECIFIC CSA OLDER POOR PERSONS POLICIES

A. Outreach and Followthrough

Policy: CSA will support programs designed to increase the outreach capabilities of CAA's and other community organizations and institutions to reach the older poor.

B. Access and Advocacy

Policy: CSA shall continue to advocate directly and to assist national and local public interest advocacy efforts for the recognition of the needs of the older poor and allocation of resources to meet those needs.

C. Innovative Programing and Integrated Services

Policy: CSA will support programs which coordinate multiservice delivery and simplify and codify application procedures. CSA shall also fund innovative programs which demonstrate an integrated approach in dealing with the total life and environment problems of the older poor.

D. Income Maintenance and Employment

Policy: CSA will continue to support programs to train or retrain the older poor for specific job opportunities that will assist them in supplementing their incomes up to the amount allowed by existing legislation. CSA will advocate for changes in existing legislation which provides for reduced benefits when the elderly increase their earned income. CSA will support vocational rehabilitation programs which do not restrict the full participation of poor older adults.

E. Elderly Victimization

Policy: CSA will support programs, on its own and where appropriate with other federal agencies, which help to prevent the victimization of older poor persons and provide them with appropriate social services if they are victimized by criminals or consumer fraud.

F. Independent Living

(1) Housing.
(2) Energy.
(3) Noninstitutional health care services.
(4) Isolation: *Policy:* CSA will support and encourage programs that will help maintain the independent living style of the older poor, including the following: (1) programs that assist the older poor to retain their current home or to seek improved housing, either owned or rented, in an effort to provide a decent affordable living environment; (2) programs that implement energy conservation to reduce fuel costs for the older poor so that they can maintain independent residences; (3) programs that provide crisis intervention assistance; (4) public policies and health care models which de-emphasize the institutionalization of the elderly and which place emphasis upon community-based home health care assistance; and (5) programs which bring the older poor back into the mainstream of society.

G. Nutrition

Policy: CSA will support programs dealing with both formal and informal nutrition education for the older poor. CSA shall advocate with other federal agencies to redesign programs, legislation, and eligibility requirements to enhance service delivery. At the local level, CSA shall encourage efforts to improve the effectiveness of delivery of food and nutritional services to the older poor.

H. Transportation

Policy: CSA will support programs that will provide the older poor with access to adequate and affordable transportation, particularly in rural areas.

I. Discrimination

Policy: CSA will continue to support in its policies and programs allocation patterns which insure a fair share of resources to all age groups. CSA will support programs and policies which encourage the elimination of age, sex, and race as a factor in determining federally supported services and benefits.

ATTACHMENT B.—*Senior Opportunities and Services (SOS) Program National Summary of Program Priorities*

	Number of Services or Assistance Provided [1]
Independent living:	
Housing assistance	913,100
Nutrition: Congregate meals, home-delivered meals, food, pantry service, farmers markets	3,603,300
Home care	319,710
Health care	1,321,350
Elderly day care	5,873,520
Safety and consumer education and counseling	4,872,120
Community or senior centers	12,960
Community or senior center	10,303,200
Access and advocacy:	
Transportation (two-way rides)	2,489,880
New SSI enrollees	344,550
New food stamp enrollees	511,350
New training enrollees	138,570
New jobs provided	471,061

[1] These are duplicated total numbers of low income senior adult services and assistance and are not intended to indicate the number of individuals served or assisted.

ITEM 18. COMPTROLLER GENERAL OF THE UNITED STATES

JANUARY 27, 1981.

DEAR MR. CHAIRMAN: In response to your committee's October 30, 1980, request for information on our major activities concerning Federal initiatives or programs which affect the aged, we are enclosing a list of reports issued during fiscal year 1980 on reviews of Federal programs that concern the elderly (enclosure I). We have also included a list of audits in process which concern the elderly (enclosure II) and a statement of the General Accounting Office's "in house" activities which related to older persons (enclosure III).

Copies of the issued reports are being provided to your office separately. A summary of the major findings and conclusions for each report is included in a digest bound in the report or in the letter transmitting it.

Sincerely Yours,

ELMER B. STAATS,
Comptroller General of the United States.

Enclosures.

ENCLOSURE I.—*General Accounting Office reports issued which concern the elderly*

Title of report	*Date*
Report to Chairman, Subcommittee on Social Security, House Committee on Ways and Means: "Controls Over Medical Examinations Necessary for the Social Security Administration to Better Determine Disability" (HRD-79-119).	Oct. 9, 1979.
Letter to the Secretary of Health, Education, and Welfare: "Social Security Should Obtain and Use State Data to Verify Benefits for All its Programs" (HRD-80-4).	Oct. 16, 1979.
Report to the Congress: "Identifying Boarding Homes Housing The Needy, Aged, Blind, and Disabled: A Major Step Toward Resolving A National Problem" (HRD-80-17).	Nov. 19, 1979.
Report to Chairman, Subcommittee on Social Security, House Committee on Ways and Means: "Indirect Costs of the Social Security Administration's Disability Programs are Excessive and Should Be Reduced" (HRD-80-23).	Nov. 19, 1979.
Report to the Congress: "Entering A Nursing Home—Costly Implications For Medicaid and the Elderly" (PAD-80-12).	Nov. 26, 1979.

Title of report	*Date*
Report to the Congress: "Minimum Social Security Benefit: A Windfall That Should Be Eliminated" (HRD–80–29).	Dec. 10, 1979.
Letter to the Secretary of Health, Education, and Welfare: "Changes Needed to Prevent Commuters and Transients From Receiving Supplemental Security Income" (HRD–80–35).	Jan. 4, 1980.
Report to the Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate: "Hospitals in The Same Area Often Pay Widely Different Prices for Comparable Supply Items" (HRD–80–35).	Jan. 21, 1980.
Letter Report to the Chairman and the Ranking Minority Member, Special Committee on Aging, U.S. Senate: "Comparison of Well-Being of Older People in Three Rural and Urban Locations" (HRD–80–41).	Feb. 8, 1980.
Report to the Chairman, Joint Economic Committee, U.S. Congress: "An Actuarial and Economic Analysis of State and Local Government Pension Plans" (PAD–80–1).	Feb. 26, 1980.
Report to the Congress: "U.S. Income Security System Needs Leadership, Policy, and Effective Management" (HRD–80–33).	Feb. 29, 1980.
Report to the Chairman, Committee on Ways and Means, House of Representatives: "Legislation Authorizing States to Reduce Workers' Compensation Benefits Should be Revoked" (HRD–80–31).	Mar. 6, 1980.
Letter to the Chairman, Subcommittee on Human Services, Select Committee on Aging, House of Representatives: "Opportunities are Available for Action to Enhance Older American Voluntarism" (HRD–80–58).	Mar. 7, 1980.
Report to the Congress: "Health Maintenance Organizations Can Help Control Health Care Cost" (PAD–80–17).	May 6, 1980.
Letter to the Chairman, Subcommittee on Oversight, Committee on Ways and Means, House of Representatives: "Evaluation of Health Care Financing Administration's Proposed Home Health Care Reimbursement Limits" (HRD–80–84).	May 8, 1980.
Letter to Senator Bob Packwood: "Evaluation of the Health Care Financing Administration's Proposed Home Health Care Cost Limits" (HRD–80–85).	May 8, 1980.
Report to the Congress: "Slow Progress and Uncertain Energy Savings in Program to Weatherize Low-Income Households."	May 15, 1980.
Report to the Congress: "Need to Prevent Windfall Benefits to Supplemental Security Income Recipients" (HRD–80–44).	May 30, 1980.
Report to the Secretary of Health and Human Services: "States Should Intensify Efforts to Promptly Identify and Recover Medicaid Overpayments and Return the Federal Share" (HRD–80–77).	June 10, 1980.
Letter to Congressman George O'Brien: "Questions About the Cost-Benefit Analyses of the Professional Standards Review Organization Program" (HRD–80–93).	June 12, 1980.
Report to the Congress: "Problems Remain in Reviews of Medicaid Financed Drug Therapy in Nursing Homes" (HRD–80–56).	June 25, 1980.
Letter to the Administrator of HCFA: "Hospital Use of Contract Management Services."	June 30, 1980.
Letter to the Chairman, Subcommittee on District of Columbia, Committee on Appropriations, U.S. Senate: "Financial Audit of the District of Columbia Office on Aging" (GGD–80–70).	July 17, 1980.

Title of report	*Date*
Letter to Senator Bob Packwood: "Oregon's Financial Management of Funds Under the Older Americans Act" (HRD–80–97).	July 17, 1980.
Report to Chairman, Committee on Veterans Affairs, House of Representatives: "VA Improved Pension Program: Some Persons Get More Than They Should and Others Less" (HRD–80–61).	Aug. 6, 1980.
Report to the Congress: "The Lump Sum Death Benefit—Should it be Changed?" (HRD–80–87).	Aug. 8, 1980.
Letters to the Senator Jesse Helms, Congressman Donald Ritter, Congressman Robert H. Michel, Congressman Bill Gradison, Congressman John B. Anderson, Senator Gaylord Nelson, Congresswoman Virginia Smith: "Review of Selected Aspects of Low Income Energy Assistance" (HRD–80–115, 118, 119, 120, 121, 122, 123).	Sept. 15, 1980.
Report to the Congress: "Federal Funding for State Medicaid Fraud Control Units Still Needed" (HRD–81–2).	Oct. 6, 1980.
Letter to the Secretary of Health and Human Services: "Reasonable Change Reductions Under Part B of Medicare" (HRD–81–12).	Oct. 22, 1980.
Report to the Secretary of Health and Human Services: "Continuation of More Model Projects Could Increase the Delivery of Services to the Elderly" (HRD–81–9).	Oct. 23, 1980.
Report to the Congress: "Federal and State Actions Needed to Overcome Problems in Administering the Title XX Program" (HRD–81–8).	Oct. 29, 1980.

ENCLOSURE II.—*General Accounting Office audits in process which concern the elderly*

Questions relating to the effectiveness of the section 8 housing program.[1]

Review of Federal efforts to house handicapped persons.

Survey of Federal efforts to improve transportation to rural areas.[1]

Review of the dine-out features of the food stamp program.[1]

Review of Federal nutrition research planning and coordination.[1]

Review of the Department of Energy's weatherization activities under title IV of the Energy Conservation and Production Act.

Survey of the organizational structure of the Office of Human Development Services.[1]

The need for a separate Consumer Price Index for retirees.

Review of the tax-exempt home health agencies.[1]

The effect of estate provisions on farm and timberland estates.

Review of the effectiveness of State and area agencies on aging.[1]

Establishing a comprehensive, coordinated system of services for older Americans.[1]

Survey of social services provided under the Social Security and Older Americans Acts.

Review of role of sheltered workshops in serving the handicapped.[1]

Followup on certain GAO reports concerning savings potential in vocational rehabilitation programs.

Review of medicare and medicaid controls over physician and supplier program overutilization.

Review of utilization controls for home health services.[1]

Review of the fixed-price contracting experiments in medicare.[1]

Review of revised conditions of participation for skilled nursing facilities and intermediate care facilities.[1]

Review of nursing staff pools and their impact on medicaid-medicare reimbursement.

Review of medicaid cash management.

Survey of reimbursement practices in the end-stage renal disease program.

Review of the Department of Health and Human Services' maximum allowable cost and/or estimated acquisition cost drug pricing programs.

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[1] Being performed at the request of committees or individual Members of Congress.

Review of Professional Standards Review Organization monitoring of delegated hospitals.[1]

Review of medicaid's quality control program.

Survey of medicare's carriers' claims processing system.

Survey of medicare and medicaid utilization controls over hospital ancillary services.

Survey of the interchange of data between the medicare and the worker's compensation programs.

Survey of medicare and medicaid cost allocation.

Review of the revised method of reimbursing durable medical equipment under medicare.[1]

Stopping the short-term worker's advantage could save the social security trust fund billions of dollars.

Supplemental security income resource eligibility criteria and verification procedures.

Uncashed supplemental security income, VA pension and aid to families with dependent children checks.

Implementing GAO's recommendations on the Social Security Administration programs could save billions of dollars.

Review of the administrative procedures of the Labor Department's Office of National Programs.[1]

Survey of specialized services provided by community mental health centers.

Review of need standards used in income transfer programs.[1]

Impact of the social security 1980 increase on recipient other benefits.[1]

ENCLOSURE III.—*General Accounting Office internal activities which involve the elderly*

The equal employment opportunity and merit promotion programs, both covered by GAO orders, provide the basis for our policy regarding employment of the elderly. From the prohibition of discrimination on the basis of age in employment and in the selection for job vacancies, other policies and practices evolve. For instance, because training is important to enhance effectiveness and provide opportunities for advancement, older employees are included in opportunities for training, both in-house and outside the agency.

In keeping with the policy of nondiscrimination, persons over 40 are recruited for available options with the Office. Although employment restrictions limited our level of recruitment for much of the year, 844 persons have been appointed to permanent and temporary positions this year. Of that number, 148 persons (18 percent) were age 40 and older at the time of their appointment.

As of December 31, 1980, 1,870 persons age 40 and older (32.3 percent of our work force) were on the rolls of the General Accounting Office. Although employees in this age group participate widely in all our programs, we especially note that we have three employees age 40 and older in the upward mobility program and one in our cooperative education program. These programs usually draw participants from a younger population.

The employee health maintenance examination, a comprehensive and professional medical examination, is available on a 2-year cycle for all employees age 40 and older. Employees nearing retirement age have available individual preretirement counseling. We conducted two preretirement seminars for 1980 and have additional seminars planned for 1981.

ITEM 19. CONSUMER PRODUCT SAFETY COMMISSION

JANUARY 14, 1981.

DEAR MR. CHAIRMAN: Thank you for providing the Commission with the opportunity to be included in the Special Committee on Aging's annual report. "Developments in Aging."

Improving product safety for older Americans continues to be an important goal of the Consumer Product Safety Commission even though our activities are not directed specifically to programs for the elderly.

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[1] Being performed at the request of committees or individual Members of Congress.

Our submission for the 1980 report is enclosed. Please let me know if you have any questions.

Sincerely,

LINDA B. KISER,
Director of Congressional Relations.

Enclosure.

CONSUMER PRODUCT SAFETY COMMISSION REPORT FOR 1980

The Consumer Product Safety Act (Public Law 92–573) was enacted in 1972 in recognition of the need for Federal regulation to ensure safer consumer products. The act established the Consumer Product Safety Commission and charged it with the mission of reducing the number and severity of consumer product-related injuries, illnesses and deaths. An amendment to the CPSA requires the Commission to "consider and take into account the special needs of the elderly and handicapped to determine the extent to which such persons may be adversely affected by (a consumer product safety) rule."

Our 1980 activities, including injury-data collection, research studies, standards development, and information and education programs, were not directed solely to programs for the benefit of our 20 million older Americans. However, improving product safety for the elderly is an important continuing objective of the Consumer Product Safety Commission. While none of the laws administered by CPSC apply solely to the elderly, the Commission recognized that the elderly are particularly vulnerable to injuries associated with various home structures, including bathtubs, showers, floors, stairs, unvented gas space heaters, and upholstered furniture. Moreover, the Commission has an active interest in developing programs aimed at the elderly.

INJURY DATA COLLECTION

The Commission's primary source of information on product-related injuries is the National Electronic Injury Surveillance System (NEISS). The NEISS is designed to have a statistically selected set of 74 hospital emergency rooms located throughout the country which report to the Commission, on a daily basis, data on product-related injuries treated in those emergency rooms. The Commission estimates that 494,000 persons 65 years of age or older were treated for product-related injuries in hospital emergency rooms in the United States and the U.S. Territories in calendar year 1979. The elderly were hospitalized for these injuries at a much higher proportion (19 percent) than the population as a whole (5 percent). Injuries associated with stairs, steps, floors, or flooring materials were suffered most frequently by the elderly. Other major product categories associated with injuries which particularly affect the elderly are those most commonly found in and around the home, including chairs, beds, doors, ladders, bathtub and shower structures, knives, rugs and carpets.

ACTIVITIES RELATED TO THE ELDERLY

The Commission recognizes that many products used by all segments of the population may present special problems for the elderly. These special problems are examined carefully in our setting procedures.

The Commission has formally recognized the unique needs of the elderly and special population groups in selecting project priorities. The "vulnerability of the population at risk" is one of seven factors which the Commission weighs in determining priority projects.

Unvented gas-fired space heaters and upholstered furniture flammability were two of the Commission's 1980 priority projects. In its review of hazard studies on fires associated with unvented gas space heaters and upholstered furniture, the Commission has noted that elderly Americans are frequently involved in these incidents. This information has been considered in the development of the Commission's final standard for these gas heaters. It was also used in the Commission's consideration of the need for safety requirements for upholstered furniture.

Another 1980 priority was tap water scalding of older consumers. To address this problem, the Commission has successfully worked with voluntary standard organizations to require in their standards that the pre-set temperature for water

heaters be reduced. These standards now also contain a cautionary labeling provision about scalding dangers. Moreover, the Commission initiated information and education activities to alert consumers to the possible hazard of tap water scalding.

The Commission is also working with the Community Services Administration in developing a pilot program for establishing criteria for upgrading the electrical systems in older homes of the elderly.

Another way the Commission works to assist the elderly is through the allowance of conventional packaging for products regulated under the Poison Prevention Packaging Act. This provision allows manufacturers to provide a conventionally packaged product for the aged and handicapped who may have difficulty with child resistant packaging. Elderly consumers or their physicians can also request that prescription drugs be packed in conventional packaging.

INFORMATION AND EDUCATION ACTIVITIES

The Commission develops programs, prints and distributes publications warning older consumers about potential hazards of consumer products and safe use of these products. Examples of the publications available for general distribution are: "Poison Prevention: Alternatives for Older Consumers and Handicapped," a fact sheet entitled "Older Consumers and Stairway Accidents," and a "Guide to Fabric Flammability." One of the CPSC films, "That Feeling of Falling," specifically addresses the hazards of the elderly falling against glass doors and their potential for suffering stairway accidents.

Several of our publications have been revised to make them easier for the elderly to read by enlarging the type, changing the format and eliminating the use of shiny print surfaces. Two examples of these in the Fire and Thermal Burn Area are, "It's Your Life . . . Don't Burn It Away," and "Guide to Flammability." The Commission expects to expand this technique in more of its publications. Other Commission publications directed to the general public also emphasize hazards to which older consumers are especially vulnerable, such as falls and scalds in tubs and showers and burns and fires from kitchen ranges.

The Commission's hotline, a toll free telephone system serving all 50 States including Puerto Rico and the Virgin Islands, gives many older consumers an easy opportunity to contact the Commission. This hotline provides safety information and recall warnings about potentially hazardous products to all consumers. The elderly population is active in using this facility. A teletype for the deaf and hard of hearing persons is available from 8:30 a.m. to 5 p.m. e.s.t. to those who call the hotline on special numbers.

The Commission's field offices have conducted a variety of information and education activities to increase the awareness of older consumers about potential hazards associated with consumer products. For instance, the Commission's Dallas regional office has initiated a survey to find better ways of reaching special target audiences, one of which is the elderly, regarding ways to improve the effectiveness of recalls of potentially hazardous consumer products. The elderly consumers surveyed were most helpful in identifying ways to reach their population group. This information has provided CPSC with new insight on ways to improve the content of recall messages so the public can more easily understand them and to encourage them to respond more quickly to the recalls.

The Commission's Kansas City regional office has maintained continuing cooperative relationships with State commissions on aging in that region with primary emphasis on poison prevention and fire and thermal burn problems. This overall cooperative endeavor has resulted in a number of workshops and meetings with elderly consumers and officials representing those consumers in Iowa and Missouri. In all instances, the emphasis of the presentations was on the CPSC visuals and printed materials which are specifically geared to the elderly.

Another project undertaken by the CPSC to find a better way of communicating with the public regarding product hazards is a 6-month fire safety pilot project designed to reduce fire incidents involving the elderly and low income groups. This program was launched in five communities located in the "fire belt" (an area extending from Oklahoma through North Carolina, including Alaska and the District of Columbia, identified in surveys as having a very high rate of fire incidence). Five community action agencies serving communities in this area received grants funded by the Commission to conduct fire safety information and education activities emphasizing hazards associated with flammable

products and ignition sources. The Commission selected print and audio-visual materials for use in the project and requested that the agencies consider incorporating the materials into their on-going programs. The project will be evaluated by the Commission in fiscal year 1981. If it is found that the project contributed sufficiently to increased awareness of fire hazards, it may serve as the basis for the development of a model for conducting fire safety programs in similar communities.

ITEM 20. ENVIRONMENTAL PROTECTION AGENCY

JANUARY 2, 1981.

DEAR MR. CHAIRMAN: I am pleased to respond to your request of October 30, 1980, and inform you of the very successful older worker activities taking place at the Environmental Protection Agency (EPA).

The Senior Environmental Employment (SEE) Corps was created in concert with State environmental agencies and the financial aid of the Administration on Aging. The Corps has provided meaningful and part-time employment to several hundred older Americans in jobs relating to the prevention, abatement, and control of environmental pollution. The jobs include surveying toxic chemicals used in industrial areas, educating the public on areawide water quality planning, educating the public on programs in noise abatement, establishing and managing agency environmental libraries, presenting education programs on the use of pesticides and the hazards of poisoning to farmworkers, and working on surveys of environmental carcinogens.

Our Office of Monitoring and Technical Support has found that using older worker participation in crisis situations such as Three Mile Island and Love Canal lessens the problems of creating a special work force to meet such circumstances. Under the SEE Corps, qualified older workers can be recruited on short notice to assist in work to be done in similar crises.

Enclosed is an evaluation report of how the Office of Research and Development's national work force development staff and State environmental agencies together utilized the many and varied capabilities of the older workers for the benefit of the Nation's environmental quality. The older workers benefited by confirming their self-worth and by giving them the opportunity to contribute to the improvement and protection of the environment.

As a result of this success, EPA, the States, and the Department of Labor are working to expand the program into a Senior Environmental Employment Corps, as referred to in the Older Americans Act Amendments of 1978. The SEE Corps will ultimately operate in all eight environmental program areas and in all 50 States. In preparation for this development, EPA has funded a national pesticide use survey which will employ only senior workers to carry out a statutory program to document pesticides use patterns.

EPA has supported other activities of Title V: Older Workers Program in Florida, Alabama, California, Iowa, and Washington. In addition, the Agency has helped support a poison alert project staffed by older workers in the States of California, Washington, and Iowa. Other States were supported to conduct noise surveys and studies; and in Washington State, older workers are monitoring landfills to measure the gases seeping from underground to the surface.

We believe that the SEE Corps provides excellent opportunities for older citizens to participate in and benefit from the program while improving environmental quality for everyone.

Sincerely yours.

DOUGLAS M. COSTLE, *Administrator.*

Enclosure.

THE SENIOR ENVIRONMENTAL EMPLOYMENT PROGRAM—OUTCOMES AND PROSPECTS

PREFACE

In 1977, the Administration on Aging and the Environmental Protection Agency implemented a nationwide demonstration project—the senior environmental employment (SEE) program—in which over 200 workers aged 55 and above have been employed in a wide variety of jobs in the field of environmental quality. Over the past 3 years, these older Americans have provided State and Federal environmental agencies with crucial assistance in areas such as water supply/

water quality, solid and hazardous wastes, air quality, pesticides, and noise control.

For the individual demonstration projects, the original SEE funding has been terminated. Several of these have been able to retain, at least temporarily, most or all of their SEE workers through alternative State or Federal funds. Other SEE projects, however, have been forced to shut down completely. The overall result has been unemployment for most of the SEE workers. There appears to be little prospect that many will be able to find new jobs comparable in satisfaction to those offered by the SEE program.

The SEE program was clearly a success in demonstrating the capacity of older workers to make a cost-effective contribution toward the prevention and abatement of environmental pollution. Many of the SEE enrollees performed at a level beyond their supervisors' initial expectations and often contributed time to their jobs over and above the hours for which they were actually paid. For many, the SEE program was not just a job but a new career, a fact which challenges the traditional conception of "retirement."

The application of the SEE concept to other agencies and programs has been limited to date, although several States that did not participate in the demonstration project have expanded the utilization of older workers in their environmental programs, and EPA itself has several SEE spin-off projects that are in various stages of planning or implementation. Application of the SEE concept should not be restricted to the environmental field, however, as there are shortages of skilled, experienced and highly motivated manpower in many other areas of public service employment. The fields of energy conservation, public health, consumer protection, recreation, and social services hold great promise for the development of SEE-type programs. It should also be stressed that the potential supply of older workers will greatly increase in the coming years, from 22.4 million Americans over 65 in 1975 to 31.4 million over 65 in 1995 (Bureau of Census estimates). If the SEE program is any indication, a large proportion of these citizens will offer and want to play a productive and socially meaningful role in their nation's economy.

The FAR professional staff who participated in our evaluation of the SEE program were John Faris, Paul Taff, Leo Kramer, and Gary Davis.

LEO KRAMER,
Director, Foundation for Applied Research.

I. STATUS OF THE INDIVIDUAL SEE PROJECTS

At the conclusion of the initial 2 years of the 11 SEE pilot projects, project directors held a strongly positive evaluation of the program. Two-thirds viewed it as "very successful," and the remainder regarded the program as "successful, with substantial room for improvement." Most (more than three-quarters) felt that the program in their States should be expanded; the others thought it should be retained at the present level.

Project directors were asked to provide some quantification, where possible, of the major accomplishments of the SEE program. Their responses are as follows:

Connecticut

Air quality

In the enforcement section, SEE staff were primarily responsible for scheduling field inspections, handling complaint response, and coordinating field staff schedules. The following numbers of inspections were scheduled on average per quarter (10/1/78–6/30/79):

Industrial inspections	600
Gasoline stations	600
Complaint response	180
Compliance inspections	45
Routine surveillance	120
Special surveillance	60

Solid Waste Unit (10/1/78–6/30/79)

Two SEE participants visited 71 towns and conducted surveys and completed survey reports on disposal areas within these towns. They also completed 90 site maps showing site boundaries, wetlands, water courses and structural features at each site.

Water Quality (Safe Drinking Water Program) (10/1/78–6/30/79)

During the first 9 months of fiscal year 1979, five field workers in this program completed the following:

Water samples collected	2,170
Resamples (of problem sites)	490
Special samples (on request)	1,774

Many of these samples were analyzed initially in the field by the SEE participants before being delivered to the State health department laboratory (such as pH tests, etc.).

Noise Control (10/1/78–6/30/79)

Responded to 34 complaints (25 resolved, 9 pending action). Thirteen on-site field inspections were also conducted during this period. In addition, the following training sessions were attended:

(a) Noise Control Seminar in Boulder, Colo. (10/9/78–10/13/78).

(b) A 1-day instrument seminar by Gen. Rad. Corp. (11/16/78).

(c) A 2-day instrument training session at the University of Massachusetts sponsored by EPA region I (3/22/79–3/23/79).

This SEE person also served as cochairman of an all day seminar at the University of Hartford sponsored by University of Hartford and EPA region I, which concerned Connecticut's noise control program and legislation. This was attended by many town officials from Connecticut.

Land Acquisition (10/1/78–6/30/79)

One SEE member processed 26 letters of credit payment requests totaling over $4,000,000.

A second member conducted 50 preliminary site inspections prior to acquisition which included inspection of property, boundaries, legal status and title, local land records, etc.

The third member actively negotiated for the purchase of seven land sites for the State (totaling over 459 acres) for future use as State parks and forests.

Information and Education (10/1/78–6/30/79)

Processed over 480 film library loan requests.

Completed a 5-year index of the Department's monthly newsletter.

Cataloged over 600 books.

Completed a file system for periodicals, reference materials, and educational materials.

Wrote one article per month for the Department's monthly newsletter including two feature articles.

Water Quality (Construction Grants Program) (10/1/78–6/30/79)

One SEE participant processed and reviewed 14 construction contract awards valued at over $8,195,930 and also processed nine payment requests.

New Jersey

As of August 30, 1979:

—6,505 industrial sites visited, 2,603 of which were identified as hazardous waste generators. These have all been included on the computerized "manifest" (waste-tracking) system. SEE personnel have assisted with the implementation of the system.

—1,003 DEP employees have been trained in defensive driving. By having this mandated training done by a SEE employee, over 15,750 has been freed-up for expenditures relating to technical (environmental) training.

—Technical training records were compiled and verified for DEP's 2,400 employees.

—Thousands of registration forms for Safe Drinking Water Act Seminars for plant operators and engineers were processed and all attendant administrative work performed by one SEE employee.

Pennsylvania

The major accomplishment of SEE workers has been the completion of the closed dump site inventory in the areas worked by SEE staff. As a result of the survey activities, several closed dump sites were shown to be active and actions

to close them have been initiated. Ninety percent of the municipal waste water treatment plants in western Pennsylvania were surveyed to determine details of sludge disposal techniques employed. Public information presentations were given in two service areas by SEE workers when regular staff were not available.

Kentucky

There were 197 business surveys done for unregistered pesticide products. Six unlicensed pest control operators were uncovered.

Out of an estimated 2,500 open dumps in the State, the SEE program employees located 1,004.

Kansas

We were able to take our 208 proposals to the citizens of Kansas with much greater success than we would have if we had not used SEE workers.

In our water supply program the SEE workers have located some 1,100 noncommunity water supplies. At this time they have covered about two-thirds of the State.

South Dakota

Investigated 117 individual wastewater complaints; inspected 200 noncommunity water supplies; closed 25 disposal sites; discovered five hazardous waste sites; and inspected 300 grain elevators. Performed sampling for the 208 water quality management program and monitoring for water quality study areas. Also assisted the health department in medic preparation, glassware preparation, and receiving and mailing sampling kits.

Other statements of the accomplishments of the SEE program include:

Arkansas

Public awareness relating to the seriousness of solid waste.

Public response to keep waters clean and free of foreign agents.

The asbestos program was fantastically received by all citizens and received all statewide TV and press coverage. Extremely expensive airtime was voluntarily offered to this interest.

California

Our local SEE program, being an educational and/or information and pesticide accidents reporting program, has been very successful in accomplishing these objectives. As a result, it has helped also in the protection of the environment by reporting improper disposal of empty pesticide containers and reducing the usage of them by people who do not realize the danger.

Noise Program

In the Boston EPA Regional Office, the SEE program employee was responsible for the development and implementation of the new ONAC grant program for State and local noise control projects. The same situation was the case in the Atlanta EPA region.

In the Seattle EPA Regional Office, the SEE employee is the former executive director of the State Municipal League. He is often called upon by the EPA Regional Administrator to provide information and analysis relative to the political climate of Washington State and local governments with respect to all environmental programs—not just the noise program. This person also provides valuable liaison between EPA's Regional Administrator and units of local government within the State.

In the San Francisco EPA Regional Office, the SEE employee is a renowned expert in acoustics and serves as a regional expert on noise and noise issues. He also serves the region in complex local noise problems and gives presentations on noise and acoustics throughout the region.

In the Denver EPA Regional Office, the original SEE employee has been placed in a permanent part-time GS–11 Federal position within the Regional Office of Public Affairs. The Regional Administrator utilizes this individual's writing talents extensively for papers and speeches. This former SEE employee often accompanies the Regional Administrator to State and local events within the region.

Several SEE employees manage the ONAC equipment loan program which is designed to assist States and locales with their noise problems by providing the

necessary equipment for them to take noise measurements within the jurisdictions. They also provide training on the use of the equipment.

All of the SEE employees are involved in the ONAC ECHO (each community helps others) program—a high priority ONAC program which initiates self-help activities between and among States and local governments with respect to noise control.

Several of the SEE employees are educators who take an active part in school noise programs as well as in public information/education components of the regional noise program.

In six of the individual projects (Connecticut, New Jersey, Kentucky, Arkansas, Washington, and the noise program), one or more of the SEE workers were retained through alternative funds when the original funding was exhausted. Three of these projects (Connecticut, Kentucky, and the noise program) were able to retain, at least temporarily, most or all of their SEE workers. In the other projects, however, termination of funding resulted in termination of employment for all of the SEE workers. The employment status of the SEE workers subsequent to termination of Federal funding is addressed in the following sections.

II. POST-SEE EXPERIENCE OF SEE WORKERS

Following the termination (and subsequent exhaustion) of Federal funding to the SEE program, the Foundation for Applied Research surveyed the former SEE workers regarding their present employment status and attitudes toward their participation in the SEE program. As with previous surveys of SEE workers, FAR obtained an extremely high response rate, approximately 95 percent. Most (54 percent) of the responding SEE workers were unemployed at the time of the survey; a substantial number (27 percent) were employed in the same job they had while under SEE funding; and 15 percent had found new employment. Only 4 percent considered themselves to be retired.

As table 1 shows, post-SEE employment status is not strongly linked to age.

TABLE 1

[In percent]

	Age					
	55–59	60–64	65–69	70–74	75 or over	Tota
Employed in same job	20	38.5	29.4	21.1	9.1	27
Employed in different job	20	7.7	14.7	21.1	18.2	15
Unemployed	60	46.2	52.9	52.6	72.7	54
Retired	0	7.7	2.9	5.3	0	4
N	(1)	(26)	(34)	(19)	(11)	(100)

Younger SEE workers (under 65) were only slightly more likely than others to be retained in their environmental jobs. All age groups had a high rate of unemployment; younger workers did not appear to have an easier time in finding alternative employment. It should be noted that many of the SEE workers were surveyed shortly after termination of their SEE employment; it is reasonable to expect that the percent unemployed should decrease. Several of those who did find jobs following termination from the SEE program indicated that their participation in SEE had helped in locating their new job. This help included recommendations from supervisors, an expanded range of contacts, and development of new marketable skills.

The majority of former SEE workers felt that the SEE program was valuable and felt that they had personally benefited by participating. Over 80 percent felt that the SEE program should not have been terminated but should have been expanded and made permanent. The others recommended that the program be retained with substantial changes. None felt that it should have been terminated. Their comments indicated that their approval of SEE was based on the conviction that SEE made a valuable contribution to protecting and improving the environment:

> I feel the good the SEE program has done toward improving our environment should call for a permanent program of this type.
>
> I think the SEE program was a good one and very important to the health and well-being of people of all ages.

The people in the counties that I contacted realized that the program was important to their health and the improvement of their community as well.

There is no question that the environmental work is needed and that in most cases the individual States do not have fast enough or efficient enough implementation for sufficient environmental employees.

This program did a great job while it lasted by providing the government with seasoned and valuable personnel, most of them willingly working below their monetary worth. I was personally acquainted with most of our 20 SEE workers and can testify to their industry and integrity.

There is so much pollution in this country that the SEE program should never have been terminated.

Former SEE workers were asked what effect their participation in the program had on their lives. Over 90 percent indicated a positive effect; most of these (75 percent of all respondents) regarded nonfinancial benefits as the most important effect:

It made me feel that I was worth something and could accomplish something in my life at this age and helped me very much in my health condition. I felt very good at the time.

Gave me a feeling of being useful. Made me feel like a person again. I felt like living and doing things. Nothing is harder on a person then being retired and put on a shelf and forgotten.

It gave me an opportunity to meet a great number of people and see what problems exist in the environment.

Provided an opportunity to use skills which since retirement were to some extent idle. Provided a sense of need, duty and the realization that I was accomplishing something of importance.

The SEE program provided me with the most enjoyable working experience in my lifetime.

One of the most rewarding experiences of my life. Made new friends. Learned about government, politics, and environmental problems. Very stimulating activity, and won recognition of department head and Commissioner.

Confirmed self-worth—established confidence—regained esteem of family and friends (so fragile for a retiree).

The responses of former SEE workers to the question of the impact of SEE participation on their lives are grouped according to present employment status in table 2.

TABLE 2

[In percent]

Effect of SEE program on life	Employment status				
	Employed in same job as in SEE program	Employed in new job	Unemployed, seeking work	Retired	Total
Positive—Financial	25.9	0	13.5	0	14.5
Positive—Other	66.7	78.5	84.6	75	78.3
None or negative	7.4	21.5	1.9	25	7.2
N	(27)	(14)	(52)	(4)	(97)

A solid majority of all four categories of former SEE workers—retained in the environmental job, working in a new job, unemployed and seeking work, or retired—regarded their participation in SEE as having had a positive impact on their lives which was principally of a nonpecuniary nature.

It is interesting to note that this effect was as strong (if not stronger) among those who were unemployed following termination from SEE (84.6 percent reported a nonfinancial positive effect) as among the others. It is evident from the survey comments of former SEE workers that many retain their positive assessment of the effect of SEE participation despite sharp disappointment at the termination of funding and, in some cases, depression at having lost the useful and active role which SEE provided.

Analysis of the effects of SEE participation on workers' lives by age and type of SEE job yielded similar results. Regardless of age group or type of job—office or field, technical or clerical—the majority of SEE workers in all categories felt that the principal benefit of the SEE program was not financial but was a

result of being involved in useful and interesting activity. This feature of the SEE program clearly seems to be linked to the high motivation of the SEE workers and the supervisors and project directors in the environmental agencies.

III. DISSEMINATION OF THE SEE CONCEPT

As part of FAR's research to determine the long-term impact of the senior environmental employment program, a questionnaire survey was sent to selected officials (typically the personnel officer) in the environmental agencies of the 40 States not included in the SEE demonstration project. The initial mailing was followed by a reminder to those who did not respond initially. Through use of telephone interviews (after two mailed followups), a 100 percent response rate was achieved. Following a brief description of the SEE program, respondents were asked if they had previously heard of the program. A substantial number (35 percent) responded affirmatively. Most of these had heard of SEE through contact with the Federal Environmental Protection Agency, in most cases through an EPA regional representative. All of those who had heard of SEE who reported an impression of the program had a favorable impression, e.g.:

Excellent program.

The concept is excellent. It provides an opportunity for less employable people who have a great deal of usable expertise and who are willing to work.

Good concept. Very limited application caused by salary and population guidelines.

This program seems to be a useful way to involve experienced older persons in environmental programs—taking advantage of their knowledge and skills, in addition to providing some possibility for employment of underemployed older Americans.

Respondents were invited to indicate a desire for more information on SEE. About two-thirds, including those who had already heard of SEE, would like to have more information on SEE.

Nine of the forty respondents indicated that one or more environmental agencies in their States has a program designed to recruit and employ older workers. At least four of these (in South Carolina, Iowa, Arizona, and Florida) were a direct result of the SEE program. On the less positive side, the survey results indicate that, in 31 of the 40 non-SEE States, there was no program to increase the utilization of older workers in the environmental field.

The survey results indicate that there is a large potential for increased utilization of older workers in the environmental field. Respondents were asked if they saw any potential for future application of the SEE concept. A strong majority (84.4 percent) of those who answered replied in the affirmative, e.g.:

We are usually understaffed in the engineering/technical sections, air, solid waste, water quality.

Perhaps in food protection and hazardous waste.

The county health departments could use talented older workers in enforcing and establishing these programs. We will undoubtedly have numerous special projects which will offer limited employment to these people.

In offices requiring clerical skills such as filing and typing. Some positions are seasonal such as inspection of swimming pool, collecting water samples.

Possibly a program could be developed to provide assistance in the area of proofreading or administering questionnaires which involve environmental programs, such as the 208 water quality management program.

We could use additional staff in water quality control, toxic materials control, solid waste management, and air quality control.

All environmental programs need people with knowledge and experience. It is difficult to find those people who will work for lower pay than their private sector counterparts.

Both the State and local pollution control agencies could, if funds were available, substantially increase their present service to the public—these agencies have been chronically understaffed. Additionally, there is a need for part-time water supply and waste water system operators in rural areas that might be met, in part, by older workers.

Yes, there are areas of potential benefit in a variety of environmental programs, e.g.: water supply/pollution, air pollution, noise, radiation, solid wastes and hazardous material, vector control. Matching of a senior citizen's background and experience to any of the above programs would be helpful.

Individuals with backgrounds in maintenance and operation of industrial manufacturing equipment would be of value for in-plant inspections of pollution control equipment.

We could use assistance, funds permitting, in the entire spectrum of environmental control programs. We are desperately in need of professional staff in our water and air pollution control programs as well as our solid waste and hazardous waste activities. Ad hoc assistance would be helpful in our pesticide, noise, institutional sanitation, radiation, and other activities.

It is quite evident from the above that while the majority of States not involved in the initial SEE demonstration program do not have any program to increase the utilization of older workers, most of these States indicate a significant potential for such utilization.

The SEE program has resulted in the planning of several new EPA programs designed to utilize older workers. These programs, in varying stages of planning and implementation, are a direct consequence of the success of the SEE program in demonstrating the value of the older worker in environmental work. They include:

1. Senior environmental employment program for asbestos control training. Ten older workers are being trained for assignment to the regional offices of toxic substances to assist in developing and implementing a program to inspect and control asbestos in schools. This program is being administered by NRTA/AARP.

2. National pesticide usage survey. This program, also administered by NRTA/AARP, may eventually enroll 100 older workers for a national survey of nonagricultural pesticide usage. Several older workers have been hired for a pilot study. Implementation of this project has been delayed pending approval by the Office of Management and Budget of the proposed survey form.

3. Hazardous waste monitoring project. Modeled after the New Jersey SEE project, this project may eventually provide employment for 10 older workers in each participating State. The project is in the planning stage. Funding, half of which is to be provided by EPA and half by title V, is uncertain.

4. Project to distribute literature and provide training on auto emissions control. EPA hopes to put one older worker in each State and in each regional headquarters in the project. It is in the early stages of planning.

5. Senior environmental employment noise program. The original noise program, which has continued and may be made permanent, now has several spinoffs. Twenty older persons are now working as noise counselors in local governments. (Half of these are administered under a grant to NRTA/AARP and half through a grant to the National Urban League). Also, the number of older workers in the noise program at the Washington, D.C., EPA office has been expanded.

6. EPA has also provided funds (for travel, administration, equipment, etc.) to support various State and regional environmental programs employing title V older workers (e.g., in Florida, Iowa, Kansas City, South Carolina). As an example, EPA has paid for the monitoring equipment needed by title V older workers in region VIII and Bremerton, Wash., who are measuring potentially hazardous methane emissions from sanitary landfills.

Dissemination of the SEE concept has proceeded in varying degees. The greatest acceptance and appreciation of the value of utilizing older workers in public service employment has been at the Federal level of the Environmental Protection Agency and in the 10 SEE States. It is important to note that those State SEE programs (Connecticut, New Jersey, Kentucky) in which older workers were placed in diversified positions directly within the State environmental agencies (as compared to the special project approach in States such as Pennsylvania and Arkansas) have a much higher rate of retention of SEE workers in the environmental positions following termination of SEE funding. In the 40 non-SEE States, as the survey results indicate, dissemination of the SEE concept is very limited, though there exists great potential for the utilization of older workers in these States. Further, perhaps the greatest potential for dissemination of the SEE concept remains almost completely untapped. This is the utilization of older workers in SEE-type projects in public service employment (such as in energy conservation and weatherization) outside the field of environmental work. The Foundation for Applied Research regards the viability and value of the SEE concept—both from the point of view of the older worker and from the point of view of the employing agency—as amply demonstrated. It is equally clear that the dissemination of the SEE concept is far from what it should be and that this should be an urgent priority before the SEE experience becomes just a set of old memories.

IV. SUMMARY AND CONCLUSIONS

From the perspectives of both Federal sponsors, the Administration on Aging and the Environmental Protection Agency, the senior environmental employment program was successful. The pilot projects showed that older persons could be employed in a wide variety of environmental positions on a cost-effective basis. SEE workers performed an impressive number of measurable contributions to protecting and improving the quality of the environment. At the same time, the SEE workers benefited significantly from their participation, in part through the additional income derived from their employment, but even more from the intrinsic satisfactions of being involved in interesting and worthwhile activity. A substantial number of SEE employees were retained within State or regional environmental agencies after the termination of Federal funding; most of the others are seeking to remain active. Nearly all of the SEE workers regarded their experience in SEE as being very positive, often despite feelings of disappointment at the termination of the program.

In order to be successful, the SEE program had to overcome at least two types of obstacles—attitudinal and structural. With regard to the first type, the majority of project directors from State environmental agencies were highly skeptical of the efficacy of the SEE concept at the beginning of the program. Further, there were indications that other environmental officials not involved with SEE were, and are, even more resistant to the idea. In the case of the SEE project directors, this skepticism was overcome by the success of the program and the effectiveness of the SEE workers.

A second type of obstacle to the SEE program was structural. In many States, there were problems in fitting SEE workers into the administrative and financial structure of the environmental agency. In some cases (New Jersey, for example), SEE workers were paid by the State as hourly workers but did not qualify for fringe benefits. In other States, the administration of SEE was undertaken by a third party (Green Thumb, NRTA/AARP) which effectively resolved the structural problems. In still other cases (Connecticut, for instance), new job titles were created and variances granted to permit the inclusion of fringe benefits to SEE workers. In at least one State, such bureaucratic obstacles appeared to be insuperable, and the State was forced to withdraw its grant application.

The obstacles which confronted the original SEE projects may be significant factors in the slow pace of development of new applications of the SEE concept. While some spin-offs have appeared and others are being planned, it remains the case that the potential utilization of older workers in the environmental field is far from being realized despite the demonstrated success and cost effectiveness of the SEE Program. Publicity is not sufficient. What is needed are presentations of documentary evidence to overcome skepticism and suspicion and technical assistance to cope with administrative bureaucratic obstructions. Priority should now be given to initiatives which would capitalize on the success of SEE and effectively stimulate an expansion of valuable employment opportunities for older Americans.

ITEM 21. FEDERAL COMMUNICATIONS COMMISSION

JANUARY 16, 1981.

DEAR SENATOR CHILES: This is in response to your and Senator Domenici's letters of October 30 and November 26, 1980, which requested fiscal year 1980 information regarding initiatives or programs by this Commission that impact either directly or indirectly on the elderly. Such information would be included in part 2 of your committee's next periodic report of "Developments in Aging," scheduled for publication in February 1981.

The Federal Communications Commission has the mandate to regulate communications "* * * so as to make available, so far as possible, to all the people of the United States a rapid, efficient, nationwide, and worldwide wire and radio communication service. * * *" 47 U.S.C. § 1. Consequently, our actions are generally broadly based and do not focus directly upon the needs of the elderly.

During the past several years, this Commission has assisted in the initiation of efforts to provide closed captioning of television for the Nation's deaf and

hearing impaired. Since a significant proportion of all persons with bilateral hearing losses are aged 65 or older, consideraton of telecommunication needs of the deaf is a matter of interest to the elderly, although not specifically directed to the elderly.

Following the Commission's grant of authority in 1972 to the Public Broadcasting System (PBS) to initiate experiments in closed captioning and the Commission's adoption of rules in 1976 to permit closed captioning on the vertical blanking space of line 21 of the television broadcast signal for the transmission of captioned information for the deaf, PBS and the National Bureau of Standards, with funding provided by the Department of Health, Education, and Welfare (HEW), worked together on the development of the closed captioning technology. As announced by HEW on March 23, 1979, a closed captioning project was initiated to include: (1) The provision of a total of up to 20 hours of captioned programing a week by PBS, ABC, and NBC, (2) the provision of special decoding devices by Sears, Roebuck & Co., and (3) the establishment and funding of a nonprofit National Captioning Institute by HEW to caption programs for the television networks.

On April 5, 1979, the Commission held an open, public meeting to receive a comprehensive briefing on the status of the closed captioning project by representatives of ABC, NBC, PBS, and HEW. The Commission later stated in regard to that meeting:

> We expect that the closed captioning project will be a success. However, if at a later date it is demonstrated that the project is not successful in making television programing more available and enjoyable to the hearing impaired, then it may be necessary for the Commission to determine if a rulemaking is warranted to insure that the hearing impaired are not deprived of the benefits of television.

Additionally, the Commission is currently analyzing responses to its February 1978, notice of inquiry regarding the provision by communications common carriers and equipment manufacturers of communications equipment for the deaf and hearing impaired. As in the case of closed captioning for television, we anticipate that the information assembled by this inquiry will be of interest to the elderly, although not specifically directed to the elderly. Tactile paging is an example of a service proposed in this inquiry that will help the elderly especially, though not exclusively. The Commission reallocated two low-band radio channels on November 18, 1980. They will be used in part for paging a deaf, blind, or otherwise handicapped person by means of a device that vibrates. The paged person will be able to use the device to transmit an acknowledgment.

Finally, this Commission regularly receives from the elderly which urge relaxation of the international Morse code speed requirements for operator licenses in the amateur radio service. Recognizing that the Commission is currently precluded by article 41, section 3(1) of the ITU radio regulations from waiving or eliminating the telegraphy requirement in its entirety, the Commission in August 1978, sought public response to this issue as part of its notice of inquiry regarding the administration of telegraphy examinations to handicapped applicants for operator licenses in the amateur radio service. The Commission's staff analyzed responses to this notice of inquiry, and the Commission's delegation to the 1979 World Administrative Radio Conference at Geneva proposed changing the requirement of article 4, section 3(1) of the ITU radio regulations to a less restrictive recommendation which would allow the United States future flexibility in the development of licensing requirements in the amateur radio service. WARC rejected the proposal in pertinent part.

It must be noted that many elderly handicapped people are among the amateur radio licensees opposing relaxation of the speed requirements, notably that the licensee be able to receive Morse code at five words per minute. Regarding procedure, the Commission is considering amending the rules to let candidates, including the elderly and hearing impaired, take the test by sight or by touch, not only by sound.

Other than the efforts described above, the Commission has not expended funds during fiscal year 1980 on specific programs for the elderly. nor are we aware of any court decisions or litigation which would directly affect our concern for the elderly.

I hope this information will be of assistance to your committee.

Sincerely,

CHARLES D. FERRIS, *Chairman.*

ITEM 22. FEDERAL TRADE COMMISSION

JANUARY 15, 1981.

DEAR MR. CHAIRMAN: I am pleased to report to you on the Commission's activities for fiscal year 1980 which affect the elderly. While virtually all of the Commission's efforts to promote a free and fair marketplace may benefit older persons, many of our activities are of particular significance for the aged. A staff summary of those activities is enclosed.

If we can be of further assistance to the committee, we hope you will call upon us.

By direction of the Commission.

MICHAEL PERTSCHUK, *Chairman.*

STAFF SUMMARY OF FEDERAL TRADE COMMISSION ACTIVITIES AFFECTING THE ELDERLY

VISION CARE

Over 90 percent of persons over the age of 65 wear corrective lenses. The FTC has two programs designed to lower the price of vision care. The first, the "Eyeglasses Rule," gives consumers the right to obtain a copy of their prescription after having their eyes examined, thereby enabling them to comparison shop for eyeglasses. A portion of the rule which eliminated restrictions on advertising of eye care goods and services was remanded by the U.S. Court of Appeals for the District of Columbia Circuit in February 1980. The rule was remanded so that the Commission could consider whether the regulation is necessary in light of recent Supreme Court decisions regarding constitutional protections for advertising by professionals. The Commission's staff is collecting evidence to determine whether any further Commission action regarding advertising is appropriate.

The second vision care program, known as "Eyeglasses II," is examining several proposals aimed at increasing competition and lowering prices in the vision care market. One portion of the investigation is focused on restrictions which inhibit so-called commercial practice of optometry, including restrictions which prevent optometrists from practicing under a trade name, working for a lay corporation, locating their practice in a commercial location, and operating branch offices. In addition, the FTC is examining staff proposals to expand the prescription release requirement contained in the Eyeglasses I Rule. These proposals would give consumers the right to: (1) Retain a copy of their eyeglasses prescription after it is filled; and (2) obtain a copy of their complete contact lens prescription at the conclusion of the fitting and dispensing process. These proposals would enable consumers to comparison shop for duplicate or replacement pairs of eyeglasses or contact lenses.

DENTAL CARE

Slightly over half of all persons over age 65 have lost their teeth, and approximately half of this group needs denture care, either because they have no dentures at all or because the dentures they do have are so ill-fitting as to be beyond repair. The high cost of denture care and the maldistribution of dentists in certain parts of the country (most notably in rural and inner-city areas) may prevent many elderly consumers from obtaining denture care. Preliminary evidence from Canada suggests that consumer costs may decrease and access to denture care may increase where dental laboratory technicians, known as denturists, are permitted to provide dentures directly to consumers. In the United States virtually all States prohibit nondentists from selling dentures directly to patients and require that dentures be fitted only by dentists. The FTC is gathering evidence to determine the potential effects on consumers of permitting denturists to offer their services directly to the public.

PRESCRIPTION DRUGS

Persons over the age of 65 comprise 11 percent of the population, but pay 25 percent of the national prescription drug bill. Consequently, savings on prescription drug purchases are especially significant for elderly consumers. The FTC staff has examined State laws which prevent pharmacists from substituting lower

cost generic drugs, and has concluded that modification of these State laws could result in significant consumer benefits, with no compromise in the quality which consumers receive. The Commission's staff, in conjunction with the Food and Drug Administration, has proposed a model drug product selection statute for consideration by the States, and the staff is providing assistance to States contemplating legislation on this issue.

HEARING AIDS

The majority of hearing aids are purchased by the elderly. Statistics indicate that over 40 percent of persons over 65 have some type of hearing impairment. In 1975, the Commission began a rulemaking proceeding dealing with the advertising and sale of hearing aids, and in 1979 proposed an enactment of a trade regulation rule which would give the consumer a right to return a hearing aid and obtain a refund after trying it for 30 days. The principal purposes of this provision are to discourage manufacturers and sellers from overstating the value of the hearing aids, to discourage high pressure sales tactics, and to protect consumers from the risk inherent in the purchase of a hearing aid that the aid will not provide a benefit.

COMPETITION IN THE HEALTH CARE SECTOR

The following projects are aimed at preventing anticompetitive conduct in the health care industry. Their purpose is to stimulate and strengthen competitive forces in the industry, thereby decreasing the need for government regulation, increasing consumer choice among providers of health care services, and lowering the cost of health care. Consumers age 65 and older spend almost three times as much on health care per capita as do consumers aged 19–64. Given the fixed income status of many persons over 65, these Commission initiatives may have a significant impact on elderly consumers.

American Medical Association (AMA).—In October 1979, the Commission issued a decision in its case against the AMA. The Commission found that the AMA had imposed illegal restrictions on truthful advertising by physicians and medical organizations and on the ability of physicians to work on a salaried basis for hospitals and health maintenance organizations. The Commission ordered the AMA to stop imposing such restrictions. Pursuant to the decision, physicians will be able to provide consumers with truthful information about the services they offer, and hospitals and HMO's will be able to seek to hold down costs by employing physicians on a salaried basis. The Commission's order expressly provides that the AMA may adopt reasonable ethical guidelines to prevent false and deceptive advertising. The Commission's order was upheld, with minor modifications, the U.S. Court of Appeals for the Second Circuit in October 1980.

Blue Shield and certain other prepayment plans.—This matter consists of a comprehensive review of the role of physician organizations in controlling Blue Shield plans—the largest source of private insurance for payment of medical bills. Commission staff analyzed the operation and control of the 70 Blue Shield plans to assess whether dominance of their operations by physician groups has any impact on increasing physicians' fees or on discrimination against nonphysician providers. An econometric study by the Commission's Bureau of Economics indicates that Blue Shield plans which are controlled by representatives of medical societies may have higher reimbursement rates than other Blue Shield plans.

The Commission has solicited public comment concerning the possible initiation of a rulemaking proceeding to consider limiting or prohibiting participation in control of Blue Shield and certain other open-panel medical prepayment plans by physician organizations. The Commission is currently considering this and other possible courses of action.

Indiana Federation of Dentists.[1]—On October 18, 1978, the Commission issued a complaint alleging that the Indiana Federation of Dentists obstructed cost-containment measures instituted by insurers. An initial decision ordering the dentists to stop collectively refusing to supply X-rays used by the insurance companies in making reimbursement decisions is currently on appeal to the Commission.

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[1] This matter is currently in litigation, and the Commission expresses no view whatever as to the merits of the case.

Michigan State Medical Society.[1]—On July 27, 1979, the Commission issued a complaint alleging that the society's members conspired to fix prices and to boycott cost-containment procedures instituted by the Michigan Blue Shield Plan. The trial of this case has been completed and an initial decision is expected in 1981.

Sherman A. Hope, et al.—On July 30, 1980, the Commission issued a complaint charging the five doctors practicing in Brownfield, Tex., with threatening to boycott the local hospital if it hired a new doctor on financial terms unacceptable to them. The hospital, the only one in the county, had tried to recruit a new doctor into the area by offering him a guaranteed minimum income. According to the complaint, the doctors threatened not to perform their emergency room and administrative jobs at the hospital and not to deal professionally with the new doctor. The complaint has been withdrawn from adjudication while the Commission considers a proposed consent agreement.

MOBILE HOME SALES AND SERVICE

Mobile homes comprise a substantial portion of the low- and moderate-income housing stock, and a large proportion of mobile homeowners are elderly persons. In August 1980, the FTC issued a staff report recommending adoption of a proposed trade regulation rule designed to improve warranty service on mobile homes. Although nearly all new mobile homes are sold with a written warranty, evidence gathered in this rulemaking proceeding indicates that service under these manufacturers' warranties is inadequate, delayed, or simply refused for as many as 40 percent of owners of new mobile homes who request such service. In its report, the staff recommended a rule that would set 30-day time limits within which mobile home manufacturers or their service agents must complete warranty repairs, and would require them to perform preoccupancy inspections of the home. In addition it would require that manufacturers enter into written service agreements with dealers and others who perform warranty repairs.

CREDIT

The FTC enforces the Equal Credit Opportunity Act, which prohibits discrimination on the basis of a number of factors including age. While Federal law permits a creditor to consider information related to age, credit cannot be denied, reduced, or withdrawn solely because an otherwise qualified applicant is over a certain age. Furthermore, retirement income must be included in rating a credit application and credit may not be denied or withdrawn because credit-related insurance is not available to a person of a certain age.

NURSING HOMES

It has been estimated that three-fourths of all nursing home residents are 75 years and older. The FTC staff has been examining the business practices of nursing homes as they affect the approximately one-third of the Nation's nursing home residents who pay directly for their own care. Although the industry is heavily regulated by Federal, State, and local governments, these regulations generally focus on health and safety rather than consumer issues. Staff is particularly interested in the information disclosed to residents before entering a home and the fairness of nursing home admission contracts.

MEDICARE SUPPLEMENT INSURANCE

More than 50 percent of the Nation's elderly have at least one private health insurance policy to supplement their medicare coverage. Consumers have complained about a variety of problems connected with the sale of medicare supplement insurance, including: Confusing policy provisions which inhibit effective comparison shopping; exploitative sales practices which focus on the special vulnerability of the elderly; the sale of policies which duplicate existing coverage; and low rates of return (expressed as the ratio of benefits paid to premiums collected). In 1979, the FTC initiated a study to determine what types

[1] This matter is currently in litigation, and the Commission expresses no view whatever as to the merits of the case.

of regulatory schemes are most effective in combating these problems. FTC staff is now cooperating with the Department of Health and Human Services in a major study of State medicare supplement regulations.

FUNERALS

Since 1975, the FTC has been conducting a rulemaking proceeding which could affect the almost 2 million persons who arrange funerals each year, including numerous elderly citizens. The Commission tentatively approved in substance a proposed rule in March of 1979. Subsequently, specific limits were placed on the scope of any final rule by the FTC Improvements Act of 1980. The act required that the funeral rule be revised in accordance with these limits and that the revised rule be published for public comment prior to determining whether or not to adopt a final rule. In January of 1981, the Commission will publish a revised rule for a 60-day public comment period. A 20-day rebuttal period and opportunity for oral presentation will follow the written comment period, with final Commission action on the rule expected this spring or early summer.

The revised funeral rule is intended to create a marketplace environment in which consumers will have access to accurate information prior to and at the time of purchase. The rule would: Require funeral directors to disclose itemized price information; prohibit misrepresentations of legal and cemetery requirements and the preservative or protective value of embalming, caskets and vaults; prohibit funeral directors from engaging in certain practices such as requiring a casket for cremation and embalming without express permission; and prohibit boycotts and threats by funeral providers against others.

DELIVERY OF LEGAL SERVICES

The Commission's staff is currently conducting an investigation to determine whether various public and private restrictions have hindered the development of legal clinics and closed-panel third-party payment plans for legal services. Legal clinics and closed-panel plans reputedly offer reduced fees and increased access to high quality legal services. These advantages may be of particular benefit to the elderly, whose income often exceeds limits established by government-sponsored assistance programs, yet may be insufficient to cover the high costs of private bar assistance.

U.S. SAVINGS BONDS

In response to a complaint by the Gray Panthers, FTC staff met with Treasury Department officials to discuss advertising of U.S. savings bonds. The Gray Panther complaint alleged that the Government's advertising was unfair and deceptive because of its failure to disclose the adverse impact of current inflation on a savings bond investment. In cooperation with the FTC staff, the Treasury Department rewrote its savings bonds ads to remove any implication in the ads that savings bonds are a highly profitable investment and hedge against inflation.

ITEM 23. LEGAL SERVICES CORPORATION

JANUARY 7, 1981.

DEAR MR. CHAIRMAN: In response to your letter of October 30, 1980, the Legal Services Corporation is pleased to report on the services and benefits offered by our organization to older Americans.

As you know, the Legal Services Corporation was established by Congress in 1974 to provide financial support for civil legal assistance to poor people. The Corporation presently funds over 300 legal services programs around the country which provide legal assistance to the general poverty population. Because the elderly are found in disproportionate numbers within the poverty population, they are a major target for the provision of legal services.

Eligibility for legal services is governed by income and resources. The Corporation, as required by statute, has established a maximum income level for the receipt of legal services—125 percent of the OMB poverty line—and has set forth factors which local programs must take into consideration in developing their own eligibility guidelines. Within these parameters, each program has established procedures for determining the eligibility of applicants for legal services.

Similarly, priorities for the types of legal problems which will be addressed by local programs (again, within the parameters of the Legal Services Corporation Act and regulations) are determined on a local level, based on the legal needs of the particular community to be served. Thus, although the elderly poor are generally eligible for Corporation-funded legal services, one must look to the specific program's guidelines as to the types of cases handled and the actual financial eligibility requirements for that particular area.

While most local legal services programs do not exclusively serve older Americans—the elderly poor are served along with all low-income persons—many programs are beginning to identify, separate units to address the special legal problems of the elderly. This has often been made possible through the joint funding of such specialized elderly units by the Legal Services Corporation and the Administration on Aging. The Older Americans Act funding has enabled the legal services programs to undertake additional efforts on behalf of the elderly such as outreach and community legal education with a concomitant increase in the quantity and quality of services to the elderly.

The Corporation also funds the National Senior Citizens Law Center, a national backup center to provide support and technical assistance to local program staff on the legal issues unique to the elderly population. The center has provided training, developed manuals, and established a network of elderly advocates and clients. The center undertakes impact litigation on elderly issues as well as providing administrative and legislative representation on these issues in Washington, D.C. The center also communicates on a regular basis with the elderly network to keep them informed of the latest developments in elderly law.

Recently, the Legal Services Corporation conducted a nationwide study of the special legal problems of the elderly and of their special problems in obtaining access to legal services. The results of this study are included in the enclosed summary report and shall guide the Corporation's future plans for meeting our goal of providing high quality legal assistance and assuring equal access to our system of justice for the redress of grievances for those otherwise unable to afford adequate legal counsel.

Although actual expenditures on service to the elderly are difficult to determine with any precision, statistics gathered during the above-mentioned study do provide a basis for comparison. The study found that the median program had a caseload containing 13.9 percent elderly clients. During the fiscal year 1980, the Corporation operated on a budget of $300 million. Approximately 2 percent of this budget is utilized for national administrative costs with the remainder going to field programs and field program support.

Your letter also requested information regarding interagency agreements. In 1977, the Corporation and the Administration on Aging (AoA) entered into an agreement, the purpose of which was to encourage cooperative relationships between the Legal Services Corporation-funded programs and AoA-funded projects and agencies at the State and local level. Under the aegis of this statement of understanding, as the agreement is entitled, the Corporation and AoA have worked cooperatively on a number of efforts to benefit the low-income elderly population. Recently, the two agencies extended an existing agreement for the utilization of Corporation employees by AoA to assist with the development of legal services activities authorized and funded under the Older Americans Act. These employees serve as the Corporation's liaison in the continuing implementation of the statement of understanding between the two agencies.

Finally, the Corporation entered into an agreement with the Administration on Aging, the U.S. Commission on Civil Rights, the Department of Health and Human Services' Office of Civil Rights, the Equal Employment Opportunity Commission, and the American Bar Association Commission on Legal Problems of the Elderly to establish a Task Force on Older Americans Civil Rights and Age Discrimination. The purpose of the agreement is to facilitate communication, coordination, and cooperation among the parties to reduce or eliminate negative social stereotyping of older people, to assure full protection under established civil rights laws, to reduce or eliminate barriers which deny access to services or benefits, and to promote an individual's right to pursue economic and social independence and self-sufficiency.

I hope this information will be helpful to you. If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,

DAN J. BRADLEY, *President.*

Enclosure.

SUMMARY OF THE STUDY ON THE SPECIAL DIFFICULTIES OF ACCESS AND SPECIAL UNMET LEGAL PROBLEMS OF THE ELDERLY AND HANDICAPPED

I. INTRODUCTION

The findings of the study conducted by the Legal Services Corporation (LSC) on the special difficulties of access and special unmet legal problems of the elderly and handicapped are reported in this executive summary. The policy decisions made and actions which LSC will take to implement the study findings in this summary also are presented. The full study details the study findings and describes and analyzes the current efforts of legal services programs in representing the elderly and the handicapped.

Section 1007(h) of the Legal Services Corporation Act required LSC to study the special difficulties of access and special unmet legal problems of veterans, Native Americans, migrants and seasonal farmworkers, people with limited English-speaking abilities, and persons who reside in sparsely populated areas.[1] Section 1007(h) did not mention the elderly and the handicapped. However, the elderly and handicapped are specifically mentioned in section 1007(a)(2) of the Legal Services Corporation Act. Because of this express statement of congressional concern for these groups and the existence of the research team to meet the specific section 1007(h) mandate, LSC broadened the study to include them.

Research Questions

The study of the elderly and the handicapped used the same research questions as the study of the section 1007(h) groups, that is: (a) Whether or not the elderly and handicapped have special difficulties of access to legal services; (b) whether or not the elderly and handicapped have special legal problems which are unmet; and (c) what should LSC do about the special access difficulties or special legal problems it finds. This study also examined the needs of the elderly and handicapped in relation to the total of resources providing civil legal assistance for them. The availability and intended uses of non-LSC resources are major areas of inquiry for the elderly and handicapped because the resources are substantial and little has been written about them in the past.

Access

The term "access" is vague. In general, this study opts for a broad use of the term, encompassing not only physical access—that is, the ability of an eligible person to reach and receive some service from a legal services program—but also the actual nature and extent of service, including the extent to which the provider meets the special needs of the client. There are two main reasons for adopting this broad definition. First, it is important as a matter of study methodology to start with the broadest notion of access possible, so that in gathering information all factors relevant to the perceptions of access by interested persons and legal services programs are considered. Second, even if a narrow view of access were adopted, it would be necessary to relate difficulties of access to the end product—the representation provided or its effect—and, thus, all factors relating to that end product must be examined.

At the outset of this study, seven major possible access barriers were hypothesized for the section 1007(h) study. This was done both to target information collection and to provide a context for analysis. The most obvious access barrier—true to some extent for all groups—is no available legal services.

A related (second) access barrier is inability to reach program offices because of physical distance, lack of transportation and the like.

A third access barrier is the inability to obtain service on a particular legal problem after a potentially eligible client reaches a legal services office because of program inability or unwillingness to provide representation. A number of factors can cause this barrier to emerge for any group: Local priority determinations, caseload pressures or the like. The study sought to determine the extent of this barrier by questioning various relevant organizations (e.g., does the local program serve members of the group?) and by examining local program priorities and policies.

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[1] Special Legal Problems and Problems of Access to Legal Services of Veterans, Migrant and Seasonal Farmworkers, Native Americans, People with Limited English-Speaking Abilities, Individuals in Sparsely Populated Areas. Legal Services Corporation, June 1979.

The fourth access barrier is lack of knowledge—that is, potential clients do not understand either that there is a legal services program available to serve them or that it can be helpful on a particular problem. The study explored the extent to which programs engage in activities, such as publicity, outreach, community education, and training of lay advocates, which impact on client awareness.

A fifth barrier concerns sources of information or referral which direct clients elsewhere irrespective of the desirability and potential effectiveness of assistance from a legal services program.

The sixth access barrier is due to language, ethnicity, and culture. Potential clients may not seek services from a program unless, through its staff or otherwise, there is some ethnic or cultural identification that makes the individual feel a sympathetic audience is available.

A seventh access barrier relates to expertise and, at least inferentially, to quality. Access may exist but be ineffective or of limited use for any particular group if a program is unprepared to handle the type of problem presented. This can occur because a program is presented with a problem only infrequently, because the problem is particularly complex, because resolution requires substantial resources, because the staff is inadequately trained or the like. Because this study focuses on the special problems of particular groups and not the problems of all poor persons, it is not surprising that this barrier was often found for parts of each group on some problems.

In addition to the seven access barriers originally hypothesized for the five section 1007(h) groups, eight barriers were added for the elderly and handicapped for purposes of information collection. These eight represent both a broadening and narrowing of the original list. A few are different from the original list; most, however, address a specific aspect of general statement.

(1) *Stigma of charity.*—This barrier is often asserted for the elderly. The theory is that the elderly will not use services having a "means" test because of association with charity and/or will not use the services of a provider who serves primarily poor persons.

(2) *Staff discrimination and/or disinterest.*—This barrier would exist, for example, if staff believed the legal problems of elderly and handicapped persons are insignificant or unimportant and refused to serve them. It might arise from a disinterest in or dislike for serving the elderly and handicapped whatever their legal problem, because of frustration dealing with clients who don't communicate well.

(3) *Eligible individuals are unaggressive and won't take risks.*—Adding this concept and labeling it as a possible barrier probably represents the outer limits of the concept of "access" since client choice and control is a basic tenet of legal services. However, a client may forego rights or refuse to pursue them to the point where legal services, theoretically available, are of little value. When lack of aggressiveness reaches this level, it is appropriate to regard it as an access barrier.

(4) *Service is in dangerous neighborhoods.*—It is often asserted with respect to urban areas that elderly persons—and to a lesser extent handicapped persons—will not go to service providers in areas where there is a real fear for personal security. This could be viewed as a corollary of (1) above since location in dangerous neighborhoods is commonly a basic method of service delivery to the poor.

(5) *Communications is difficult or impossible.*—This barrier might particularly be applicable to certain subclasses of the handicapped—the deaf, the blind, the severely mentally disabled. It is, however, also asserted about the elderly at least to the point of suggesting that particular patience and understanding is a prerequisite to effective communication.

(6) *The potential client can speak only through surrogates who won't use legal services.*—The surrogate here could be a parent of a mentally retarded child or a guardian of an older person. The interests of the surrogate may be different from those of the handicapped individual and the surrogate may even be the source of the legal problem.

(7) *The facilities of the legal services provider are structurally inaccessible.*—This barrier is primarily applicable to the physically handicapped and relates to the structure of facilities rather than their location.

(8) *The potential clients are institutionalized and cannot seek services.*—Age and disability are, of course, two major reasons for institutionalization and thus it is appropriate to raise this access barrier here.

The study mandate requires examination of access difficulties only if they are "special." Throughout the study, "special" has been used interchangeably with "status related," so that the inquiry covers access difficulties directly related to the characteristics used to define the group. "Special" has not been defined to mean "unique." Use of a definition that narrow would eliminate almost all access barriers for the groups in the study.

The list of possible barriers was developed only as a starting point. It served to direct the inquiry and provide some categorization for initial analysis. As the full report details, however, national level conclusions premised on precise characterizations of access barriers are all but impossible where substantial variation in circumstances, attitudes, and needs as well as in services exists.

Unmet Special Legal Problems

As with the study of the section 1007(h) groups, this study used a broad notion of what is an "unmet special legal problem." Thus, the inquiry was not narrowed by a limited view of what legal problems are "special" or of what problems are "legal." Nor were certain problems omitted because of some belief they are not "unmet."

Using a broad starting point delays but does not avoid the narrowing process. The elderly and handicapped are large and diverse groups. Analysis of all their possible legal problems is well beyond the resources of a study of this nature. There was an attempt from the beginning to concentrate on legal problem areas that seem to have the highest incidence and are most related to group "status." Thus, the study looks least at problems that are shared by all poor but are otherwise unrelated or only loosely related to elderly or handicapped status. It also looks least at problem areas that appear to affect only a few persons.

There is a philosophical choice behind these targeting decisions. The purpose of the study is not to list legal problems or to analyze them like a legal text. Rather, the purpose is to determine whether there is unmet need with respect to special legal problems. This purpose can be realized best by looking at the most visible, important and pervasive of the special legal problems on the assumption that legal services should be most responsive to these problems, and thus the problem can serve as a bellwether of the overall legal services effort.

Categorization

During the course of the study, it became apparent that one subclass of the elderly and the handicapped—those who are institutionalized—were so related that the fact of institutionalization is more important to both access and to the presence of legal problems than either age or disability. For this reason, the institutionalized have been separated out and are discussed separately. Specific findings and recommendations covering solely the institutionalized are included.

The special treatment of the institutionalized is actually one aspect of a larger overlap between the elderly and the handicapped. A substantial part of the handicapped are elderly; a substantial part of the elderly are handicapped. This means that any findings or conclusions arrived at with respect to persons under one label (either elderly or handicapped) are applicable to some extent under the other label.

While the overlap between elderly and handicapped is substantial, it generally was not explored in the study. Many of the persons interviewed in the study and many who served on study advisory groups recognized the connection, but no one suggested any particular policy directions that should come from it. In fact, these persons usually considered only one label relevant and suggested policies around that one label. Thus, someone might suggest certain actions for an elderly blind person because that person was elderly or because that person was blind but not because the person was elderly and blind. The study generally adopts this approach.

II. NONINSTITUTIONALIZED ELDERLY

A. Background

For purposes of this study, an eligible elderly person is a person who has an income equal to or less than 125 percent of the poverty level and who is 60 years or older. Because of limitations on data availability on important issues, the

study was occasionally required to use data based on an age cutoff of 65 years or data based on all elderly persons irrespective of income. In those instances, the data is being used as if it related to the definition of elderly otherwise used in the study, and the error involved in the substitution has to be considered in looking at any findings or conclusions based on such data.

According to the "Survey of Income and Education" (SIE) conducted by the Census Bureau in 1976, 16.5 percent of the poor persons in the United States are age 60 or older. Although there is a higher incidence of poverty among the elderly than among the nonelderly, there has been a steady decrease in poverty among the elderly since poverty statistics were first compiled.[2] Today, the elderly are a smaller share of the poverty population than the SIE reflects.

The elderly have always been part of legal services caseloads although special targeting on their needs has historically not been the rule. The Office of Economic Opportunity (OEO) funded a number of model projects for legal services to the elderly and in 1972, established the National Senior Citizens Law Center to serve as a national support center for legal services to the elderly delivered by local programs.

Overall there was little special activity for the elderly until the passage of the title III of the Older Americans Act (OAA) in 1973. Legal services activities for the elderly funded under the OAA have steadily grown since 1973. In 1978, each area aging agency (AAA—the local distribution point for OAA funds) was required by amendments to the Older Americans Act to devote "some funds" to legal services. Recently, the Administration on Aging (AoA) has promulgated regulations defining standards for legal services providers. Additionally, AoA has created a number of biregional centers to provide technical assistance, support, and training to assist advocacy efforts of AAA's State offices on aging and legal services providers.

Although since 1973 AoA has become the major source of special legal services for the elderly, the Legal Services Corporation funds legal services programs covering almost all of the country and serving the elderly poor as part of service to the overall poverty population. To facilitate some coordination of activities at the national level, LSC and AoA have entered into a cooperation agreement whereby two LSC staff persons are stationed at AoA and work on legal services.

The involvement of two major funding sources makes the situation at the local level difficult to describe. Roughly 70 percent of the AAA's were providing "some funds" to legal services in mid-1979. In many instances, however, the funds were going to only a part of the AAA service area. At that time, approximately 80 percent of the counties in the country were covered by an LSC-funded program.

The most common arrangement around the country—applicable to 60 percent of the AAA's which fund legal services—is that the AAA provides funding to the LSC-funded legal services program which then establishes a special unit for the elderly using primarily AAA and LSC funds. In the remaining 40 percent of the areas, there is great diversity of approach. Often, a separate legal services program is established solely to serve the elderly. In other cases, law schools, bar associations, AAA staff, and other social programs have been funded.

Because LSC will not complete full geographic coverage until the end of 1980 and because not all AAA's fund legal services, there are a few areas of the country where the elderly have no legal services available. In many areas, they have available only the services provided to elderly persons by the LSC-funded program.

While 70 percent of the AAA's provide some funds for legal services, the amount is generally small in relation to the population to be served. This is especially true if the population to be served includes nonpoor elderly.

One other point about local legal services to the elderly is important. The term "legal services" is sufficiently broad to encompass many advocacy, counseling, and educational activities. Especially among AAA-funded programs not connected with an LSC program, the type of service delivered to the elderly and, as a result the staffing, are atypical for legal services generally. Thus, a program for the elderly might provide primarily legal education or social worker counseling with little lawyer involvement or advocacy.

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[2] In 1959, the Census Bureau reported that 35.2 percent of the elderly were poor. In 1978, the Bureau found that 14 percent of the elderly were poor. See U.S. Bureau of Census, Current Population Report: Money Income and Poverty Status of Families and Persons in the United States: 1978 at 28 (November, 1979).

B. Special Difficulties of Access to Legal Services

There are two ways to look at access to legal services for the elderly: (1) Whether the elderly overall have sufficient access to legal services; (2) whether hypothesized special access barriers for the elderly are present. Data on 48 staff programs from the Delivery Systems Study (DSS)[3] were examined to address the overall access issue. The examination covered the extent to which elderly clients appear in program caseloads in comparison with the percentage of poor persons who are elderly. The hypothesis behind this examination was that numerical underinclusion—a percentage of program clients who are elderly which is less than the percentage of poor persons in the area who are elderly—could be equated with access insufficiency.

The DSS data did not show significant underinclusion of the elderly in program caseloads overall. Further, the data showed the methodological weakness of looking at numerical underinclusion in caseloads as a measure of anything, including access insufficiency. From the data, it is apparent that the percentage of clients who are elderly in any LSC program is determined primarily by whether the program handles case types that are de facto age targeted either at younger persons—e.g., juvenile, AFDC, domestic relations, employment—or at older persons—e.g., wills, guardianship, nursing home problems. The decision of whether or not to handle such cases to any particular extent involves considerations beyond numerical inclusion of elderly persons or those of any other age.

From the data and site visits, however, it is apparent that some programs serve very few elderly clients. Depending on the reason for this limited service, these programs may be discriminating based on age. Since HEW has recently issued model age discrimination regulations and LSC can, but is not required to, issue its own age discrimination regulations, this finding suggests that some age discrimination standard must be created. Therefore, as a result of the finding that a small minority of programs serve very few elderly clients:

> As part of a general effort to define the civil rights responsibilities of programs, LSC will enact a regulation to enforce the Age Discrimination Act. Further, LSC will inform all programs of their obligations under the Age Discrimination Act.

The second aspect of access—where hypothesized special access barriers for the elderly exist and are unmet—is more difficult to address from a national perspective because of the tremendous variation in local circumstances and responses. Generally, where there is AoA-funded legal services for the elderly and this funding results in a special unit or program for the elderly, the major special access barriers are addressed. In fact, most of the major access barriers of the elderly covered in this study are special in degree only and it is common in a local area for the barriers to be addressed for the elderly but not for others.

There are exceptions as well as solutions that appear to raise their own problems. Programs and special units for the elderly often find the elderly do not want to use legal services or assert rights because of an unwillingness to take risks or a belief that problems will take care of themselves. This attribute, to the extent it exists, may be generational and may disappear or decline as time goes by. There is, however, no definitive way to deal with it.

While there is some feeling that even poor elderly will refuse to seek services governed by a "means test," the special units and programs appear able to overcome any problems by a careful creation of an image that the program or unit is only for the elderly and separate from any general program for the poor of which it might be a part. At the same time, most of the programs units use some form of means test.

The elimination of means testing in services to the elderly can only cause a reduction in service to the poor elderly irrespective of the method used to target services to those with greatest social and economic need. Thus, absence of a means test will itself raise access difficulties because the poorest, least assertive and least vocal segment of the elderly will be required to be more aggressive about seeking service and asserting rights. It will also very likely exacerbate a problem of the underinclusion of minorities in some areas since minority elderly are more likely to be poor than majority elderly.

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[3] The Delivery Systems Study was undertaken by LSC pursuant to section 1007(g) of the Legal Services Corporation Act. An initial report was issued in July 1977. A final report will be available in July 1980.

While staff in most LSC-funded programs appear willing and able to serve the elderly, there are some problems with program staffing and policies that bear on elderly service. Only a minority of LSC programs have any elderly staff and the number of these programs is small. Even in special units for the elderly, many programs do not have elderly staff. Since there is a belief that at least some elderly staff are likely to improve representation of the elderly and producing job opportunities for elderly persons is itself a desirable end:

LSC will inform all programs of their obligations under the Age Discrimination in Employment Act.

There is a widespread belief that the extent of local services to the elderly by LSC programs has been determined by priority setting and in that process, service to the elderly has somehow been reduced in relation to others. From the site visits in this study, it appears that at least half the programs have no formal priorities that govern service delivery, though most are somewhere in a priority setting process. Further, among those that have priorities, it does not appear that they give more or less service to the elderly than those without priorities.

The main influence on consideration of the elderly in priority setting has been the availability to the program of non-LSC funding for services to the elderly or, alternatively, the availability of special services for the elderly from another program. There is a tendency to consider the non-LSC resources together with the money they "leverage"—either LSC or other—as the proper resource commitment to the elderly whether or not a program goes through a formal priority setting process.

Addressing the needs of the elderly in priority setting produces logical and practical difficulties because it mixes people characterized by age with issues or areas of legal problems that concern some poor people. Program staff almost invariably believe that only categorization by legal problem makes sense in priority setting, so they lump the elderly in with others to reach a delivery structure that would not separate clients by age. Advocates for the elderly (including staff serving them) take the position that mixing the elderly with others under legal problem headings is wholly inappropriate; they pursue a separatist structure irrespective of duplicate coverage of legal problems. There is no clear compromise except that caused by non-LSC resources supporting a special unit. Without non-LSC resources, program staff would generally not create a special unit for the elderly or specialize based on age division exclusively. Priority setting has little influence on the existence of special units or on specialization.

Although the result of priority setting for the elderly has been little or no change in the status quo, the process appears controversial because the results could theoretically dramatically change the nature of the program. In addition, there is a clear difference between promise and reality. The most obvious evidence of the latter point is the fact that the elderly and their advocates appear to be included in the process in virtually all programs and yet, the result produces little for the elderly beyond the status quo.

Based on these findings with respect to the elderly and other problems with priority setting that have emerged:

The current process within the Office of Field Services, LSC to redesign LSC policies on program priorities and planning will seek to simplify the recommended process and emphasize results not procedure.

This discussion of specific, hypothesized access barriers is intended to cover specific weaknesses in current delivery that warrants action. Overall, the examination of the hypothesized barriers only reinforces the general view that access barriers for the elderly have been overcome in most areas.

C. Unmet Special Legal Problems

The study showed two types of special legal problems of the elderly: (1) Those that apply to all ages but may have an unequal impact on the elderly; and (2) those that are somehow unique to the elderly or different in kind. Another way to categorize the problems is in terms of the solution. Again, there are two major categories: (1) Problems resolvable primarily by assistance to individual elderly persons whether that assistance be representation, counseling, education or some other service; (2) problems resolvable primarily by rule or system change for the benefit of substantial numbers of persons whether through litigation, rulemaking advocacy, legislative advocacy or some other service. Consideration of

both types of categorization are necessary to evaluate the extent to which the special legal problems of the elderly are unmet.

The following is a list of the most important special legal problems as derived from AAA's and senior citizens' organizations' questionnaire responses. The list is used primarily as a vehicle to understand the nature of the legal problems and categorize them. These problems might not be judged the most important in any particular local area. The problems are categorized in the terms outlined above.

(1) *Governmental income maintenance.*—The elderly share a number of income maintenance programs with others—primarily the disabled—so that the problems are not unique to the elderly although older age is usually an eligibility factor. Among the programs are supplemental security income (SSI), social security (title II, retirement benefits), railroad retirement benefits, and veterans' benefits. The programs and beneficiaries are generally lumped together so that actions to benefit one type of recipient is likely to benefit another.

Income maintenance programs of primary benefit to the elderly are generally run at the Federal level. While there is a need at the national level for advocacy affecting overall operation of programs, the primary need is for individual representation and assistance.

(2) *Housing.*—The housing problems of the elderly poor are similar to those of poor persons generally. However, there is a higher incidence of homeownership among the elderly than among all poor. Some public housing programs are partially targeted on the elderly, but the problems appear similar to those for all public or subsidized housing tenants.

Many of the housing problems are resolvable through individual representation, counseling, and education. Especially as to public and subsidized housing and housing-related consumer problems, there appears to be a real need for an institutional perspective and orientation.

(3) *Alternatives to institutionalization.*—While this area generally applies to any group which is institutionalized, the unique situation of the elderly with respect to nursing homes, mental hospitals, and other institutions means the problems and solutions are different in kind for the elderly. While there is room for individual counseling and representation to obtain what benefits are possible with existing programs and resources, the real need is for systems change that creates realistic alternatives to institutionalization. This need, in turn, demands legislative, administrative and litigation advocacy on a broad-based level.

(4) *Wills and estate planning.*—While this might be seen as a legal need to be satisfied primarily when a person is younger, the reality is that it is not met or even perceived in most cases until a person becomes elderly. This reality and the common need or desire to change testamentary arrangements makes it an area special for the elderly. While a limited amount of systems advocacy may be necessary to create effective testamentary disposition laws, the need is primarily for individual counseling and document preparation.

(5) *Medicaid/medicare.*—These health care financing programs are related to income maintenance programs and many of the same considerations apply. However, medicaid is administered by the States and issues of consistency of State policies with Federal requirements are common. Moreover, medicare is an unexplored area. As a result, there may be a greater need than in income maintenance programs for more systematic advocacy aimed at program operation—including legislative, administrative, and judicial.

(6) *Guardian/protective services.*—Older age, with associated infirmities, is one reason for protective services and guardianship. In most States it is the most common reason. In this area the need is primarily for individual counseling and representation of the involved elderly person and relatives and friends. There is a tremendous need to modernize guardianship and protective services laws; legislative advocacy is desirable for all elderly. Improving the practices and procedures by which guardianships are obtained may also be a serious issue in many jurisdictions.

(7) *Utilities.*—Problems of utility price and supply are shared by all poor persons, although the impact on the elderly of service interruption or rate increases is the most severe. While there is some need for assistance with individual disconnection or deposit issues, the real need is for legal advocacy in the regulatory agencies to insure fair distribution policies and to minimize price. These are generally very large proceedings involving both tremendous time commitments and the use of various professionals, including economists and engineers.

(8) *Other health problems and insurance.*—These problems are related because insurance for special problems of the elderly invariably covers health care. The insurance issues—generally involving the relation of private insurance to medicare or medicaid (so called "medigap" insurance)—are largely unique to the elderly. The solution may involve both client education and administrative (rulemaking) advocacy. Otherwise, the health problems not covered above (medicaid/medicare, alternatives to institutionalization) appear to require group advocacy.

The degree to which these legal problems are met varies from local area to local area. Two findings are possible at the national level:

(1) Except for estate planning, special legal problems of the elderly are most likely to be addressed and met if they are shared with other poor persons;

(2) Special legal problems of the elderly are most likely to be met if the solution involves individual education, counseling and representation.

The first finding is self-evident from the nature of programs delivering legal services at the local level. To the extent problems are shared by a significant segment of the poor, it is likely there are specialist staff addressing the problem. Particularly where the need is for system or rule changes, actions for the nonelderly do not directly benefit elderly persons with the same problem. While this is true for almost all problems discussed above, the use of special units for the elderly not connected with substantive-area specialists considering similar problems results in duplication. Duplicated service reduces the likelihood that problems will be addressed only if they are shared.

The second finding is consistent with the nature of programs and units delivering legal services to the elderly. The high emphasis on physical access and education and the accompanying heavy dependence on nonprofessional advocates and nonlawyer professionals makes it difficult for many programs and units to engage in litigation, legislative, or administrative policy advocacy.

Thus, the issues discussed above that require more than individual representation are generally not sufficiently addressed, and there is clear unmet need. Even those issues that necessitate only individual representation may be unaddressed if litigation is required. Where there are special units or programs, the lawyer staff—if there is any—is often tied up in supervising nonprofessional staff and in outreach and is not available for litigation. About half the special units visited during the site visits were engaged in virtually no litigation.

In addition to the special legal problems discussed above, there are others directly related to older age. They include age discrimination, particularly in employment, and pension rights. The fact that these problems were not raised by AAA's or senior citizens' organizations probably reflects a lack of understanding that rights exist and can be enforced. This is another indication that special legal problems are often insufficiently addressed.

To stimulate and increase work in particular areas two methods have been used in the past: (a) Training, and (b) support. These are related activities and often come from the same source, e.g., a support center.

Although the National Senior Citizens Law Center provides support assistance on most special legal problems of the elderly and other support centers (for example, Center on Social Welfare Policy and Law and National Health Law Program) cover substantive areas of particular concern to the elderly, no manuals on law relating to the elderly have been developed by LSC. Similarly, there has been no national training in most of the special legal problem areas in a number of years. The training and manuals available under the auspices of AoA or within the aging network are too basic to be of assistance in motivating programs to address unmet special legal problems.

As a result of the above findings on coverage of unmet special legal problems, the following actions will be taken:

To the extent funding is available for substantive training and development of manuals, LSC will develop manuals and training on the special legal problems of the elderly (particularly, including issues not covered in previous training). The training will be open and the manuals available to clients and staff in both special elderly units and other program units. LSC will continue consistent with its allocation process to provide funds to existing support centers to assure that adequate support and advocacy are undertaken on age-targeted issues, such as age discrimination, pensions, medicare and long-term care. Other actions relating to support and training are discussed below under LSC/AoA cooperation.

D. Conclusion Relating to Both Access and Special Legal Problems

There is an inverse relationship between a program's ability to meet all access difficulties and simultaneously address special legal problems, particularly those requiring extensive resource commitment to litigation, legislative, or administrative advocacy. The current special units created with a mixture of AoA and other (LSC included) funding generally give highest priority to access, often to the exclusion of many special legal problems of the elderly.

While the special units for the elderly seem effective in achieving access, the gaps in services provided and problems addressed suggest caution in endorsing the approach without reservation. Even if the needs of the non-elderly were not considered, it may be that delivery systems structured along substantive speciality lines without age divisions would produce a better balance of substantive expertise and access to service. Thus, this study does not conclude that LSC should insist on any specific approach by local programs.

To a great extent, the effectiveness of service to the elderly is dependent upon local cooperation and coordination between LSC and AoA resources and national level coordination.

There appears to be sufficient coordination and reasonably fair allocation of responsibilities at the local level. At least within LSC programs, AoA funding through AAA's leverage other resources to the overall benefit of the elderly. The mix of resources is locally bargained in a way that appears in many areas to achieve sufficient resources for the elderly within limits of available funds. Of course, the severe limitations on resources available both from AAA's and legal services programs makes the total resource commitment for legal services to the elderly inadequate in many areas.

While cooperation may be the norm, there are many instances of lack of cooperation. Often this lack of cooperation can be traced to philosophical differences, although disagreements over issues like the means test have occurred. Overall, a thorough discussion and explanation of the nature, role and expected result of legal services would probably facilitate cooperation.

National cooperation is largely based on an agreement for coordination between LSC and AoA and the placement of LSC staff at AoA. It is particularly important that both LSC and AoA create an atmosphere whereby aggressive, quality advocacy will result.

The one place where there needs to be more effort is national support. AoA has recently established a new biregional support center structure although National Senior Citizens Law Center (NSCLU) is funded to undertake some national training and support. The national contract to NSCLC will terminate shortly and may not be renewed. AoA's biregional centers have primarily a training role. However, training efforts have been aimed at delivery issues and not at creating expertise on the special legal problems of the elderly. Further, because training policy is controlled by State aging offices, the training may be of only limited benefit to legal services providers. Meanwhile, assistance on advocacy, including help on specific cases, legislative and administrative projects, is a secondary part of the mission of the AoA centers.

The result of the AoA biregional centers' orientation appears far short of developing expertise in aggressive advocacy to respond to special legal problems of the elderly. LSC can fill some of this gap but the overall result still appears to be a misplaced emphasis on access.

Based on the above findings, the following actions are appropriate:

LSC will work with the Administration on Aging to help develop an effective legal services network and to encourage local area aging agencies to support aggressive, quality legal services for the elderly. LSC will seek to establish with the Administration on Aging a national support structure that will assure that LSC grantees receiving AoA funds, as well as other AoA grantees providing legal services, have access to effective training, technical assistance, clearinghouse services, manuals, advice and assistance, cocounseling, coordination, and communication on issues affecting the elderly, and to gain AoA assistance in funding a national support structure that will provide advocacy (including legislative and administrative representation) on a national level on elderly issues.

III. NONINSTITUTIONALIZED HANDICAPPED

A. Background

The term "handicapped" can be given many definitions based on the nature, severity, and duration of the disabling condition. For purposes of this study, the definition of handicapped used is that of the Rehabilitation Act of 1973, as amended, and regulations implementing the act. The definition of "handicapped person" is:

> [A]ny person who (i) has a physical or mental impairment which substantially limits one or more major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment.

45 CFR § 84.3(j)(1). Note this definition includes the terms "physical or mental impairment" and "major life activities" which, in turn, are defined. It is sufficient to say the definition of "physical or mental impairment" is very broad. The definition of "major life activities" is:

> [F]unctions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

45 CFR § 84.3(j)(2)(ii).

In this summary as well as in the study report, the term disabled is often used. It is intended to be a synonym for the handicapped and not to have the particular meanings ascribed to it in the Social Security Act and elsewhere.

For many purposes the section 504 definition is too broad. For example, it imposes no permanency requirement so that a person with a temporary illness may be handicapped during its duration. Similarly, persons may have impairments that "substantially limit" a major life activity but the impairment may raise no legal services access barriers either because the impairment is of insufficient severity or because it relates to a life activity that is irrelevant to legal services access.

It is important to emphasize, however, that any overbreadth in the section 504 definition for purposes of the study is limited to only some issues. Any person within the scope of protection of section 504 may have enforcement of rights under the section as a special legal problem. An individual suffering from "black lung" may have no difficulty of access to legal services but still have a legal problem arising out of difficulty in obtaining appropriate black lung benefits. In general, this study looks at access questions in the context of the more severely handicapped persons and special legal problems in the context of a broad definition of handicapped persons.

Adoption of the relatively broad definition of the Rehabilitation Act necessitates use of subcategories in many instances. For example, distinctions are often made based on whether a person is physically or mentally disabled. Distinctions are also drawn to distinguish a person who is severely handicapped from one who is less than severely handicapped. While some narrowing of the meaning of these terms is possible, any definition ultimately has to vary based on how the terms are used. For example, with respect to a mentally disabled person, the term "severely handicapped" might be used to indicate that client decisionmaking and effective communication between attorney and client is impossible. When describing a physically disabled person, the term might be used to indicate a person who would be wholly unable to enter a building with an architectural barrier.

Because the category "handicapped" has emerged only recently for use in social programming, there is no definitive enumeration of the number of handicapped persons in the United States or the number of poor handicapped. Estimates of the number of handicapped persons in the country vary widely with the upper ranges exceeding 70 million persons. Because handicapping conditions affect the ability to earn income, it is fair to assume there is a higher incidence of poverty among handicapped persons and, thus, a higher percentage poor than nonpoor are handicapped. It is not outside the range of possibility that 50 percent or more of the poor persons in the United States are handicapped.

The following are "order of magnitude" estimates of significant parts of the handicapped population by handicapping condition.

a. Visually impaired	
Severe (can't read with lenses)	1,391,000
Not severe	10,240,000
b. Hearing impaired:	
Deaf	2,200,000
Bilateral loss	5,800,000
Single ear loss	8,200,000
c. Speech impaired	1,995,000
d. Physical disabilities:	
Absence of major extremity	358,000
Paralysis of part of body	1,532,000
Orthopedic disorder (w/o paralysis)	9,365,000
e. Mentally retarded	4,400,000
f. Epilepsy	2,135,000
g. Cerebral palsy	760,000
h. Multiple sclerosis	300,000
i. Muscular dystrophy	200,000
j. Mental illness	32,000,000

Traditionally, there has been no special emphasis on the handicapped in legal services programs. In part, this is because the categorization and legal issues and rights based on categorization are relatively new. Also, this is because (as described below), the noninstitutionalized handicapped have been an integral part of program caseloads so that any kind of special emphasis appeared unnecessary.

As new legislation created rights based on handicapped status, there has been some experimentation both locally and nationally in meeting special needs of the handicapped. A few programs have created specialists or special units to serve the handicapped, usually on specific legal problems. LSC has specially funded Community Action for Legal Services (CALS) to operate a special support unit (called the Handicapped Persons Support Unit) to focus on problems of the handicapped, cocounsel cases and train CALS staff.

Many of the major legal problem areas are covered in the national support structure. For example, a substantial percentage of the time of the Center for Law and Education is used in providing support on issues related to the Education of All Handicapped Children Act and education rights of the handicapped.

Probably most of the special efforts for the handicapped or significant subcategories of the handicapped has come from non-LSC resources. The Development Disabilities Protection and Advocacy (P&A) systems, funded in each State by HEW, have in most States provided legal representation to the developmentally disabled. (Historically, this has been the mentally retarded and those with epilepsy, autism, or cerebral palsy, although the definition is now expanded.) Because the P&A systems receive very little funding, it is not likely they approach meeting completely the needs of the developmentally disabled anywhere.

In some States or local areas, legal services to the noninstitutionalized mentally disabled has grown out from commitment representation (treated under the institutionalized, infra) or from representation of institutionalized mentally disabled. These efforts are sporadic at best.

A number of private organizations have provided legal services to the handicapped. The American Bar Association Commission on the Mentally Disabled used foundation money to fund a number of bar associations to deliver services to the mentally disabled. Some of these projects emphasized the noninstitutionalized mentally ill or developmentally disabled.

Some of the advocacy organizations for subclasses of the handicapped provide limited legal services, usually from Washington staff attorneys or funding local attorneys. Some of the organizations—for example, the Association for Retarded Citizens—have local chapters large enough to afford an attorney and/or lay advocates at least part time. Some law schools have emphasized the handicapped.

The situation with respect to national and regional support is similar. HEW funded the National Center for Law and the Handicapped to provide national support primarily on issues of concern to the physically handicapped and developmentally disabled. It also funded regional projects to advocate for the developmentally disabled and support the P&A systems.

The National Center for Law and the Deaf and the Mental Health Law Project have been supported generally by private funding to provide national support. legislative advocacy, national litigation representation, training, etc. in the rights of the deaf and hearing impaired and rights of the mentally ill or allegedly mentally ill. Other national organizations to some degree offer national advocacy support from Washington.

As is obvious from the foregoing discussion, most of the special efforts funded outside of LSC cover only the mentally disabled or part of this group. Almost no public resources go to special legal services efforts for any physically handicapped people.

B. Special Access Difficulties

As with the elderly, it is appropriate to look at the access difficulties of the handicapped from two perspectives: (a) Overall to determine whether or not programs fairly serve the handicapped; (b) in relation to hypothesized access barriers. The following discussion gives an overview from both perspectives.

It is difficult to determine the overall level of LSC program service to the handicapped because of lack of data. There is no way to ascertain the incidence of handicapped persons in the service area of any program. Even if there were, it is unlikely that any programs have kept data on whether or not clients are handicapped.

In the absence of data on services to the handicapped, this study must rely on the perceptions of local staff, clients and advocates as well as the information available on types of cases handled by programs.

From this information, it appears that the handicapped are fairly served overall. This is because many programs have emphasized income maintenance and staff have handled many cases in this area for the handicapped. The overview has to be tempered, however, with an understanding of the existence of some significant gaps. Thus, it does not appear that most programs serve the severely handicapped to any great degree. This lack of service is no doubt the result of specific access barriers discussed below.

The study covered a number of specific access barriers to gauge the extent to which they exist and the extent to which programs seek to address them. The following is a discussion of the most significant access barriers.

The access barriers raised first with respect to the handicapped relate to the effect of their disability or ability to take advantage of program services. Included are the effects of architectural barriers and the absence of special efforts to communicate with the sight. hearing or speech impaired. The problem is often stated as one of "facility accessibility".

To a great extent, the issue of "facility accessibility" is simply an issue of compliance with section 504 of the Rehabilitation Act and regulations issued pursuant to section 504. The theory is that facilities are inaccessible to the handicapped if they do not comply with this law and regulations.

Because of the technical nature of the requirements of the facilities accessibility regulations, it is impossible to cover every aspect of it in this study. A survey of 99 sample programs was done in 1979 covering four areas of program facilities and operation: (a) Reception area; (b) confidential interview space; (c) rest rooms; and (d) availability of deaf communications. In addition, programs were asked whether or not alternative accessible sites were available to serve handicapped clients when the local office is to some extent inaccessible, and whether or not arrangements have been made with sign language interpreters to serve the deaf.

The survey showed that the availability of accessible facilities depends most on the kind of service or type of facility involved. Thus, over half the programs (53 out of 99) reported that all their interview areas are accessible to the handicapped. Somewhat less than half (42 out of 99) reported all reception areas in the program are accessible to the handicapped. Most of the remaining programs (36 for interview areas, 48 for reception areas) reported some but not all facilities accessible to the handicapped.

There is a greater problem with respect to deaf communications and rest rooms. Only 16 programs reported that all rest rooms are accessible (33 reported some rest rooms are accessible). Only one program reported that it had deaf communications equipment in all offices (one other said it had such equipment in less than all its offices). Thirty-four reported having made arrangements for deaf interpreters at some time.

Compliance with section 504 does not always require all facilities be accessible as long as the program overall is accessible. Often compliance can be achieved through use of alternative accessible interview and service sites. The sample programs reported using alternatives for 47 percent of the facilities wholly or partially inaccessible (excluding whether or not they have deaf communications equipment). More often than not (68 percent of the programs) the alternative sites are publicized.

The foregoing data was gathered before LSC issued a regulation covering, inter alia, facilities accessibility requirements. See 45 C.F.R. Part 1624 (effective October 25, 1979). Both because of the regulation and because complete facilities accessibility is usually achieved over time, the data understates current LSC program facilities accessibility.

Even if programs are significantly more accessible than the data shows, there clearly needs to be improvement. Facilities inaccessibility is probably the major reason why there is a gap in service to the severely handicapped. This is particularly true with respect to the sensory impaired.

The weakness in accessibility for the sensory impaired probably has not been significantly alleviated by LSC's regulation. The regulation has an auxiliary aids requirement but it is so vague that programs cannot determine their compliance responsibility. Therefore:

> LSC will clarify the auxiliary aids requirement contained in its section 504 regulations to provide more specificity for the guidance of programs.

One way to achieve better facilities accessibility is through education of programs on what are often highly technical requirements. Accordingly:

> LSC will develop and disseminate a technical assistance manual on section 504 compliance by June 1, 1980.

Another way to improve facilities accessibility is through direct assistance, encouragement, and monitoring from the regional offices, the part of LSC closest to programs. Accordingly:

> Following the development of the technical assistance manual, LSC will train one staff person in each regional office to disseminate information to programs, to encourage local compliance with section 504 and give technical assistance on request, and
>
> As currently planned, the monitoring process will cover compliance with section 504. One person who is part of the monitoring process should be sufficiently familiar with section 504 requirements to determine program compliance.

Although LSC may not have a legal requirement to make its own facilities accessible, the formulation of policy covering the handicapped may require full participation of handicapped persons which is possible only if the facilities involved are accessible. Further, by making its facilities accessible, LSC sets an example for local programs. Accordingly:

> LSC will as soon as possible make its Washington facilities and activities fully accessible to the handicapped including the purchase of a TTY machine and the dissemination of information in such a way as to reach those with sight or hearing disabilities. Each of the regional facilities and activities will be evaluated to determine the extent to which handicapped persons may be affected and the extent to which they are accessible. To the extent necessary, regional facilities and activities will be made accessible.

While inaccessible facilities may present the foremost access barrier for the handicapped, they are only a part of a larger problem of immobility, at least for the physically handicapped. Thus, an eligible person may know of services and be able to use them but is unable to reach them. More likely, the handicapped person with limited mobility is unaware of legal services or how to use them because he/she couldn't reach such services.

A few programs have overcome this barrier by participating in transportation programs. Some programs could assist the clients in using available transportation programs. Most programs were willing to make home visits but never publicized this policy.

The best solution to the access problems appears to be outreach to the various groups and organizations that are interested in particular subclasses of the handicapped. The outreach is not generally designed for case intake at special facilities but instead to develop referrals from persons who are in contact with the handicapped, know how to handle mobility problems and are aware of the services of the program. Publicity and education through such referral sources is

probably the most effective way to alleviate physical access problems while making potential clients aware of the presence and role of legal services.

Based on this finding:

> In order to encourage programs to engage in outreach to handicapped advocacy groups and to provide education, publicity, attendance at meetings and increased representation, the regional office person trained on § 504 compliance will also be knowledgeable about service delivery structures and policies that are effective and responsible in serving the handicapped and will be prepared to give technical assistance in this area.

Note that this action, while first addressed here, meets other access and special legal problem needs discussed infra.

A third access barrier of the handicapped may result from the policies, staffing and attitudes in programs. The issues here are similar to those raised for the elderly. Sometimes programs are perceived to give low priority to the handicapped. Further, staff are often seen as incapable or unwilling to deal with some handicapped persons, particularly the mentally disabled.

The relation between program priorities and service to the handicapped is almost identical to their relationship with service to the elderly. Similarly, all the findings made with respect to the elderly apply here with two exceptions. The first exception is the effect of non-LSC resources. Because such resources are less available for the handicapped than for the elderly, they are not such a dominant factor in determining what programs do for the handicapped. Second, there have been programs that have used LSC funds to create special units or staff for the handicapped. However, these units or staff actually cover certain special legal problems—like enforcing section 504—rather than serving the handicapped generally. Thus, they are aimed primarily at addressing special legal problems and not at overcoming access barriers. Despite these differences, the overall conclusions with respect to the elderly are equally applicable here.

Staff attitudes and ability to serve the handicapped obviously vary markedly. While staff unwillingness or inability to deal with mentally handicapped clients was seen as a problem for a few clients in a few programs, the problem does not necessitate special treatment for the mentally disabled. Developments in defining clearly the attorney's role in representing a mentally disabled client will be helpful; an explicit definition would give guidance to the attorney and hopefully engender an effective attorney/client relationship.

There is a very strong perception that use of handicapped staff will improve the client's view of program responsiveness and lead to candor and trust. Unfortunately, there are fewer handicapped staff in legal services than elderly staff—only 10 percent to 15 percent of the programs have any handicapped staff of a specified type: lawyer, paralegal, other. Very few programs (under 10 percent) have made any facilities modifications to accommodate handicapped staff.

The LSC regulation covering facilities accessibility also prohibits employment discrimination against the handicapped and requires a program to make "reasonable accommodation" to the limitations of a qualified handicapped applicant or staff person. Thus, the actions discussed earlier with respect to enforcement of this regulation, training and technical assistance cover the problems discussed here.

Finally, significant access difficulties may occur for the handicapped, particularly the mentally disabled, because of the intervention of surrogates, relatives, friends, or guardians whose interests conflict with those of the handicapped person. This is particularly a problem with the institutionalized handicapped although it can apply to the noninstitutionalized.

For the noninstitutionalized handicapped, the most common surrogate is a parent or guardian of a minor or mentally disabled adult. Experience in a number of areas shows that a working relationship between a legal services program and handicapped interest and advocacy groups tends to reduce but not eliminate inappropriate interference by surrogates. Two reasons for reduced interference are: (a) The surrogates generally have the best interest of the handicapped person in mind, and education of the surrogate breaks down hostility or reluctance to use legal services; and (b) the advocacy organizations can in some instances bring the disabled person and the legal services program together directly to prevent control by the surrogate.

The policy action of LSC with respect to outreach meets this barrier to the extent possible.

Based on the foregoing discussion, the following is a synopsis of findings with respect to the special difficulties of access of the handicapped.

Overall, the handicapped appear to have sufficient access to legal services although there is insufficient service to the severely disabled. However, there are specific special access difficulties of the handicapped that should be addressed. First, some LSC facilities are inaccessible to the handicapped generally and most are inaccessible for those with severely impaired sight, hearing or speech. This access difficulty is particularly responsible for under-service to the severely handicapped.

Second, there is a significant problem with mobility that is addressed only in some areas. It is best addressed by outreach to handicapped interest and advocacy groups.

Third, with respect to the mentally disabled in particular, there may be access difficulties caused by program policies, staffing type and attitudes. Barriers in this area require continuing development of priorities within LSC, more employment of handicapped staff and ongoing contact with handicapped interest and advocacy groups. Similarly, the fourth type of barrier—inappropriate intervention of surrogates—is prevalent in some areas for some types of handicapped and should be addressed by outreach to advocacy and interest groups.

C. Unmet Special Legal Problems

Legal rights for the handicapped, efforts to bring them into the mainstream of society and defend them from ongoing discrimination, are recent developments. Reflecting these developments is a tendency to equate the important special legal problems with areas where new legal rights are present or are emerging. Thus, based on site visits, interviews with national organizations and questionnaires to local organizations, the areas judged most important are the areas of newly created or emerging rights: education, employment, facilities accessibility, transportation and rehabilitation and habilitation services. The only area that doesn't reflect this tendency is income maintenance.

The following is a brief overview of the nature, scope and complexity of legal problems in each of the areas and a synopsis of the extent to which such problems are addressed by legal services:

(1) *Income maintenance.*—This is a traditional area of legal services involvement. Most of the programs for the handicapped, or subcategories thereof, are shared with other groups (usually the elderly). As a result there is a broad client base that necessitates specialization by programs. The recurring problem—establishing disability—is usually met both by the LSC program and by some members of the private bar who will take some cases for a percentage of the lump sum recovery.

Overall, the problems in this area are being addressed.

(2) *Education.*—Rights to an appropriate education tailored to the specific needs of the handicapped child are of recent origin under the Constitution (as interpreted by some courts), the Federal Education for All Handicapped Children Act and some State statutes. The services needed involve education of parents, counseling, representation in administrative hearings, representation in litigation and representation of groups with respect to policies and legislative actions. All these services are delivered though the law is yet unclear on many major issues.

Education has probably been the chief area of the developmentally disabled P&A systems, yet they meet only part of the need. Because of limited resources they have largely excluded some handicapped children—e.g., those with learning disabilities, or the blind. Involvement of LSC programs has been sporadic despite much more national support involvement—through the Center on Law Education—than on any of the other issues discussed here.

To a great extent, the need in this area remains unmet.

(3) *Employment.*—The Rehabilitation Act and regulations implementing it prohibits employment discrimination by Federal contractors and grantees and in Federal employment. State statutes in a number of States prohibit employment discrimination against the handicapped generally.

Primarily, the need in this area is for litigation representation of applicants or employees with legislative/administrative representation at the State or local level to establish the handicapped's rights. Few LSC programs show any activity in the area. Nor has employment discrimination been a particularly high involvement area for P&A systems. Even if it were, most of the physically handi-

capped would be unlikely to receive service from the P&A systems. There is some national support available in this area from the National Employment Law Project and from the private support entities—e.g., National Center for Law and the Deaf.

The need in this area is almost wholly unmet.

(4) *Facilities accessibility/transportation.*—As with employment, the rights flow primarily from the Rehabilitation Act and implementing regulations, although other Federal statutes can be involved and some States have passed similar statutes. Transportation is included here because in one sense it is an example of a specific facilities accessibility problem. There may be a need, however, for comprehensive advocacy services to ensure that transportation planning includes the handicapped and fairly addresses their needs.

Unlike employment, however, this is primarily group advocacy. Much of the litigation done in this area has been controversial as well as lengthy and complex, requiring a substantial resource commitment.

Some work on facilities accessibility has been done by P&A systems but mostly they have avoided complex and lengthy litigation. There is also some activity in legal services programs. Generally, the need is unmet.

(5) *Habilitation/rehabilitation services.*—The nature of the legal problems in this area is unclear. Various Federal and State programs establish rights to habilitation programs. Their purpose is usually to enable the handicapped person to live independently, be self-supporting and remain in the community. The overall perception is that these programs often don't accomplish their purpose and legal advocacy is necessary to ensure they will.

There is, however, no typical problem one can describe to discuss the services necessary to resolve it. This is an emerging area and, presumably, a full range of services including education, counseling, litigation representation and legislative and administrative representation will be necessary. To some extent the P&A systems are trying to address the need. Their role has been largely to comment on regulations and handle individual complaints for the developmentally disabled. LSC programs have done virtually nothing in the area. Most of the need in the area is unaddressed.

Overall from this discussion, it is clear that the special legal problems judged to be the most important for the handicapped are largely unaddressed. With respect to LSC programs, the reason for limited service appears to be lack of demand and lack of expertise. While either of these reasons can be labeled as the cause of the other, it is clear they have a symbiotic relationship.

If outreach is initiated to alleviate some of the access problems discussed earlier, improvement is likely because of the strong interest in these issues. When there has been an ongoing relationship between handicapped organizations and a legal services program, invariably the special legal problems begin to be addressed.

There will, however, be a need for training and support. At present there is no basic source of information or training on most of the issues. Support is available on some of the issues but not on all. Thus, the following actions are appropriate:

If increased money is available in future years for national support, high priority will be placed on covering all issues of concern to the physically and mentally handicapped. The support capacity will include coverage of delivery issues. Among the methods of implementation to be explored are use of existing LSC centers and programs, use of non-LSC centers and separation (or integration) of physically and mentally disabled, and

LSC will create a manual on the major issues of concern to the physically and mentally handicapped. The manual will be followed by national training, strategy seminars and trainer training.

To encourage programs to address the special legal problems, there needs to be some focus from LSC nationally. Accordingly:

LSC will actively participate in the United Nations sponsored International Year for Disabled Persons in 1981 with appropriate activities.

IV. INSTITUTIONALIZED ELDERLY AND HANDICAPPED

A. Background

To define "institutionalized" the study uses the definition adopted by the Bureau of Census for an "Inmate of an Institution":

[A person] under care or custody in [an] institution . . . regardless of the number of people in that place.

The census goes on to create a list of institutions with appropriate definitions. The list includes: (1) Correctional institutions, (2) mental hospitals, (3) residential treatment centers, (4) tuberculosis hospitals, (5) homes for the aged and dependents, (6) homes and schools for the mentally handicapped, (7) homes and schools for the physically handicapped, (8) homes for neglected and dependent children, (9) homes for unwed mothers, (10) training schools for juvenile delinquents, and (11) detention homes for delinquent children.

This study is concerned primarily with persons who are institutionalized because they are elderly or handicapped. This specification includes persons in institutions labeled (2) through (7) and (9). While there may occasionally be some consideration of other institutionalized elderly or handicapped (for example, prisoners who are treated for mental illness), the primary focus is in these categories.

As with the noninstitutionalized elderly and handicapped, some concept of limited income or wealth must be applied to the institutionalized. However, the term "poverty," which is the normal reference point for eligibility, is inappropriate to the institutionalized because all or most of the necessities of life are supplied by the institution, often at no cost to the institutionalized person.

There is some national level income information available on the institutionalized. It shows that few institutionalized have any substantial income. For this reason, the study adopts the approach that income and/or wealth can be ignored for purposes of drawing conclusions about access difficulties, unmet special legal problems and policy recommendations. This is not a finding, however, that no means test should be imposed on the institutionalized for determining eligibility for legal services. It is instead a determination that such a small percentage of institutionalized persons would be ineligible under any means test imposed that they can be ignored for purposes of this study.

Based on figures from the 1976 Master Facilities Inventory compiled by HEW, there are 1,829,117 institutionalized elderly and handicapped persons in the country, excluding those who are in psychiatric, chronic disease or alcohol/drug treatment wards of general hospitals. Of these, the vast majority—1,320,141—are nursing or custodial care homes, including homes for the aged. The remainder are in mental hospitals, other facilities for the mentally ill, schools and residential facilities for the mentally retarded, tuberculosis and other chronic disease hospitals, alcohol and drug treatment facilities, schools and other facilities for the physically handicapped and homes for unwed mothers.

There are a number of significant trends in the institutionalized population. The first is a decline in population in the larger—usually public—institutions offset by substantial increases in the population of smaller—often private—facilities. Thus, the population in mental institutions was cut in half from 1970 to 1976. On the other hand, the population in nursing and community care homes rose approximately 340,000 persons over the same period.

The result of this trend is that a typical institution is a small community facility. The 1.8 million institutionalized persons are in 27,203 institutions with an average population of 67 persons per institution.

The second trend is a continuing increase in the overall size of the institutionalized population despite shifts in the type of institutions involved. Thus, the 1976 institutionalized population is 107,000 persons larger than that enumerated in the 1970 census.

LSC and its predecessors placed no particular emphasis on the institutionalized. In fact, as discussed below, the omission of the institutionalized from counts used for funding may be taken as a policy that programs funded by LSC have no responsibility to serve the institutionalized. Some programs have served the institutionalized or brought cases which affect them. Also legal services have sometimes been available through other sources. All but one State provide counsel to indigents when they seek to commit a person to a mental institution. Thirty-six States provide counsel to indigents they seek to commit to an institution for the mentally retarded. In both instances, the usual policy is to appoint private attorneys although a number of States use public defenders or other agencies and a small number use LSC programs.

The right to representation may extend beyond proceedings for commitment, to obtain release or periodic reviews of statutes. In a few States (for example, New York and New Jersey) the State created system may provide counsel for other problems.

Federal programs are responsible for some legal services for the institutionalized. The Developmentally Disabled Protection and Advocacy Systems provide

legal services for the institutionalized developmentally disabled in some States. HEW has started some mental health legal advocacy demonstrations, some of which serve the institutionalized. The AoA initiatives in nursing home ombudsmen services have resulted in limited legal services in some areas.

Also there have been private sector initiatives. The largest was the ABA Commission on the Mentally Disabled bar funding program which used foundation money for demonstration programs to provide legal services to the mentally disabled. Some of these projects served the institutionalized.

Finally, there are local programs established with a combination of resources. They are most likely to be present in large health institutions and rely on State and local funding.

While there are no definitive estimates of the extent to which the need is met by these various efforts, it seems clear that they barely scratch the surface. They are aimed almost exclusively at persons in the large institutions which increasingly house only a small share of the institutionalized population in any area. Except for the State provided commitment defense, it is unlikely special legal services exist for the institutionalized in any given area, even in the large public institutions.

B. Special Difficulties of Access

The major special access difficulty of the institutionalized is obvious—either because of the condition that resulted in institutionalization, the law or institutional rule, they cannot go to a service provider. Institutionalization also means the person is not likely to be informed of services. Institutionalized persons also may be unaware of legal rights and how to vindicate them.

As a practical matter, the only effective solution to this access problem is to bring services directly to the institutionalized person, including representation, publicity and legal education. While some institutionalized persons may be mobile and may in theory be able to go to the office of a service provider, this is too much to expect from all but a very small segment of the institutionalized population.

The extent to which LSC programs meet the barrier by bringing services directly to the institutionalized varies markedly by type of institution:

(1) *Institutions for the mentally ill.*—Roughly 30 percent of the LSC programs having one or more institutions for the mentally ill in their service area provide some services to the residents of the institution. A small percentage (under 5 percent) have established an office at the institution. About 20 percent conduct case intake at the institution. On average, this circuit riding intake occurs twice per month or less. About 10 percent to 15 percent of the programs reach the residents of the institutions with publicity or education activities (usually a pamphlet on legal rights).

(2) *Institutions for the mentally retarded.*—Less than 20 percent of the LSC programs having one or more institutions for the mentally retarded in their service area provide any services to residents of such institutions. Roughly one program in 100 has an office in the institution. About 6 percent of the programs conduct case intake at the institution. Less than 10 percent reach the residents of the institution with publicity or education activities.

(3) *Treatment centers for alcoholics or drug abusers.*—Service to residents of these institutions is very rare. Less than 10 percent of the LSC programs extend any service at such institutions. Less than 5 percent conduct case intake at the institution. Roughly 5 percent to 7 percent reach the residents with publicity or educational activities.

(4) *Nursing homes.*—A third of the LSC programs provide some services to residents of nursing homes in their area. About 20 percent conduct case intake at such institutions. However, this is primarily an "on call" service with sporadic, short duration trips to the facility. Essentially, these are "home visits" to persons who happen to reside in nursing homes.

About 20 percent of the programs reach the residents of nursing homes with publicity or legal education materials. Over half of these programs do not conduct case intake at the home.

(5) *Community care homes including homes for the aged.*—About a quarter of the programs having one or more facilities of this type in their service area extend some service to the residents. Roughly 20 percent conduct case intake at these homes. Again, the visits are sporadic and of short duration, like a "home visit" to persons that happen to be in community care homes. About 15 percent of the programs publicize services or conduct educational activities at these facilities.

The pattern of service (or nonservice) is clear. Irrespective of the type of institution, the likelihood is that a resident will have no access to services of the local LSC program. Those most likely to have some access are residents of mental institutions or nursing homes. Even with respect to these facilities, however, the number of programs engaging in systematic intake at the institution is minute.

The major reason for lack of service to the institutionalized is probably lack of funding for this population as discussed below. It is important to emphasize, however, that it is often the institution that refuses access to the legal services staff. This is particularly true of small, private facilities. Because it is otherwise difficult to reach these small, scattered facilities in an effective way, programs may not challenge refusal to give access.

Based on this finding, the following recommendation is made:

> To alleviate the physical barriers to access to legal services faced by institutionalized persons, LSC recommends that Congress enact legislation to ensure legal services staff have access to institutions in which eligible clients reside.

Inability to reach a service provider is not the only access barrier of the institutionalized. As elderly and/or handicapped persons, they have most of the access difficulties discussed earlier under the non-institutionalized elderly or handicapped. Some of these difficulties deserve special mention.

Often it's very difficult to communicate with the institutionalized mentally disabled, and often they lack the capacity to make informed decisions needed to employ counsel and pursue their rights. Not only does this make representation difficult, but it also may render publicity and legal education activities ineffective. Effective service requires extreme care and patience. Even with this care and patience, the lawyer's role is often unclear, requiring a kind of judgment that comes only with time and effort.

There are often surrogates between the lawyer and the client, such as when the client is mentally disabled, elderly or young. Typically, the surrogate is a relative, although non-relative guardians are common in some areas. The actions of the surrogate may be the legal problem and, because of the control given to the surrogate by law, the disabled person is prevented from contacting a legal services provider. Even if the disabled person and the surrogate do not have directly conflicting interests, the surrogate may oppose pursuit of particular rights or use of legal services.

The major reason for the existence of access barriers with respect to LSC programs appears to be the funding allocation policy of LSC. Because of this policy few programs offer access to the institutionalized. The other access barriers discussed above may be a serious problem where a legal services program does offer physical access to services. This is such a minority of cases, however, that these barriers are relatively unimportant *at this time.*

LSC's basic funding allocation formula—often called "minimum access"—awards grants to programs based on the number of poor persons in the program service area. As a matter of definition, no institutionalized person is "poor" and thus, the institutionalized are omitted from the Bureau of Census counts of poor persons that form the basis for LSC funding. By saying that institutionalized persons are not poor by definition, does not mean they can afford legal counsel. Available data indicate that over 95 percent of the institutionalized elderly and disabled lack sufficient income to afford private counsel.

The omission of institutionalized persons from the poverty population and therefore from the LSC funding base has two consequences. It means that all programs are less adequately funded than has been recognized previously. The addition of over 1.8 million elderly and handicapped persons to the pool of eligible persons is no small adjustment; furthermore, this figure doesn't account for all the institutionalized, e.g., prisoners.

The second consequence is an unequal capacity to serve institutionalized persons because they are not distributed in the same way as poor persons generally. Thus, the number of institutionalized elderly and handicapped in the service area of one program is equal to 64 percent of the poverty population. In another, the number is equal to .3 percent of the poverty population.

There are really two aspects of the distribution of institutionalized elderly and handicapped in comparison to the poverty population that contribute to unequal capacity. In LSC's New England region, the median program has in its

service area about 13 percent as many institutionalized elderly and handicapped as poor persons. In the Southern region (region VI), the median program has roughly 4 percent as many institutionalized elderly and handicapped in the service area as it has poor persons. Generally, there are many more institutionalized elderly and handicapped, in relation to the poverty population, in the northern tier of the states than in the southern states.

The second difference is intraregional and even intrastate. This is especially true in states or regions with programs covering a relatively small geographical area (e.g., one or two counties). For example, in the regions covering New York, New Jersey, and Pennsylvania, there are programs where the number of institutionalized elderly and handicapped is over 25 percent of the poverty population; in contrast there are also programs where it is under 5 percent.

Looking at both interregional and intraregional differences, the following picture emerges. The capacity of a program to serve the institutionalized depends on whether the program is in the northern part of the country or the southern part and then on more local factors like intrastate placement of institutions.

Given the unequal impact of the institutionalized on programs not funded to serve them, it is unrealistic to expect the programs, especially those having relatively high institutional populations, to serve the institutionalized without additional funding. Therefore:

> LSC will develop a plan to achieve full coverage for the institutionalized. Funds for partial implementation were sought in the 1981 budget request. LSC will seek additional funds in future budget requests until the plan is fully implemented.

If appropriation for the institutionalized is available, LSC will have to design a plan to determine appropriate grantees, nature of delivery system, populations covered, etc. While it is premature to determine the nature of the plan, it is important for LSC's involvement over the long term to be somewhat limited. While current resources available for legal services for the institutionalized don't begin to meet the need, they should not be supplanted by LSC funded programming. Further, the typical level of per capita funding for legal services for the institutionalized is quite high (based on average population). It is unrealistic to expect LSC to obtain and distribute the $100 million plus level of resources that would match the level of funding now common for institutional programs. Therefore:

> LSC will affirmatively seek out funds from Federal and other sources to increase the funding of programs (whether LSC funded or not) that provide representation to the institutionalized.

Besides taking into account both LSC and non-LSC funds, the plan should be tailored to LSC's ability to plan, develop, and monitor programs serving the institutionalized. The plan should be based on delivery methods that have proven effective as well as innovations and improvements in delivery that will develop with experience. The plan should provide service to all institutionalized populations and assure funding of a fair mix of different types of institutionalized persons. A clear preference should be given for delivery systems which involve joint participation by current LSC programs. Favor should also be given to projects that link together various segments of the institutionalized population, either because they share a common reason for institutionalization or because they have common legal problems.

While there is enough experience both with legal services delivery generally and with delivery of legal services to the institutionalized to ensure that efficient and effective delivery systems can be established for the institutionalized, it is appropriate with any new endeavor to invest some resources in creating a technical assistance capacity on delivery of services. This kind of assistance will help avoid some of the access problems that would hinder effective service. Therefore:

> LSC will seek to establish a sufficient capacity for technical assistance on substantive issues, delivery system assistance, and national and state support for the institutionalized. The development of this capacity will be dependent upon the amount of funds appropriated for the institutionalized and for other categories of LSC's budget.

Finally, it is unlikely in the small, community facilities in which the institutionalized overwhelmingly reside, legal services programs can give access to every resident in every institution. This is an access problem akin to that of migrant farmworkers in labor camps.

One solution to the difficulty of providing access to the small, scattered populations involved is to rely on other advocates who have greater access to residents. Accordingly:

> LSC will affirmatively seek to cooperate with other federal and state agencies involved in programs of advocacy or assistance to the institutionalized (such as the nursing home ombudsman program operated through AoA).

C. Unmet Special Legal Problems

Where there is almost no access to legal services for the vast majority of the institutionalized, it is almost hypothetical to talk about unmet special legal problems. All legal problems, special or otherwise, are generally unmet except in those instances like commitment defense where the state has assumed a specific responsibility to assure provision of service.

One can divide the special legal problems of the institutionalized into three categories as follows: (1) Those connected with the process of institutionalization or commitment; (2) those arising as a result of residency in the institution; and (3) those connected with release from the institution.

Special legal problems in the first category are probably addressed to the greatest degree partly because the eligible person is in the process of institutionalization and may have access to legal services. Thus, a lot of LSC programs handle cases connected with, for example, medicaid eligibility to enable a person to enter a nursing home.

The first category also includes cases where the state typically provides counsel. This does not, however, mean the legal problems are sufficiently addressed. In fact, the adequacy of representation of counsel in commitment hearings is under challenge in a number of states.

Problems in the second category are not addressed generally because of the lack of access. Some of them—for example, the adequacy of institutional conditions—are major and will not be resolved simply by creating access to legal services. The legal services provider must have sufficient expertise and resources to address large, systematic issues often through protracted litigation.

Problems in the last category are probably addressed the least because of lack of access and the nature of the problem. Despite a commonly expressed adherence to the principle of the least restrictive alternative, many persons remain in institutions when they should be in far less restrictive settings, often outside institutions altogether. Many others are released to improper or woefully inadequate placements. Turning a right to a proper placement into the reality requires not only access to legal services but also skillful and imaginative counsel who understands the various options and resources required. At this point, such legal services appear to be very rare.

It is important to emphasize that even if access to legal services is achieved for the institutionalized, effective services that directly address the important special legal problems of the institutionalized will not automatically appear. Development of expertise—both in the substantive problems and in relating to the client group—along with a great deal of imagination will be prerequisites to effectiveness.

Based on this finding:

> LSC will seek to establish sufficient capacity for national and state support for services to the institutionalized. The extent of the capacity will depend on the amount of funds appropriated for the institutionalized and other budget categories.

V. METHODOLOGY AND DATA USED IN THE STUDY

A. Methodology

This part of the study was also conducted by the Research Institute of LSC. The process of issue development utilized earlier to study the five section 1007(h) groups was identical for this study of the elderly and handicapped.

The information collected and analyzed in the course of the study came from eight main sources:

(a) The existing literature bearing on legal services for or legal problems of eligible elderly or handicapped persons.

(b) Legal Services Corporation records, primarily grant applications.

(c) Questionnaires to a sample of LSC funded field programs.

(d) Questionnaires to area aging agencies, organizations and groups of elderly persons, and groups and organizations concerned with the interests of handicapped persons (usually a segment of the handicapped, such as the blind).

(e) Information collected by LSC's delivery systems study on cases handled by a sample of staff programs.

(f) Interviews conducted in 16 areas of the country. Included among interviewees in most areas staff delivering legal services to the elderly and/or handicapped (whether or not in LSC-funded programs); management and supervisory staff of the LSC-funded program in the area; area aging agency staff; persons delivering services to the elderly and/or handicapped; advocates of the elderly and/or handicapped; and others knowledgeable about the access difficulties or special legal problems of the elderly or handicapped.

(g) Enumerations and other demographic information primarily from the 1970 census, Current Population Surveys (conducted by the Bureau of the Census), the Survey of Income and Education (also conducted by the Bureau of the Census) and the Master Facilities Inventory (gathered by HEW).

(h) Interviews with knowledgeable and interested persons with a national perspective. Most of the persons interviewed in this category are in Washington, D.C.

As with the other groups, the basic methodology is to draw on all these information sources to the extent possible, and to specify the important special legal problems and determine the degree to which they are now being addressed. The interviews and questionnaires were also used to obtain informed opinions on the appropriateness of possible actions by LSC.

It is important at the outset to recognize limitations inherent in the methodology. There is enormous variation around the country with respect to any issue addressed in the study. The multiplicity of information sources, and the information from the site visits particularly, are invaluable to show national trends and the range of variation. Indeed, without information from many areas and many people, national conclusions would be wholly inappropriate. On the other hand, there is no precise scientific method at work here. Further, the variation and diversity is so substantial that any conclusions that attempt to describe a phenomenon as national are wrong in many places. In fact, as will be seen, the promise of multiple information sources appears illusory when the information from different sources disagrees dramatically on a particular issue.

F. Data and Information Used in the Study

Technical questions of data reliability and accuracy will be discussed in an appendix to the report. Included are approximations of sampling error for the LSC program information obtained by survey by the Research Institute; for the case and client type information obtained by the delivery systems study; a display of response rates for the various questionnaires, sampling error for these questionnaires to the extent applicable, and conclusions about reliability based on these factors; and a discussion of strengths and weaknesses of the demographic information used in the study.

Some aspects of the information base of the study necessitate some textual discussion or elaboration. They are discussed in the following subsections.

(1) *The site visits.*—The report relies heavily on information gathered during the site visits. The site visits had a definite purpose in the study. The areas visited were chosen because there was some special activity within the LSC-funded legal services program, or another program, for the elderly and/or handicapped. As a result, neither the areas nor the programs within them should be viewed as typical of the country or legal services as a whole. In fact, it is not clear the areas are typical of places where special legal services attempts to help the elderly and/or handicapped have occurred.

What these areas and programs show primarily is the effectiveness of various methods to deal with access difficulties and special legal problems as viewed from a number of perspectives. Because sixteen areas were visited, most methods were observed more than once and under different circumstances.

The site visit interviews also gave the Research Institute the opportunity to explore many persons' attitudes and perceptions with respect to the interview questions without the limitations of a written survey instrument. Those attitudes and perceptions were gathered by over a dozen different people, most of whom visited more than one area. The interviewers generally were persons who

are knowledgeable about legal services for the elderly and/or handicapped and their own perspectives were combined with that of the persons they interviewed to give the study additional information.

Finally, while the areas were chosen because of some special activity for the elderly and/or handicapped, there were always gaps which permitted the interviewers to observe the situation without special activity. For example, in some areas there were special units for the elderly but none for the handicapped. In others, there were special units for the mentally handicapped but none for the physically disabled. While it is not necessarily intended, the interviews showed as much about access and special legal problems where no targeted legal services activity was occurring as they did where there was special activity.

While the interviewers had two written instruments (one for the elderly, the other for the handicapped), they were used only as guidance. Ultimately however, the written instruments were used to record a composite of the information obtained during the interview. These instruments show varying points of emphasis and degrees of completeness depending primarily on the interviewees. In some areas, the interviews were slanted toward legal services providers and agencies funding legal services (e.g., area aging agencies, developmental disabilities councils). In other areas, the interviews were primarily with clients, client groups, advocacy organizations and the like. The differences were determined primarily by the availability of interviewees, the number of potential interviewees within a category, the time available for interviewing, etc.

(2) *Use of surrogates.*—Under ideal circumstances, one would want to determine the needs of persons eligible for legal services assistance by direct questioning. In a national study of this type one can rarely produce this ideal: there is a constant use of surrogates—that is, persons who to some degree, speak for eligible persons within the surveyed group. There are actually two types of surrogates used in this section of the study: (a) Those who are surrogates for individuals in the handling of legal problems—e.g., parents and guardians; (b) those who, because of their position, are expected to speak for the interests of eligible persons generally but are not usually individual intermediaries.

During this phase of the study, information was often obtained from persons who are surrogates in both senses. In many cases an information source is both acting as a surrogate and speaking from an independent perspective. Whenever information was obtained through surrogates—whether by personal interview or written questionnaire—the interviewers evaluated the interests of the surrogate and viewed the information received in light of this evaluation.

(3) *Absence of comparative information on poor persons not studied.*—Probably the most important point that can be made about the data is that it is limited solely to the groups under study. This means it is impossible to say anything that compares the situation with respect to the elderly and/or handicapped with the situation with respect to other poor persons.

It is indeniably difficult to keep this point in mind and to adhere to its meaning. It 50 percent of questionnaire respondents say, hypothetically, that elderly persons have insufficient access to legal services, one wants to read into this statistic not only that there is a serious access problem for the elderly in need of correction but also that the problem must be more serious than for other poor people. One only has to review the answers given to that question by other groups to see that the latter conclusion is probably wrong, at least in relation to some poor persons. Even the former conclusion—at least in the use of the label "serious"—is also wrong or simplistic if it conveys any sense of relative urgency about the problem.

To a certain extent, the lack of comparative information and the resulting limitation on the use of data about the elderly and handicapped reduces the need for data precision. Conclusions are based largely on relationships in the data rather than absolute values. Thus, the extent to which the elderly may judge access to a program as sufficient is less important that the reason for that judgment. Reasons that recur are treated as significant even if others recur more frequently.

VI. ACTIONS AND RECOMMENDATIONS

The policy decisions and implementation steps below were discussed within the body of this summary text for each group studied. This section lists the recommendations made and the actions planned to fulfill the findings of the study. Following each recommendation the LSC division with principal responsibility for its implementation is indicated in parentheses.

A. Noninstitutionalized Handicapped

Specific actions

(1) LSC will clarify the auxiliary aids requirement contained in its section 504 regulations to provide more specificity for the guidance of recipients (General Counsel).

(2) LSC will develop and disseminate a technical assistance manual on section 504 compliance by June 1, 1980 (Equal Opportunity Office and General Counsel).

(3) Following the development of the technical assistance manual, LSC will train one staff person in each regional office to disseminate information to programs to encourage local compliance with section 504 and provide technical assistance on request (Office of Field Services).

(4) As currently planned, the monitoring process will cover compliance with section 504. One person who is part of the monitoring process should be sufficiently familiar with section 504 requirements to determine program compliance (Office of Field Services).

(5) LSC will make its Washington facilities and activities fully accessible to the handicapped including the purchase of a TTY machine and the dissemination of information in such a way as to reach those with sight or hearing disabilities. Each of the regional facilities and activities will be evaluated on their accessibility to and effect on handicapped persons. To the extent necessary, regional facilities and activities will be made accessible (Office of Administration).

(6) If increased money is available in future years for national support, high priority will be placed on covering all issues of concern to the physically and mentally handicapped. The support capacity will include coverage of delivery issues. Among the methods of implementation to be explored are use of existing LSC centers and programs, use of non-LSC centers and separation (or integration) of physically and mentally disabled (Research Institute).

(7) LSC will create a manual on the major issues of concern to the physically and mentally handicapped. The manual will be followed by national training, strategy seminars and trainer training (Office of Program Support).

(8) In order to encourage programs to engage in outreach to handicapped advocacy groups, to provide education, publicity, and attendance at meetings, and to increase representation, the regional office person trained on section 504 compliance will also be knowledgeable about service delivery structures and policies that are effective and responsive in serving the handicapped and will be prepared to provide technical assistance in this area (Office of Field Services).

(9) LSC will actively participate in the United Nations sponsored International Year of Disabled Persons in 1981 with appropriate activities (Executive Office).

General policy questions

(1) In evaluating improvements and changes in the monitoring process, LSC will consider a process to increase efforts in obtaining the views of clients, advocates and other community people who are not part of the program staff (Office of Field Services).

(2) In evaluating improvements and changes in the monitoring process, LSC will consider more detailed examination of activities covered in whole or in part by non-LSC funds and involving persons who are knowledgeable about such activities (Office of Field Services).

(3) LSC will reevaluate the priority setting process it currently requires and/or recommends in light of the findings of this study (Office of Field Services).

(4) LSC will evaluate the feasibility and propriety of developing recommendations on delivery systems to meet the needs of special groups and on methods to accommodate the needs of special groups in the development and implementation of LSC policy (Executive Office).

B. Noninstitutionalized Elderly

(1) As part of a general effort to define the civil rights responsibilities of programs, LSC will enact a regulation to enforce the Age Discrimination Act (General Counsel).

(2) LSC will inform all programs of their obligations under the Age Discrimination Act and the Age Discrimination in Employment Act (General Counsel).

(3) The current process within the Office of Field Services to redesign LSC policies on program priorities and planning will seek to simplify the recom-

mended process and emphasize results, not procedure (Office of Field Services).

(4) LSC will work with the Administration on Aging to help develop an effective legal services network and to encourage local area aging agencies to support aggressive, quality legal services for the elderly (Office of Field Services).

(5) LSC will seek to establish with the Administration on Aging a national support structure that will assure that LSC grantees receiving AoA funds, as well as other AoA grantees providing legal services, have access to effective training, technical assistance, cocounseling, coordination and communication on issues affecting the elderly. LSC will attempt to gain AoA assistance in funding a national support structure that will provide advocacy (including legislative and administrative representation) on a national level on elderly issues (Research Institute).

(6) LSC will continue, consistent with its process for the allocation of funds, to provide funds to existing support centers to assure that adequate support and advocacy are undertaken on age-targeted issues, such as age discrimination, pensions, medicare, long-term care (Research Institute).

(7) To the extent funding is available for substantive training and the development of manuals, LSC will develop manuals and training on the special legal problems of the elderly (including, particularly, issues not covered in previous training). The training will be open and the manuals available to those in special elderly units as well as to generalist staff within local programs (Office of Program Support).

C. Institutionalized Elderly and Handicapped

(1) LSC will develop a plan to achieve full coverage for the institutionalized. Funds for partial implementation were sought in the 1981 budget request. LSC will seek additional funds in future budget requests until the plan is fully implemented (Executive Office and Office of Field Services).

(2) LSC will seek to establish a sufficient capacity for technical assistance on substantive issues, delivery system assistance and for national and state support for the institutionalized. The development of this capacity will be dependent upon the amount of funds appropriated for the institutionalized and for other categories of LSC's budget (Office of Field Services and Research Institute).

(3) LSC will affirmatively seek funds from federal and other sources to increase the funding of programs (whether LSC funded or not) that provide representation to the institutionalized (Office of Government Relations).

(4) LSC will affirmatively seek to cooperate with other Federal (and State) agencies involved in programs of advocacy or assistance to the institutionalized (such as the nursing home ombudsman program operated through the Administration on Aging) (Office of Government Relations).

(5) To alleviate the physical barriers of access to legal services faced by institutionalized persons, LSC recommends that Congress enact legislation to ensure legal services staff have access to institutions in which eligible clients reside.

ITEM 24. NATIONAL ACADEMY OF SCIENCES

DECEMBER 15, 1980.

DEAR MR. CHAIRMAN: Thank you for again inviting the National Academy of Sciences to contribute to part 2 of your report, "Developments in Aging," 1980 edition. As has been indicated in earlier responses, the National Academy is not a Federal agency, rather it is a nonprofit, private organization operating under a charter issued by the Congress in 1863 to provide advice to the Federal Government on matters of science and related technology. Nevertheless, we have felt that it would be useful to report on our advisory programs to the Federal Government that relate to aging.

In response to a similar request in December 1978 and 1979, information was provided concerning the establishment of a Committee on Aging within the National Research Council's Assembly of Social and Behavioral Sciences. Current Academy programs that relate to aging include the study entitled "Mammalian Models for Research" and the program presented at the Food and Nutrition Board annual meeting on December 8, 1980, as described by Dr. Councilman Morgan of the Assembly of Life Sciences in his letter to you of November 20,

1980. The program included a symposium on nutrition and the aging covering an overview of the aging process, cellular mechanisms in aging, and dietary factors affecting the aging process together with a panel discussion on nutrition programs for the aging. Panelists participating were from the White House Conference on Aging, the U.S. Department of State, the National Association of Retired Persons, George Washington University, the Gerontology Research Center, Tufts University, and the National Institute on Aging.

The Assembly of Behavioral and Social Sciences has completed a three-volume report on the workshops referenced in our letter of December 31, 1979. These volumes are now in press and will be published by Academic Press in mid-1981. The Assembly has plans to pursue its work in support of Federal programs related to aging and is negotiating arrangements with the National Institute of Aging for continuation of the Committee's work. In addition continuing committee efforts to strengthen the contributions of the behavioral and social sciences to the study of aging, the formation of four panels is proposed to consider topics such as: Aging and formal organizations, gentics and aging behavior, the aging brain and behavior, methods of analysis of longitudinal and cohort studies, and close relationships in the family.

In response to a request from the National Institute on Aging, a study is underway in the Institute of Medicine on the scientific evidence relevant to mandatory age retirement for airline pilots. Through a committee with expertise in the fields of aviation medicine, the study will outline the nature of the problem, develop criteria for evaluating scientific information relating to pilot performance, review the significance of existing studies, and indicate research that might provide more precision in future evaluations of medical and psychophysiological factors affecting performance. The committee will consider the medically and behaviorally important characteristics and factors relevant to airline pilot performance with specific attention to the relationship of the incidence of those factors to the aging process. A final report is scheduled to be submitted to the National Institute on Aging by March 1981.

The above are the three areas in which the National Academy of Sciences is currently engaged in work relating either directly or indirectly to the problems of the aged or aging. Please do not hesitate to let us know if we can be of any further assistance to the Special Committee on Aging.

Sincerely yours,

PAUL L. SITTON, *Executive Officer.*

ITEM 25. NATIONAL ENDOWMENT FOR THE ARTS

JANUARY 27, 1981.

DEAR MR. CHAIRMAN: It is my pleasure to have the opportunity to share the Arts Endowment's efforts for our older population with the Special Committee on Aging. Enclosed is a summary of the Endowment activities specifically related to older Americans.

Recent congressional hearings on "The Arts and the Older American" found the Endowment's efforts to be substantial for our older constituency. Further, the very effective testimony given by Mrs. Mondale, our National Council members, Endowment staff, and grantees concerning the many benefits of professional arts programs prompted committee chairman, Congressman Mario Biaggi, to state that he "will seek to expand the definition of social services under the Older Americans Act to include arts and cultural services to permit senior centers to provide these services." Such an action and such leadership would be a landmark, greatly increasing the number of quality arts programs for our senior population.

In my testimony to the Subcommittee on Human Services of the House Select Committee on Aging last February, I said that "we strongly believe that the arts should be viewed in much larger context—as employment and volunteer opportunities for older people; as new learning experiences; as potential second and third career options; and as elements essential to the general physical and mental well-being of older citizens. But, above all, we should emphasize how the arts serve to enrich lives and how their benefits serve to open new horizons for all who participate."

The Endowment continues to increase its funds for programs that involve older adults. A total of 124 grants in the amount of $2,124,159 were awarded to arts organizations in fiscal year 1980, and I have included examples of these Endowment-sponsored activities that specifically include older Americans as participants and audiences.

This report also includes information on the cooperative agreement that we developed with the Administration on Aging, the National Endowment for the Humanities, and the White House Conference on Aging. The centerpiece of the agreement is a symposium on the Arts, the Humanities and Older Americans that will be held in Philadelphia on January 31 through February 3, 1981. We view this proposed agreement not only as a unique opportunity to sponsor a symposium which will have nationwide impact, long-lasting results and benefit all concerned, but as the beginning of a partnership among our respective Federal agencies, which will hopefully produce a catalytic response, resulting in cooperative efforts at the regional, State, and community levels. Also attached is a copy of my letter to the executive directors of our 50 State arts agencies and the regional arts organizations.

As you may know, the Endowment was the third Federal agency to publish proposed regulations in the Federal Register which prohibit discrimination by Endowment grantees on the basis of age. These regulations will serve to reinforce our continued efforts to assure that older Americans have as many opportunities in the arts as everyone else.

Be assured that the National Council on the Arts and the Endowment will continue to advocate and support quality arts programming for this very important segment of our society.

We very much appreciate the committee's interest in the National Endowment for the Arts. If we may provide further assistance or information in this matter or in any other regard, please do not hesitate to advise me.

Most sincerely,

LIVINGSTON BIDDLE, Jr., *Chairman.*

Enclosures.

SUMMARY OF ACTIVITIES RELATING TO OLDER AMERICANS, FISCAL YEAR 1980

The Endowment is actively engaged in an effort to make the arts more accessible in the firm belief that the arts can be catalysts in bringing people of all ages closer together, and that this contact between generations contributes to the revitalization of community life. The Endowment encourages State and community arts agencies and arts organizations to seek older people's participation in their programs and services. We understand the value of including older persons as audiences, students, teachers, supporters, volunteers, staff, and creators.

The purpose of the Endowment, as declared in the National Council's statement on goals and basic policy, is to foster "professional excellence of the arts in America * * * and equally to help create a climate in which they may flourish so that they may be experienced and enjoyed by the widest possible public."

The Endowment endeavors to support only works of the highest quality, and we encourage all of our grantees to make their programs accessible to the broadest spectrum of the American population in the firm belief that the arts enrich the lives of all individuals, regardless of age.

Older Americans are currently participating in many programs around the country in which they are instructed by professional artists, such as visual arts, theater, music, dance, creative writing, and crafts. The National Endowment for the Arts and State arts agencies are the primary sources of funding for these projects.

The position of Coordinator of the Office for Special Constituencies was established by the National Council on the Arts in 1976. The Coordinator and her staff work with the Endowment programs, Endowment grantees, State/community arts organizations and other Federal agencies to educate and advocate quality arts programing for older adults, handicapped, gifted and talented, and institutionalized populations. The efforts of this Office include: (1) Providing technical assistance to individuals and organizations needing information and assistance in developing arts programs; (2) initiating cooperative projects with other Federal agencies which serve to educate administrators and professionals serving special constituencies concerning the value and benefits of arts programing for

special constituencies; (3) advocating more support for addressing the needs of special constituencies through the Endowment programs, and through State and national conferences, seminars, et cetera, that are concerned with the arts or special constituencies; (4) providing technical assistance to Endowment grantees regarding compliance with Federal regulations concerning special constituencies, including nondiscrimination of older adults, as well as, program accessibility for special constituencies; and (5) providing support for model projects which demonstrate innovative ways to make programs available to special constituencies.

THE ARTS AND THE OLDER AMERICAN HEARINGS

Recent congressional hearings by the Human Services Subcommittee of the House's Select Committee on Aging in February 1980, focused on "The Arts and the Older American." Mrs. Joan Mondale, members of our National Council on the Arts, Endowment staff and grantees gave testimony concerning the value of quality arts programing for older people and contributions of older artists: Witness after witness described how arts programing provides elements essential to the mental, physical, and spiritual well-being of older people. Their testimony led the committee to recommend that arts and cultural services be included in the funding provisions of the Older Americans Act. This action would be a landmark, making it possible for State and local aging agencies to develop more professional arts programs in nursing homes, senior centers, and at nutrition sites. As stated in my testimony to the committee, the arts have a central value:

"All arguments in favor of accessible arts programing and services are as applicable to older Americans as they are to any other age group * * * Older Americans' participation in cultural activities is not an answer to all aging problems, but the arts do heighten self-esteem, stimulate self-growth, and offer exciting opportunities for self-expression * * *. We feel that meaningful creative and cultural experiences should be considered an integral part of the services available to older citizens, and we think this is an issue that the committee and Congress might review."

Attached are copies of the hearing record and the Cultural Post article on the hearing for your information.

The Endowment has continued to support the National Council on Aging's Center on the Arts and Aging for the past 6 years. The Center's Director continues to work effectively with arts and aging organizations to create a national awareness on the importance of including quality arts programs as an integral part of activities supported by State and local aging agencies.

During the past 4 years, over 6,000 artists and aging professionals have participated in this advocacy effort to build partnerships between the two fields. Additionally, the Center's technical assistance efforts have reached all 30 States and territories.

As a direct result of the Director's work, several major aging organizations have established an arts component in the form of a subcommittee or program section: Included are the Gerontological Society, the Western Gerontological Society, and the American Association of Retired Persons.

The primary focus of the Center is not only to involve more older Americans in cultural activities, but to open up new career opportunities for artists in the burgeoning field of aging.

THE ARTS, THE HUMANITIES AND OLDER AMERICANS SYMPOSIUM

There will be approximately 24 million Americans over 65 years of age when the White House Conference on Aging convenes in December 1981. At the previous White House Conference on Aging in 1971, arts and issues of life enrichment were subsumed by other concerns such as housing and health. To assure that cultural activities are on the 1981 agenda, our Office for Special Constituencies developed an interagency agreement with the National Endowment for the Humanities, the Administration on Aging, and the White House Conference on Aging, which I signed, together with the heads of the respective agencies, on September 16, 1980. In essence, the four agencies will plan and implement cooperative arts and humanities programing efforts for older people, including a policy symposium to be held January 31 through February 3, 1981. To be convened by the National Council on Aging's Arts and Humanities Centers, the symposium will focus on the need, demand, and character of arts and humanities programs for

our older population. This working conference will bring together experts on the arts, humanities, and aging to: (1) Build a foundation and framework for a mutually supportive working relationship among the fields of the arts, the humanities and the aging; (2) develop policy recommendations for consideration at the 1981 White House Conference on Aging; and (3) propose an agenda for the 1980's in the fields of the arts, the humanities, and aging through the publication of a symposium volume after the White House Conference on Aging.

The conference intends to have results of both a short-term and long-range nature: (1) So that the results of the conference can be fed quickly into the White House Conference on Aging process, a concise report (perhaps 25–30 pages) will be published and distributed at the White House Conference on Aging State and regional meetings. This document will become part of the 1981 White House Conference on Aging working papers and included in the final White House Conference on Aging report; (2) a symposium volume, gathering the more complete papers and proceedings of the conference, will be published late in 1981. Although this volume may not be available in time to influence the White House Conference on Aging deliberations directly, it is intended to be a milestone marking the development of the arts, humanities, and aging and also a touchstone suggesting future directions, stimulating new activity, and identifying important researchable topics. I will be sure that you receive copies of the report and symposium volume.

The most long-lasting result of the symposium and its products, particularly the symposium volume, should be to inform and energize the broad spectrum of artists, humanists, and leaders in aging about the importance, value, and ways to bring the arts and the humanities to older people and vice versa. Certainly, we see the symposium and its products as a blueprint for life enrichment in the 1980's.

In order to complement the policy symposium and assure quality arts and humanities programing for the White House Conference on Aging, the Endowment is also supporting an arts and humanities specialist, who is housed at the White House Conference on Aging Office, to coordinate all arts and humanities activities through the life of the December 1981 conference. Attached is a copy of the interagency agreement for your information.

THE NATIONAL ENDOWMENT FOR THE ARTS' AGE DISCRIMINATION REGULATION

In accordance with the Department of Health, Education, and Welfare general regulations, 44 Fed. Reg. 33768 (1979), the National Endowment for the Arts issued proposed regulations under the Age Discrimination Act of 1975, 42 U.S.C. 6101, et seq. The regulations prohibit discrimination on the basis of age in programs or activities receiving Endowment financial assistance. The proposed regulations were published in the Federal Register, October 2, 1979, 44 Fed. Reg. 56725 (1979). Public comments were invited through December 15, 1979. Following the comment period, the proposed regulations were drafted in final form and submitted to the Secretary of HEW for review (this responsibility since has been assumed by the Secretary of the Department of Health and Human Services, HHS). The final regulations currently remain under review by HHS and are expected to be issued in final form pending resolution of certain issues by HHS and the Office of Management and Budget. As stated in my previous report, the Endowment was the third Federal agency to publish proposed regulations in the Federal Register.

ENDOWMENT FUNDING

The Endowment awards grants to arts organizations and individuals through 14 programs such as Expansion Arts, Inter-Arts, Design Arts, Folk Arts and Literature. Each program provides grants in several funding categories, devised to address current and anticipated needs in the field, as well as the goals of the agency as a whole. These categories and their application guidelines are constantly monitored and revised.

Nearly 20,400 grant applications arrived at the Endowment during fiscal year 1980, and more than 87 grant panels reviewed them. Panels in the various programs meet throughout the year and make recommendations on grant applications in an attempt to meet seasonal needs of the field and to distribute the application workload.

The panels serve the individual programs of the Endowment much as the National Council serves the Endowment as a whole. Together the Council and panels provide a system of professional peer review to evaluate applications,

identify problems, and develop the policies and programs through which the Endowment responds to changing conditions. Approximately 15 percent of the panel members are 55 years of age and older.

I am happy to report the Endowment has made progress through expanded advocacy and improvements in funding for activities involving older people. It is difficult to estimate the number of Endowment-supported programs that serve older adults, since people of all ages benefit from Endowment grants awarded to a multitude of museums, theaters, performing arts groups, media, and other arts organizations. The Endowment, for example, supports touring groups, particularly in the area of dance and theater, which bring the performing arts to people in smaller communities who otherwise might not travel to a large city to attend cultural programs. In the area of dance, the Endowment provided support to 71 professional dance companies for short residencies in 53 States and territories during fiscal year 1980.

However, many Endowment grants provide arts activities that specifically include older persons as participants and audiences. A total of 124 of these grants in the amount of $2,124,159 were awarded to arts organizations in fiscal year 1980. All of these activities address arts programing for older adults and examples are included in this report.

In addition, hundreds of arts programs for older people at the State and local level are supported through our State arts agency network. We are also seeing a burgeoning interest in arts programing for older citizens on the part of over 2,000 public and private community arts councils throughout the country.

PROGRAM ACCESSIBILITY

Access to cultural opportunities is often denied older adults because of financial, architectural, and logistical barriers. We believe that the Endowment's 504 regulations, which mandate the nondiscrimination of people with handicaps, and our related advocacy and technical assistance work will benefit those older adults with physical limitations by making arts programs more accessible.

The Endowment's design arts program supports architectural research projects, some of which are designed to improve the quality of living for older Americans. One example of a design arts project of this type, is being conducted by Joseph Konecelick from Worthing, Ohio, who is currently researching and writing a book entitled "Aging and the Product Environment" which will allow designers to apply specific criteria to a wide variety of mass produced products for older Americans.

Another example of architectural research under the design arts program is being carried out by Kim Yamasaki from Yoncell, Oreg., who will study the art of design for housing older adults, producing guidelines with drawings and sketches for designers and private groups concerned with the needs of older people.

On each front, the Endowment has sought to remove these barriers through its grant programs.

Specifically, the Office for Special Constituencies supports model projects through the Endowment programs. These projects are intended to develop, implement, evaluate, and document ways of integrating special constituencies into arts activities, both as audiences and participants.

In fiscal year 1980, a total of $300,000 provided 27 model projects through six of the Endowment program areas. Examples of model projects include the Pinellas Arts Council and the Utah Museum of Fine Art.

The Pinellas Arts Council in Clearwater, Fla., provides a technical assistance program offering consultant services to five areas of the State interested in developing a "Revitalize Arts Program" for older people. The program involves artists who travel to nutrition sites and senior centers to offer visual, performing, and literary arts programing to the older population. A 1-day workshop will be held in each area to design county cooperative programs in the arts and aging field.

The Utah Museum of Fine Art/Department of Educational Services in Salt Lake City, are making visual arts more accessible to residents of retirement complexes. The museum will provide exhibits and introductory tours. Interested older adults are encouraged to participate in self-guided research and are trained to act as tour guides for other visitors.

Economic factors are another obstacle to older people's participation in cultural activities. The cost of tickets and transportation may prevent people on

fixed incomes from attending performances. Endowment programs continue to support organizations that provide ticket subsidies, schedule programs in places where transportation is not a problem, and offer free or low-cost programs. Examples of these projects include the New Stage in Jackson, Miss., which is funded through our expansion arts program. This program provides low-cost theater tickets and free transportation for 3,000 older people with low incomes, in addition to conducting interpretive discussions for each performance.

Since lack of detailed information on cultural opportunities may further limit the involvement of older people, the Endowment funds many audience development projects. One example is the Brooklyn Institute of Arts and Sciences, which provides a wide-ranging program for the older adult community that includes: (1) An introduction to the museum; (2) workshops on how the museum relates to its community; (3) a seminar on the relationship of the museum's collections to the participants' cultural heritage; (4) an examination of Brooklyn's environmental arts and sculpture; and (5) a Brooklyn Heritage Day that highlights aspects of Brooklyn's cultural diversity.

The following are more examples of projects aimed at providing arts programing for senior citizens. The projects are listed under the Endowment program from which they received their funding.

EXPANSION ARTS

Articulture, Inc., of Cambridge, Mass., offers "Arts for Life," a free performing arts series for senior citizens in housing facilities, nursing homes, hospitals, and in community sites.

Greater Falls River Recreation Commission, Inc., in Fall River, Mass., will continue their comprehensive summer "Street Theater" program of workshops and rehearsals which culminate in a dozen free performances in neighborhood and senior citizen facilities.

Jersey City Cultural Arts Commission in New Jersey sponsored "Summer Festival '80" which included ("Caravans," thrice-weekly performances at senior centers, medical centers and institutional residences throughout the city.

Lettumplay, Inc., of Washington, D.C., produces a series of free community concerts featuring jazz artists and workshops in music in senior citizen centers, hospitals, nursing homes, and prisons.

Piedmont Citizens for Action, Inc. in Worchester, Mass., supports an annual celebration of the arts and culture of Worchester's neighborhoods. Free workshops and concerts are offered in nursing homes and nutrition sites, as well as the annual Elder Extravaganza, a cabaret style celebration for senior citizens in the downtown shopping area.

Quincy Society of Fine Arts in Illinois offers art classes, workshops, and performances benefiting the black and senior populations. Three week-long residencies will occur in senior nursing homes.

Theater Research, Inc./South Street Theater in New York, will produce two one act operas of Victor Herbert, J. P. Sousa, and Pergolesi, and a total of 16 free performances for older citizens and family groups.

FOLK ARTS

Phelps Stokes Fund in New York, will support a series of performances in prisons and senior centers by Afro-Cuban master traditional musician, Julito Collazo and his ensemble. An explanation of cultural traditions and the instruments is included in these performances.

INTER-ARTS

National Council on Aging in Washington, D.C., the Council's Center on Arts and Aging provides information and consultation as well as technical assistance to organizations involved in delivering arts programs and services to older persons.

Hospital Audiences in New York responds to the cultural needs of institutionalized people. It offers several different programs which include bringing art workshops and performances into older people's homes and providing a ticket distribution system for older adults. It also provides technical assistance on programmatic compliance on 504 regulations, and disseminates information on how to evaluate arts programs using Hospital Audience's research on the effect of arts workshops for the frail elderly in nursing homes.

LITERATURE

The artist project of the Cultural Council Foundation in New York supports "Poetry Mobile," in which writers give two readings of poetry per day and onsite workshops in city parks, community centers, hospitals, and senior citizen centers.

MEDIA

The neighborhood film project in Philadelphia, Pa., is providing quality film programing at low admission prices and developing regional audiences by special outreach to senior citizens, community groups, and ethnic minorities.

MUSIC

Arts Alaska, Inc., from Anchorage, Alaska, is touring their chamber ensemble in homes for the aged and the institutionalized in rural Alaskan communities.

Canton Symphony Orchestra Association includes a senior citizen's concert as part of their outreach program.

Des Moines Symphony Association is actively working to increase the number of Sunday matinee subscribers among older people by selling tickets at a reduced price and utilizing 15 buses per concert to bring the older adults to their new civic center.

Eastern Music Festival of Greensboro, N.C., brings Project LISTEN, a weekly series of chamber music concerts, to elderly and handicapped individuals.

El Paso Symphony in Texas is providing general admission seating at the lowest possible cost to senior citizens and military personnel, attempting to develop this audience, as well as that of the Mexican population.

Florida Philharmonic, Inc., of Miami, Fla., holds concerts for their older constituency, and they provide transportation and low cost tickets.

Fort Wayne Philharmonic Orchestra, Inc., in Fort Wayne, Ind., has a core group of 18 musicians which make up four ensembles to perform in schools, senior citizen centers, hospitals, and other locations throughout northern Indiana.

Glendale Symphony Orchestra Association in Glendale, Calif., is opening up dress rehearsals for physically handicapped people and senior citizens, with transportation and other costs provided.

Jacksonville Symphony Association in Florida has expanded its outreach program to include areas such as nutrition sites, nursing and retirement homes, hospitals and public libraries.

Knoxville Symphony Society of Knoxville, Tenn., is touring their young peoples concert program and the KSO Quartet to senior citizen residential facilities.

Monterey Symphony Association of Carmel, Calif., is inviting senior citizens and handicapped students confined to wheelchairs, who are members of the Hartnell College program, to attend concerts as guests of the symphony.

New Muse Community Museum of New York has organized the New Muse jazz heritage program providing instructional workshops, a senior citizens' jazz concert series and a musicians forum.

New York Kammer Musicer in New York City is participating in a 30-day residency in Monmouth County, N.J., which includes free performances in senior centers.

Santa Barbara Symphony Orchestra Association of California has organized a Sunday matinee series for families, students, senior residents, and handicapped individuals. An added capacity of 1,000 seats at the Arlington Theater has made it possible for them to increase courtesy tickets for financially deprived students and special constituents who might otherwise be unable to afford ticket prices.

Sea Cliff Chamber Players from Sea Cliff, N.Y., are developing outreach programs for inner-city audiences and are hiring older people as musicians for works needing players outside of the regular ensemble.

Shreveport Symphony Society of Louisiana presents a matinee series of three concerts for senior community centers in Shreveport.

Strings for Schools, Inc., in Villanova, Pa., is expanding its string chamber program informal concerts and workshops to reach elementary and secondary schools and institutions for elderly and handicapped individuals.

Toledo Symphony Orchestra in Ohio is supporting concerts and educational programs in nursing homes, senior centers, and mental health centers.

OPERA-MUSICAL THEATER

Lyric Opera of Chicago, Ill., supports a String Festival which includes the production of a chamber opera and a specially prepared presentation for older and handicapped people.

Natural Heritage Trust/Artpark in Lewiston, N.Y., has expanded the number of this season's performances to 51, including a number of weekly matinees for senior citizens and youth groups.

Opera Company of Philadelphia in Pa., is broadening its scope to include educational programs, student performances, workshops, and classes for senior citizens in isolated communities in Pennsylvania, New Jersey, Delaware, and western New York.

Seattle Opera Association in Washington is expanding their outreach and education program to include older adults and those living in rural communities.

Wolf Trap Foundation in Vienna, Va., has developed a series of 12 interpretive programs conducted by American artists, designed to introduce new audiences such as senior citizens, to opera and musical theater.

PARTNERSHIP

Grand Monadnock Arts Council of Keene, N.H. is expanding their program of performances and workshop in poetry, printmaking, clay, sculpture, and creative movement to include institutionalized, elderly and handicapped people. The documentation of this process should aid other local arts agencies in developing additional programing.

PARTICIPATORY ARTS PROGRAMING

Active participation in the arts by older Americans has continued to expand because of professional arts programing. Through Endowment advocacy and financial support, professional artists are being given the opportunity to work with seniors in very special ways. The artists are becoming aware of the overwhelming sensitivity and creativity that older Americans can offer in terms of the arts. The following grantees are providing participatory arts programing for older adults.

EXPANSION ARTS

Birmingham Creative Dance in Alabama offers performances, classes, and workshops for senior citizens and emotionally handicapped youth.

Creede Repertory Theater, Inc., in Creede, Colo., offers a senior citizens drama workshop, as well as special free performances for senior and migrant workers.

The Dance Exchange in Washington, D.C., conducts movement classes in senior centers, apartment buildings, hospitals, and day care centers throughout the metropolitan area. Training teachers to work with the elderly and handicapped populations in movement is an integral part of this program. The Dance Exchange also supports an intergenerational performance group well known in the Washington area called "Dancers of the Third Age."

DeCordova and Dana Museum and Park in Lincoln, Mass., offers an outreach program in fine arts, photography, and crafts for older people in senior centers and nutrition sites. Once acquainted with the offerings of the museum, seniors are provided with transportation to the class of their choice.

Iowa Arts Council in Des Moines, Iowa, is continuing their "Arts and Older American" program, a senior citizen participatory arts program including classes and workshops, and artists-in-residence.

Madison Community Access Center, Inc., in Wisconsin, trains older Americans in video production, including instruction in production planning and the use of the portable, studio, and editing equipment.

Manchester Craftsmen's Guild in Pittsburgh, Pa., instructs inner-city elderly and handicapped individuals in ceramics, textile arts and photography.

FOLK ARTS

Department of Community Services in Jonesboro, Tenn., plans to explore the development of country music radio from its roots in traditional mountain music by tracing secular/dance music traditions from the oldest forms of stringband

music to bluegrass. Concerts will present both older and younger country musicians.

Mexican American Opportunity Foundation in Monterey Park, Calif., will support a program of cultural enrichment for migrant workers and the urban poor populations using the music of the mariachi as played by expert senior mariachi players.

Monroe County Rural Heritage Alliance, Inc., of Union, W. Va., will continue their program of free classes in traditional music taught by older master traditional musicians in homes, county high schools, and senior centers.

LITERATURE

Eight fellowships have been awarded to older writers and poets including Djuna Barnes from New York, Kay Boyle from San Francisco, Sterling Brown from Washington, D.C., and Josephine Miles from Berkeley, Calif. Josephine Miles, a poet, essayist, critic, and teacher, was born in 1911. Ms. Miles is the author of over a dozen collections of poetry, most recently "To All Appearances: New and Selected Poems," published by the University of Illinois Press in 1974. Ms. Miles has received numerous literary fellowships and has served as a source of inspiration to younger writers. However, apart from poets and serious critics, her work is hardly known.

INTER-ARTS

Multiarts programs for St. Mary's Court in Washington, D.C., provides free instruction in music, drama, visual arts, and movement for the older people who reside in this low-middle income facility.

MEDIA

Council for Positive Images, Inc., in Los Angeles, Calif., is sponsoring a series of 30-minute visits with elderly artists and scholars. These senior citizens will share their visions, remembrances, reflections, and critical observations with their public through interviews.

MUSEUM

El Museo del Bario in New York City has purchased works of older painters for a permanent Puerto Rican art collection. These painters are presently represented only by their smaller works or works on paper rather than complete paintings.

The Dublin Gallery of Art in Knoxville, Tenn., is supporting an outreach public service art program for all ages at senior citizen centers and homes for handicapped and mentally retarded individuals.

The Institute for Contemporary Art in Boston, Mass., is supporting a program designed to enhance mobility training for newly blinded adults.

The Museum of Modern Art in New York City is expanding their educational programs that are conducted by graduate students in the museum and in community centers, senior citizen residencies, associations for the handicapped, and other social services organizations.

VISUAL ARTS/PHOTOGRAPHY

Andrea Gray from Carmel, Calif., is involved in producing a 1-hour documentary film on the life of Ansel Adams, one of the most important photographers of the 20th century who is almost 80 years old.

Donald Sunseri of West Glover, Vt., is involved in a program of discovering and promoting native talents in the northeastern section of Vermont. Sunseri has exhibited and lectured on the high quality of work produced by older residents, whose average age is 87 years old.

Coast Community College District in Costa Mesa, Calif., is researching and recording segments of the history of photography by videotaping interviews with six senior women photographers.

Fine Arts Museum Foundation of San Francisco, Calif., will support "San Francisco/Los Angeles, 1945–80," a photographic exhibition of approximately 60 works by Max Yavno, an important senior west coast photographer. The Yavno exhibition reflects the development and social changes in San Francisco and Los Angeles as Yavno recorded them over the last 35 years.

ITEM 26. NATIONAL ENDOWMENT FOR THE HUMANITIES

JANUARY 15, 1981.

DEAR SENATOR HEINZ: I am pleased to enclose a report summarizing major activities for or about the aging which were supported by the National Endowment for the Humanities in 1980.

It is my hope that you and your committee will find this summary of our activities and plans useful. I also hope that other readers of the report will be stimulated by it to develop other kinds of humanities projects to benefit older Americans and to increase understanding of the special problems and challenges they face.

Please let me know if we can be of any further help to your committee.

Sincerely,

JOSEPH D. DUFFEY, *Chairman.*

Enclosure.

REPORT ON ACTIVITIES AFFECTING OLDER AMERICANS IN 1980

I. INTRODUCTION

The National Endowment for the Humanities recognizes the important contributions made by older Americans to scholarship in the humanities and to the broader society. It also recognizes that our senior citizens have a special need for the enrichment which the humanities can bring to their lives, as well as for the knowledge and perspectives which the humanities provide all citizens, young and old, as they strive to make informed personal and civic choices. To these ends, NEH encourage utilization by the elderly of Endowment-supported products (such as print materials, museum exhibitions, radio and television programs) and seeks increased participation of older Americans in a wide variety of NEH-supported activities, including scholarship, formal and informal educational programs, and discussions of public policy and other vital questions in communities throughout the United States.

Some of the ways in which the aging do participate in the Endowment's programs are discussed in section II of this report.

Last year, in order to insure that older Americans have access to Endowment funds and programs, the Endowment developed and published in the Federal Register its proposed regulations under the Age Discrimination Act of 1975. As a result of this publication, comments on the proposed regulations were received and acted upon. Although the deadline for comment has now passed and the Department of Health and Human Services has approved the modified regulations. procedural changes now require Justice Department approval before the regulations become final.

In addition to several specific grants cited below, the upcoming White House Conference on the Aging prompted the development of a memorandum of understanding between NEH, NEA, the Administration on Aging, and the White House Conference on Aging, itself. Through this memorandum the agencies entered into agreement for long-term, comprehensive programs of cooperation in the area of humanities, arts, and aging.

II. PARTICIPATION BY OLDER AMERICANS IN NEH PROGRAMS

In carrying out its congressionally mandated mission of furthering the understanding and use of humanistic knowledge in the United States, NEH responds to the needs and interests in the humanities, primarily as they are expressed in unsolicited applications for specific projects. Therefore, the agency does not usually set aside fixed sums of money for work in any subject area or for particular groups. As a result, there is no single program for senior citizens using funds specifically allocated for that group; nor is there a single program within the agency to support the study of the aging process or of elderly people. Rather, both such interests can be pursued through the full range of Endowment programs depending on the project's goals and formats.

Through the regular selection process of these grant programs. NEH funds a great number of projects involving older individuals as project directors, project personnel, or consultants. One of the agency's most distinguished grantees, Dumas Malone, now 89 years old, is now nearing completion of his monumental

multivolume biography of Thomas Jefferson. This comprehensive history, which was begun in 1943, won the Pulitzer Prize in 1975. Speaking at a recent ceremony marking the Endowment's 15th anniversary, Mr. Malone recalled that "* * * Some years ago a distinguished historian (Carl Becker) predicted that if anyone should be so foolhardy to attempt a comprehensive biography of Thomas Jefferson, he would enter the labyrinth and never emerge. I was in the middle of that labyrinth when I approached the Endowment, and with their help I have been slowly making my way through it ever since. I am not out yet, but, God willing, shall be soon." Mr. Malone is just one of the notable older scholars aided by the Endowment who demonstrate that age is no bar to significant achievements in the fields of the humanities.

Elder Americans without scholarly training make essential contributions to many of the Endowment's projects. For instance, projects for the creation of Native American language dictionaries and tribal histories frequently use elderly members of the tribe as consultants or informants. District 1199 Hospital Workers Union's "Bread and Roses" project made similar use of the resources provided by the elderly for a very different purpose: oral history workshops with retirees from the union were used to develop the material for a musical presentation, "Take Care." Also, retirees have served as both guides and audiences for many of the exhibits, discussion programs and conferences conducted under the "Bread and Roses" project.

In the same way, the University of Baltimore's Baltimore Neighborhood Heritage Project derived substantial historical material from interviews with elderly residents of Baltimore's highly ethnicized neighborhoods. "Baltimore Voices," derived from the interviews, has been performed over 200 times before community audiences made up more often than not of the elderly in the neighborhoods or senior centers. District 1199 and Baltimore projects are just two illustrations demonstrating how older Americans have served as both resources and audiences for many Endowment funded projects in the humanities.

All of the activities supported by NEH to increase understanding and use of the humanities among the general public reach large numbers of older Americans.

Media programs. The quality radio and television productions supported by the Endowment (e.g., Odyssey, Hard Choices, the Adams Chronicles, and the American Short Story series) are especially useful to older people, many of whom cannot or prefer not to leave their homes. NEH encourages grantees to promote the use of media productions among senior citizens and urges applicants to plan media programs with this group in mind. Specific information on media programs and any adjunct material produced is provided to all organizations working for special groups, including the elderly.

Humanities radio programing, like "A Question of Place" series on National Public Radio, serves a wide audience, including the visually handicapped, who might have limited access to the humanities in other media. For many elderly people confronting problems such as impaired vision and reduced mobility, these Endowment-funded programs provide access to information as well as a mechanism for communicating with others.

Education programs. Making use of the media productions cited above and accompanying printed materials, many institutions of higher education, including community colleges, are offering courses for credit. Some of these courses are particularly suited for those elderly students whose mobility may be limited by health or transportation problems since they do not require attendance on campus. However, all provide good opportunities for continuing a lifelong education.

The Endowment's concern with continuing education goes beyond courses tied to NEH funded media productions. For the past 2 years the Endowment conducted a continuing education initiative. This initiative included seven regional workshops, each with participants from about 25 institutions, with discussions focusing on fashioning programing to meet the needs of a variety of new audiences, including the elderly. Such conferences will doubtless result in future grants similar to that which enabled Scottsdale Community College to create a program on the culture of the Southwest targeted to newcomers to the area, often the recently retired.

Courses by newspaper. In 1980–81 the Endowment-supported Courses by Newspaper programs administered by the University of California, San Diego continued to present nontraditional college-level courses. These courses are offered to the general public nationally through the cooperation of hundreds of partici-

pating newspapers and educational institutions. A series of newspaper articles prepared by outstanding scholars serves as the basis of a course offered at local colleges and universities for those readers desirous of earning college credit. More than 450 newspapers and 300 colleges and universities cooperate regularly to bring these courses to citizens of every State, Puerto Rico, Guam, the Virgin Islands, as well as parts of Europe, Canada, New Zealand, and the Far East.

Recent Courses by Newspaper have included "Death and Dying: Challenge and Change" (1979), "The American Family in Transition" (fall 1980), and "The Nation's Health" (spring 1981), subjects of considerable and special interest to older Americans.

Other projects supported by NEH are specifically designed either to increase understanding of the special problems and challenges facing the elderly or to provide learning experiences in the humanities for older citizens. These are detailed in section III of this report. In addition, regrants on NEH funds through the State-based humanities committees have supported many locally initiated and conducted projects of these kinds, some of which are described in section IV.

III. SPECIFIC NEH GRANTS SERVING THE ELDERLY

Continuing until the fall of 1981, the Endowment's grant to the National Council on the Aging for its senior center humanities program is involving 22.5 million older Americans in the humanities through activities held at more than 800 service centers (including senior centers, nutrition sites, day care programs, and nursing homes). In addition, during 1980 the Endowment made new awards totaling over $600,000 for projects designed—as a whole or in part—to increase knowledge about aging or to provide special materials or activities for older persons. Although there is obviously a good deal of overlap, these might be divided into three categories: (1) Programs about aging and the elderly in our society and others; (2) programs for older Americans; and (3) programs using senior citizens as consultants or resource people. Examples of such programs funded in 1980 follow:

A. Programs about aging and the elderly

1. "Humanistic Approaches to Aging."—This $19,900 grant to Illinois Benedictine College enabled implementation of an interdisciplinary course on humanistic approaches to aging to be taught by a special consortium faculty. It is hoped that the course will serve as a demonstration model for other institutions.

2. "Changing Male and Female Roles and the Aging Process."—This $14,994 grant to Columbia University supports a study of the impact of changing sex roles on the aging process as it is being experienced by men and women in late 20th century America.

3. "Issues in Geriatric Care."—This $12,000 grant, jointly funded with NSF through the science, technology, and human values program, will enable a specialist at a VA hospital in Portland, Oreg., to conduct interdisciplinary research concerning judgments made by health professionals about patients' competence to make decisions about their care. Conceptual inquiry and field study in a geriatric ward will result in a paper on guidelines for judging competence in borderline cases.

4. "Cambridge Women's Oral History Project: Historical and Cultural Perspectives."—This $23,100 grant to the Cambridge Arts Council will enable a core group of teenage women to collect oral histories of senior citizens and develop a slide/tape presentation and a guidebook on "life transitions" and choices among older women.

5. "Asian Americans History Youth Project."—This $5,000 Youth Project grant to Asian Americans for community involvement will enable Asian American youth in Santa Clara County, Calif., to learn about the history of Asians in America by active participation in the writing and production of videotapes on significant events and issues, including Asian American elderly.

B. Programs for older Americans

1. "White House Conference on Aging Miniconference on the Arts, Humanities, and Older Americans."—This $30,000 grant is enabling the National Council on the Aging to hold a miniconference prior to the White House Conference on Aging to develop information and recommendations concerning the arts, humanities, and aging for inclusion in the full conference agenda.

2. "Ethnicity and Aging: A Humanistic Assessment of Public Policy."—This $30,000 grant will enable the National Center for Urban Ethnic Affairs to hold a miniconference prior to the White House Conference on Aging to explore ways to improve European-American elderly, their families and communities in articulating their particular problems and in finding solutions to them with the help of government and the private sector.

3. "The Humanities in Gerontology and Geriatric Medicine: Toward a Future Integration."—This grant for $5,086 will support two sessions at the annual meeting of the Gerontological Society on: (1) The role of the humanities in geriatric health, and (2) the role of the humanities in long-term geriatric care institutions. This grant for $49,598 will enable Wichita State University to develop and implement a continuing education program in the humanities for senior citizens and nontraditional students who have been generally overlooked by university programs nationwide.

4. "Country Roads and City Streets: On the Trails of History—People, Places, Things."—This $5,000 grant to the Ocmulgee Regional Library in Eastman, Ga., will support a project in which area youth conduct field research to discover and document sites of historic importance in five counties, and present their findings to youth and senior citizen audiences through exhibits and workshops.

C. Programs using senior citizens as resources

1. "Youth-to-Elderly Oral History Project."—This grant for $5,000 to the Salem, Mass., Youth Commission will enable Salem area youth to conduct oral history interviews with local senior citizens to gather material for both an exhibit and a radio series.

2. "United Negro College Fund Oral History Project."—This $25,000 grant to the United Negro College Fund will support an intensive 1-year oral history project to collect, transcribe, and process interviews with between 16 and 24 elderly individuals who have been important in the 35-year history of the Fund.

3. "NUX BAGA (The People) Oral History Project."—This $5,000 grant to Fort Berthold (North Dakota) Community College will support a pilot project in which youth from the Fort Berthold Indian Reservation will conduct oral history interviews with tribal elders and prepare an exhibit and workshop on the environmental, cultural, and social impacts of the flooding of the reservation's most fertile land.

4. "Personal History of Five Women (1900–1980)."—This $2,000 summer stipend to a young San Francisco State University sociologist will make it possible to interview and research the sociohistorical backgrounds of five women, all in their seventies, who, despite their varied life experiences and personalities, all display caring and commitment in their daily lives. The study will examine the experiences which contributed to these values.

5. "Bridges from the Past."—This $5,000 grant to the Bethlehem Center in Charlotte, N.C., will support a project in which local youth, predominantly black and low income, will learn about life in the early 1900's for low-income black families from small group meetings with the elderly. The youth will compile a booklet and present a program of cultural recollections.

IV. STATE PROGRAMS AND THE AGING

The State programs division of the Endowment makes grants in 50 States and in Puerto Rico and the District of Columbia to State humanities committees. These committees, in turn, respond to competitive applications from institutions and organizations within the State for humanities projects of broad benefit to the citizens of the State. In recent years the majority of the projects funded across the country have focused on issues of public policy or of contemporary concern to the society. Therefore, many projects deal with the topics of biomedical ethics, death and dying, the status of the family within the society, and with other issues of particular concern to the elderly. Like the grants made directly by the Endowment, these "regrants" fund projects in a variety of formats. The following dozen examples give some indication of the breadth of these undertakings:

1. Iowa: As part of the annual Elderhostel Cultural Festival, 20 colleges and universities in Iowa received a $9,497 grant to conduct an on-campus college experience for the elderly including humanities courses with a special focus on ethnic heritage.

2. Georgia: Fort Valley State College received a $950 grant toward a 3-day festival to increase awareness of the ways in which the history of the region is preserved in the personal skills, talents, and artifacts of local people, especially the elderly.

3. Florida: The Miami Gray Panthers received a grant of $8,450 to bring together academic humanists, health practitioners and representatives of senior citizens' organizations for an examination of age-related issues as they pertain to the humanities. Twenty meetings held at different locations in the Dade County area used films, speeches, and panel discussions as means to explore the underlying values in our treatment of the elderly.

4. Delaware: The Ingleside Retirement Apartments received a grant of $762 to conduct a program of reading and discussions guided by an academic humanist on the evolution of the American short story. The stories selected include many of those in the PBS American short story television series, and Endowment-funded project.

5. District of Columbia: The Department of Social Work of the city government received a $5,515 grant to hold a conference in which humanities scholars participated in discussions focusing on changes in health status and the social worker's role in assisting individuals to deal with these changes. The two main topics for panel discussions and workshops were teenage pregnancies and the elderly.

6. Connecticut: Mohegan Community College received a grant of $8,055 to conduct drama and poetry workshops for senior citizens and out-of-school adults. Twelve of these sessions were held at Mohegan Community College, while twenty-four were conducted at senior centers in southeast Connecticut. To give additional perspectives on the literature studies, the program also included four trips to major productions of the Hartford Stage Company and the Long Wharf Theatre in New Haven.

7. California: The Gray Panthers received a $12,817 grant to hold 10 invitational meetings and workshops to consider present-day patterns of old age and of the relationships among older adults and their children in light of history, literature, philosophy, religion, and ethics.

8. Arizona: The University of Arizona received a grant to develop a program based on materials from the National Council on Aging. The program, focusing on common family dilemmas and joys, examines selected historical events (specifically immigration in the Great Depression) which have dramatically affected the course of life in individual families.

9. Colorado: The University of Colorado received a $10,500 grant to conduct lecture/panels on the parallel developments in the humanities, sciences, and social sciences. The lecture/panels are held at a senior citizen center. Senior citizens also attend classes at the college.

10. Alabama: A grant of $913 funded a panel discussion, carried over radio, examining society's values and attitudes on aging and the origins of these. Special attention was paid to the negative self-perceptions of the aged, boredom, alcoholism, and the dissolution of the nuclear family.

11. Alaska: A grant of $3,425 to Kodiak Community College funded a pre-retirement seminar involving humanities scholars and others in examining how land issues and their resolution either encourage or discourage people of retirement age to remain in the State.

12. Indiana: A grant of $2,000 funded a museum exhibit of the work of "over 90" photographer Imogan Cunningham. A film and followup discussion lead by academic humanists focused on the creativity of the elderly.

ITEM 27. NATIONAL RAILROAD PASSENGER CORPORATION

JANUARY 16, 1981.

DEAR MR. CHAIRMAN: The National Railroad Passenger Corporation (Amtrak) holds strongly to its commitment to make rail passenger service more comfortable and economical for both elderly and handicapped travelers.

As you may know, in 1980 Amtrak began offering a 25 percent discount to senior citizens and handicapped travelers on one-way trip fares of $40 or more. The special discount does not impose holiday restrictions, round trip requirements, or limits on length of stay. The fare reduction is the largest in the transportation

industry, is the simplest to use, and is the only one which applies to handicapped citizens as well as to the elderly. This program was implemented to reflect the national priority to urge citizens out of their isolation by removing both the physical barriers and the financial constraints which have often denied both groups access to the intercity transportation network.

Federal law has defined the senior citizen as being 65 years of age or older for the purpose of determining eligibility for discounts. The law has also set the definition of handicapped as persons with a physical or mental impairment which substantially limits their ability to care for themselves. A driver's license, birth certificate, or any other official document showing age is acceptable to qualify for our discount to the elderly. Cards certifying an individual as handicapped, such as those issued by the government or by groups representing handicapped persons, or a letter from a physician may be used to purchase a reduced fare ticket.

Amtrak has been directed by Congress to take all steps necessary to modify its stations to allow the elderly and handicapped accessibility to the facilities. In fiscal year 1981, Amtrak plans to expend $3.1 million in the process of complying with this requirement, adding 18 stations to the existing stations with barrier-free access.

By the close of 1981, wheelchair platform lifts will be available at 160 manned stations in 36 States across the country. These lifts will make trains more easily accessible from the low platform level for wheelchaired passengers. Amtrak is very close to the 1984 deadline for installing wheelchair lifts at all manned stations. Most of the stations currently without wheelchair lifts are either unmanned, have high-level platforms, or are equipped with wheelchair ramps.

Funds have been set aside in Amtrak's program for refurbishing old passenger cars to provide for the installation of special restrooms, accessible coach seating, and modified sleeping accommodations. All Amfleet, Turboliner, and Superliner trains are equipped with special seats and accessible restrooms.

Passengers who have special needs, such as specially prepared meals, or who require assistance boarding or leaving the train, should discuss these needs in advance with the agent at the special services desk who will coordinate their trip from beginning to end. The passenger should simply call the Amtrak toll-free number in his area and the agent will make every effort to insure the individual's comfort.

Amtrak's current services to the elderly and handicapped train travelers are described in a booklet "Access Amtrak," which is available free of charge from Amtrak, Corporate Communications, 400 North Capitol Street NW., Washington, D.C. 20001.

Thank you for your interest in this matter. We look forward to improved service to senior citizens.

Sincerely,

LAWRENCE D. GILSON,
Vice President, Government Affairs.

ITEM 28. NATIONAL SCIENCE FOUNDATION

DECEMBER 10, 1980.

DEAR MR. CHAIRMAN: Thank you for the opportunity to provide information for the annual report, "Developments in Aging," for the fiscal year 1979.

The National Science Foundation supports scientific research which, in general, does not fall within the responsibility of other agencies. The Institute on Aging in the National Institutes of Health is the primary funding agency for research dealing with the aging. Nevertheless, the National Science Foundation in its basic science programs, or in the context of more policy-oriented research programs has supported research and other activities, such as conferences, directly or indirectly related to problems of the aging.

The Directorate for Engineering and Applied Science has supported projects on policy issues related to the elderly. The Directorate for Science Education has supported programs of science for the elderly, forums on research on aging, and cosponsored with the National Institute on Aging a television series on the brain which has segments pertaining to aging.

Basic research in biology, in areas such as plant senescence, senescence of nervous systems, and developmental behaviorial problems is related to aging and continues to be funded through programs in the Directorate for Biological, Behavioral, and Social Sciences.

Enclosed are copies of project summaries and program award recommendations for some National Science Foundation projects related to aging.[1]

If you require further assistance, please let me know.

Sincerely,

HENRY C. BOURNE, Jr..
Deputy Assistant Director for Engineering and Applied Science.

ITEM 29. OFFICE OF CONSUMER AFFAIRS

THE WHITE HOUSE,
Washington, December 31, 1980.

DEAR MR. CHAIRMAN: In response to your request, I have enclosed two copies of the summary of U.S. Office of Consumer Affairs activities during 1980 relating to the elderly.

My office is pleased to have the opportunity to contribute to the committee's annual report on aging. We are keenly aware of the needs of the elderly. In 1981 the Office plans to expand its activities to provide greater assistance to elderly consumers.

Sincerely,

ESTHER PETERSON, *Director.*

Enclosure.

REPORT OF ACTIVITIES OF THE U.S. OFFICE OF CONSUMER AFFAIRS DURING 1980 RELATING TO OLDER AMERICANS

The U.S. Office of Consumer Affairs (USOCA) serves as the staff of the Special Assistant to the President for Consumer Affairs and advises Federal agencies on consumer-related policies and programs. USOCA encourages and assists in the development of new consumer programs, makes recommendations to improve the effectiveness of Federal consumer programs, cooperates with State agencies and voluntary organizations in advancing the interests of consumers, promotes improved consumer education, coordinates consumer complaints, recommends legislation and regulations of benefit to consumers, and encourages productive dialog and interaction between industry, government, and the consumer.

Major activities have primarily focused on consumer advocacy, consumer education and information, and planning and analysis. While these activities in general are initiated on behalf of all consumers, it should be noted that the elderly consumer shares fully in the benefits of USOCA programs.

Highlighted below are major activities having the greatest impact on older Americans.

CONSUMER ISSUES

Banking and Credit

The U.S. Office of Consumer Affairs has obtained agreement from the American Bankers Association to create a National Consumer/Banker Panel to seek compromises on public policy issues affecting banker and consumer. The eight consumer members will include an advocate of the concerns of older Americans.

Financial Institutions Monetary Control and Deregulation Act of 1980

In July 1979, the Office testified in favor of provisions of this act which allows interest to be paid on checking accounts and also supported its provisions to lift the limitations on interest rates paid on savings accounts. This latter provision was of particular interest to the Gray Panthers. The bill was signed by the President on March 31, 1980.

Usury Laws

Most States limit the amount of interest which can be charged for consumer loans. USOCA has worked to prevent wholesale Federal preemption of State usury laws. High loan interest rates will hit elderly consumers in need of loans since many have fixed incomes. We are supporting creation of a joint consumer-business commission to study the issue of Federal preemption.

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[1] Retained in committee files.

Regulation B: Equal Credit Opportunity Act

USOCA is currently reviewing a proposed interpretation of the Federal Reserve Board which would require that equal points in a credit scoring system be given to income from pensions or social security. USOCA filed comments last year urging the Board to make such requirement clear to creditors. This, and a related interpretation providing for giving reasons for credit denials, are particularly important if discrimination against the elderly in the granting of credit is to be prevented.

Mortgages

A number of new mortgage instruments allowing for increases in interest over the life of the loan have been proposed since April 1979. (New proposals are still being made.) In each case, the mortgages available to the elderly will affect their ability to buy a retirement home if they require a loan to do so. USOCA reviews and comments on each to assure sufficient disclosure of terms and the widest availability of mortgage loans.

ENERGY

Utility Construction Programs

The U.S. Office of Consumer Affairs has been actively involved with the issue of whether consumers should pay for the costs of construction of utility plants before plants provide service. Utility construction programs normally take more than 10 years to complete. USOCA has taken the position that only customers who actually receive service from a plant should be required to pay for it.

With such long construction periods involved, many customers, including senior citizens, may not be customers of a utility for the duration of a construction project. Most senior citizens will not be customers for the entire useful life of a plant. Accordingly, USOCA has vigorously argued that it is inequitable to require today's customers to subsidize the cost of producing electricity for future customers.

USOCA has been involved in two cases involving this issue before the Federal Energy Regulatory Commission. In addition, it has argued this position in response to a proposed guideline issued by the Council on Wage and Price Stability.

PURPA Service Termination Standard

The Public Utility Regulatory Policies Act of 1978 (PURPA) established certain standards for the regulation of gas and electric utilities which State regulatory authorities and nonregulated utilities are required to consider. Among the standards so established is a standard regarding procedures for terminating gas and electric service. On October 19, 1979, the Department of Energy published proposed guidelines to assist State regulatory authorities and nonregulated utilities in their consideration of this standard. USOCA submitted comments on several aspects of the proposed guidelines.

A utility's termination policies and procedures are of great importance to the elderly, particularly if they live in regions which experience severe winters or summers. Rapidly rising utility rates make it increasingly difficult for older persons on fixed incomes to pay their utility bills. Furthermore, the elderly generally have a less elastic demand for heat or cooling than the general population because of greater physical infirmity. Therefore, the elderly cannot very easily reduce bills by conserving energy. Also, when heating or cooling service is disconnected for nonpayment, older consumers are more vulnerable to sickness than the general population.

The USOCA comments sought to make the Department of Energy guidelines even more responsive to the needs of the elderly. We suggested, for example, that utilities should make personal contact with an adult on the premises before terminating service, since many elderly people are confused or embarrassed by written notices, and indeed, many mailed notices are lost, stolen, or never delivered. Another example was our suggestion that consumers should have the right to initiate complaints by telephone, since it is difficult for many of the elderly and handicapped to write or visit an agency. We also recommend that consumers should have the right to arrange for deferred payment plans to pay amounts in arrears, since utility budget plans are frequently not available to consumers on fixed incomes because of strict credit requirements.

HEALTH

The U.S. Office of Consumer Affairs has done significant work in the area ot medigap insurance. Working with Senate and House committee staffs, preparing congressional letters, and commenting on the enrolled bill internally, we helped to set up a voluntary certification program for medicare supplemental health insurance, to be run by the Department of Health and Human Services.

Projects in health care were highlighted in USOCA's "People Power: What Communities Are Doing to Counter Inflation." Projects focusing on the activities of elderly consumers include: A medical center owned and managed by senior citizens, an adult day care center, a hospice, prescription drug price surveys, and efforts to stop nursing home neglect.

USOCA has taken several actions in the drug area which have a greater impact on the elderly since the elderly use more drugs than any other age group: Esther Peterson persuaded 20 drug retailers and 8 suppliers to institute a price freeze for varying amounts of time (usually 3 months); the Office commented in favor of a Food and Drug Administration proposal to begin a comprehensive patient labeling program for prescription drug products; USOCA worked successfully with other consumer groups to prevent an amendment to general patent legislation which would have had the effect of prolonging the introduction of generic drug products; USOCA commented on Health Care Financing Administration's draft, "A Consumer Guide To Cutting Prescripiton Drug Costs."

With the defeat of the hospital cost containment bill, Esther Peterson testified before the Price Advisory Committee of the Council on Wage and Price Stability requesting a public monitoring system to track hospital expenditures and physician fees. High hospital bills have a devastating effect on elderly consumers living on fixed incomes.

HOUSING

One issue which is of particular interest to USOCA is the problem of displacement of people from urban dwellings. There has been a marked increase in the in-migration of middle-class homeowners and renters into many city neighborhoods. As a result, many poor, elderly, and minority owners and renters are finding themselves in the position of being bought out or "involuntarily" pushed out. Elderly residents living in neighborhoods undergoing "rehabilitation" need particular attention.

USOCA will continue to work in this and other areas of housing, mindful of the effects of all housing programs on the lives of our elderly citizens. The Office will support those legislative initiatives and Federal programs that will address the housing needs of elderly citizens, and continue to work with national and local organizations that advocate the rights of older consumers.

LIFE INSURANCE

USOCA continued efforts to promote improved disclosure of life insurance costs and benefits. (State insurance regulators are currently reviewing and testing new plans for improved disclosure to enhance consumer choice.)

TRANSPORTATION

The U.S. Office of Consumer Affairs continued efforts to obtain agreement from auto manufacturers to be bound by the decisions of consumer mediation panels seeking solutions to consumer complaints arising from car purchases and servicing of cars. Toyota joined Ford in supporting this concept for resolution of consumer complaints against franchised dealers and manufacturers. Two airline companies have indicated that they are also moving toward acceptance of this approach to resolution of complicated consumer complaints. We have advised them on methodology.

USOCA served as the lead agency for the administration with respect to reform of laws regulating household movers. Retired persons who often lack the assistance of an employer in selecting and using a mover are less able than others to move without the assistance of a professional mover. While consumer abuses in the moving industry affect all age groups, the elderly are particularly reliant on the interstate moving industry. On October 15 the President signed Public Law 96-454, the Household Goods Transportation Act, which both increases competi-

tion in the home moving industry and increases consumers remedies and the Interstate Commerce Commission's ability to enforce consumer protection rules. In addition, the bill establishes guidelines for independent informal dispute settlement bodies. In late October the ICC announced a rule to implement the new law. USOCA suggested several improvements in those rules.

The Office is reviewing a proposal submitted by the National Council on the Aging to establish an automotive safety maintenance and repair consumer education program for the elderly. Increasing consumer awareness among elderly persons regarding consumer rights in safe automotive maintenance and repair will have a significant effect on reducing the excessive number of automotive repair "rip-offs" that occur daily.

USOCA serves on the Inspection, Maintenance, and Repair Interagency Coordinating Committee Task Force (IMR–ICC) which is intended to provide a more coordinated effort among Federal, State, and local governments, automotive industry, and consumer organizations concerned with improving the auto repair process in this country. Toward this end, USOCA has assumed responsibility for cochairing, along with the Federal Trade Commission, a work group that will evaluate the efficacy of automotive consumer dispute resolution mechanisms. These resolution mechanisms often serve as a viable means of addressing automotive repair disputes.

The Office submitted written testimony before the Senate Judiciary Committee of the California State Legislature outlining some of the major problems associated with automotive repair. In light of the potential high costs of auto repair to consumers and particularly to those living on fixed incomes, the testimony emphasized the need to provide consumers with information that will enable them to evaluate the necessity, costs, and quality of repairs performed on their automobiles.

USOCA has worked with the National Highway Traffic and Safety Administration in their continued efforts to develop meaningful automotive safety and maintenance information to consumers that will assist them in making an informed decision regarding the purchase of a new car. It is anticipated that the information will facilitate comparison shopping in the purchase of a new car.

OUTREACH

Conferences and Technical Assistance

Besides providing information on an individual basis, USOCA has participated in national, regional, and State conferences and workshops designed to address issues affecting low-income and elderly consumers. In addition to providing materials and information regarding possible funding sources and technical assistance, USOCA has continued to alert these groups to proposed legislation, regulations and policies that may impact on them.

USOCA cosponsored with Howard University and the D.C. Office of Consumer Protection a low-income consumer self-help conference July 9–11, 1980. The conference attracted over 800 community leaders, consumer advocates, educators, and representatives from elderly consumer organizations. The conference was the forum for the release of "People Power: What Communities Are Doing To Counter Inflation." Many of the projects highlighted in "People Power" were designed to help elderly consumers cope more effectively with inflation. Many of the people who spearheaded projects for the elderly conducted practical workshops during the conference.

USOCA is planning to cosponsor a low-income consumer conference in 1981. The conference will be cosponsored with Howard University and the D.C. Office of Consumer Protection. The issues to be addressed will be of interest to and impact on elderly consumers: housing, health care, energy, transportation, and food. Organizations representing elderly consumers will be invited to participate.

The Office is talking with representatives from elderly consumer organizations about the publication of a "Guide to Successful Elderly Consumer Projects." Since the elderly, living on fixed incomes are hit hardest by high inflation, "Elderly People Power" would significantly assist by alerting them to inflation fighting alternatives in the areas of health care, food, housing, and energy.

During the spring of 1981, the USOCA plans to compile a bibliography of consumer information publications produced by State, county, and city government consumer offices. Many of the publications that will be listed will be of interest to elderly consumers.

USOCA assisted the National Public Law Training Center in creating a model agenda for training educators of the elderly, with respect to the insurance needs of older Americans. The Center plans to began training educators in 1981.

WHITE HOUSE CONFERENCE ON AGING

As a member of the National Advisory Committee on the 1981 White House Conference on Aging, Esther Peterson has worked with the committee and conference staff in planning preconference activities and for the conference itself. Mrs. Peterson is chairman of the Subcommittee on the National Meeting and a member of Executive Committee, Issues Subcommittee, Private Sector Subcommittee, and Technical Committee on the Economy.

Mrs. Peterson has discussed the conference in speeches and articles and has urged consumers to participate in community forums, State conferences, and hearings which are designed to identify needs and concerns of the elderly and make recommendations to the national conference. USOCA provided the conference staff with a summary of Federal activities affecting the elderly in credit, housing, health care, and energy. Recommendations were also made for future consumer activities that the conference may want to address.

The USOCA is cosponsoring a White House Conference on Aging Mini-Conference on the Elderly Consumer with the American Association of Retired Persons/National Retired Teachers Association. The conference is scheduled for January 29–30, 1981 will bring together elderly consumers and professionals working in the field of aging. Those attending will identify specific consumer issues of importance to the elderly and formulate recommendations for addressing these issues.

INFORMATION AND EDUCATION

"Consumer Action Update," USOCA's twice-monthly newsletter carries articles of general interest to consumers. Many of the articles have discussed proposed legislation, guidelines, and issues that are of interest to and impacting on elderly consumers.

USOCA also publishes a weekly news column, "Dear Consumer." The following columns dealt with issues of concern to the elderly:

"The Last Consumer Purchase" (funerals).

"Elderly Consumers Must Protect Themselves" (ripoffs).

"White House Conference on Aging."

"Organizations Serving the Elderly."

Also during 1980, USOCA distributed two major publications which provide useful information to the elderly.

The "Consumer's Resource Handbook" contains a section on aging and refers to other sections in the "Handbook" of interest to the elderly such as health care, social security, and veterans' affairs. The State and local directory section of the "Handbook" lists government offices responsible for coordinating services for the elderly. Approximately 2 million copies were distributed in 1980.

In July 1980, USOCA also released "People Power: What Communities Are Doing to Counter Inflation," featuring case studies of self-help projects throughout the country aimed at reducing expenditures for food, housing, energy and health care, which are of special concern to those on fixed incomes, including many elderly people. Activities described will serve as models for groups wanting to undertake similar pursuits in their own communities. Many of the projects are designed to help seniors cope more effectively with rising costs. From special nutrition programs and grocery stores for the elderly to home repair services and health care projects for older adults, "People Power" provides practical suggestions for those interested in developing similar programs in their communities while outlining the tools needed and generating the enthusiasm to get started. "People Power" was distributed to a wide variety of senior citizen organizations and clubs. The National Council of Senior Citizens provided us with a mailing of over 5,000 senior affiliates.

USOCA sponsored "National Consumer Education Week" in October 1980 in order to bring national attention to current consumer education programs and to point to the need for strengthened programs. Activities included community classes, workshops, exhibits, and displays. Many of these activities dealt with issues of interest to the elderly, the special problems they face as consumers and the need to be informed.

USOCA has been particularly concerned with the impact of inflation on consumers, and publishes the "National Consumer Buying Alert" to provide useful

information on saving money on food, energy, housing, and health care. The elderly are especially hard hit by inflation and can benefit from the tips and other information published in the "Buying Alert." Approximately 40,000 copies of the 2-page report are distributed each month.

LOCAL INFORMATION SYSTEMS

A major cause of inflation in consumer prices is what economists call an "imperfect" market—consumers do not or cannot obtain relative cost and quality information on competing providers. In service areas, consumers often lack the technical competence—in auto and home maintenance, health care, or appliance repair, for example—to make cost and quality comparisons. Even with an adequate technical background, gathering the necessary information is too time-consuming in most cases to be practical for individuals. Many products, in contrast to services, are distributed and regulated nationally; however, studies show that there is wide variation within local markets among prices for virtually identical products and, moreover, that consumers are substantially ignorant of these variations. Fixed- and low-income consumers, like many of the elderly, are particularly victimized by imperfect markets which often cause them to pay inordinate prices for poor quality services such as home maintenance and repair.

USOCA has proposed legislation to demonstrate that better consumer information—as an alternative to regulation—can combat inflation and increase productivity in consumer goods and services. This bill would authorize a small grant program to provide consumers with comparative cost and quality information on such products and services as prescription drugs, food, auto repair, and home maintenance. The program would make available presently nonexistent funding—on a matching basis—for development of local consumer information systems to gather and disseminate the information.

INTRAGOVERNMENTAL ACTIVITIES

Interagency Committees

USOCA was represented on the following interagency committees which have special impact on the elderly:

Administration on Aging Interdepartmental Task Force on Information and Referral which assesses the Federal information and referral resources that exists and develops plans for improving and coordinating resources.

Federal Interagency Committee on International Year of Disabled Persons is responsible for planning activities for the year. The activities include: Promoting national and international efforts to provide disabled persons with proper assistance, training, care and guidance; making available opportunities for suitable work; and insuring their full integration in society.

Congressional Black Caucus "Brain Trust" on the Elderly. Among other things, the Brain Trust assisted the Caucus in developing legislation to benefit minority and poor elderly citizens.

Executive Order 12160

President Carter issued Executive Order 12160 on September 26, 1979, entitled, "Providing for Enhancement and Coordination of Federal Consumer Programs." The order established governmentwide standards and imposed specific requirements that each Federal agency must meet in order to assure that government better serves all consumer needs. Over 40 Federal departments and agencies have established consumer programs.

The order addressed the problems of citizens in achieving adequate participation in government decisionmaking processes. For example, agencies are required to develop informational 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 evaluate their present information materials and methods of distribution to determine if groups such as the elderly are being reached most effectively.

Consumer Complaints

National consumer education week.—In conjunction with national consumer education week USOCA sponsored a consumer education fair entitled "You and the Federal Government: A Special Consumer Affair." The fair was held on the

Mall under a yellow and striped tent. Each of the 35 participating Federal agencies set up booths staffed with persons who could provide the visitors with information about their own agencies' responsibilities, functions, and consumer programs. Because USOCA recognizes that the elderly may not be fully aware of the many Federal services and programs available to them, a special effort was made to encourage senior citizen groups to attend.

Consumer complaints.—A large number of consumer complaints received by the Federal, executive, and legislative branches are from senior citizens. USOCA encourages consumers to send their individual complaints directly to the appropriate office for assistance in complaint resolution. The Office feels that it has a responsibility to help consumers locate these appropriate offices and to encourage these offices to handle complaints in a prompt efficient manner. In this regard, USOCA is updating and revising its "Consumer Resource Handbook." The focus is on providing information in a more readily accessible manner. The "Handbook" will contain a special section on consumer programs designed to help the elderly and other special interest groups. It will also contain detailed information on how and where to complain.

USOCA held a Constituent Resource Exposition to help congressional staff people more effectively work toward resolving their constituents' consumer problems. Over 1,500 persons attended the first Expo. A second Expo is planned for early spring of 1981.

The Office made site visits to over 35 Federal agencies providing technical information on how to improve their complaint systems. During these visits special emphasis was placed on the special needs of the elderly. Additionally, USOCA sponsored quarterly meetings for Federal agency complaint handling officials on subjects of common concern. The most recent meeting dealt with toll-free telephone numbers, a Federal service that can be especially beneficial to those on fixed incomes.

The "Consumer Resource Handbook" suggests as one source of complaint resolution that consumers bring their problems to the attention of State and local protection offices. USOCA began a series of training sessions on substantive issues for State and local complaint handlers. The first session dealt with credit. A future session will deal with mail orders. Both are areas in which the elderly are particularly vulnerable.

USOCA is developing a directory of business complaint offices which will be distributed to congressional offices, Federal agencies, State and local consumer protection offices, and voluntary groups. This should enhance the complaint-handling functions of these offices. A similar directory is being prepared for distribution to consumers. This should aid all consumers, especially the elderly, in quickly resolving their consumer problems that do not involve violations of law. USOCA is also developing a series of consumer communiques that will deal with major consumer concerns. Problems that are particularly troublesome to the elderly will be addressed.

ITEM 30. PENSION BENEFIT GUARANTY CORPORATION

JANUARY 16, 1981.

DEAR SENATOR CHILES: I am writing in response to your and Senator Domenici's joint request for information on our programs which affect the elderly.

Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) established the Pension Benefit Guaranty Corporation (PBGC) to administer an insurance program covering most private, tax-qualified, defined benefit pension plans. Through this program, PBGC ensures that participants in covered plans will receive the retirement benefits which they have been promised and to which they are entitled, subject to certain limitations specified in ERISA.

The most significant development affecting our programs in the past fiscal year took place on September 26, 1980, when President Carter signed the Multiemployer Pension Plan Amendments Act of 1980 (the Multiemployer Act) into law. This new law, drafted with PBGC's assistance, made major changes in the plan termination insurance program.

ERISA requires PBGC to provide insurance protection for all covered single employer plans which terminated on or after September 2, 1974, the date of enactment of ERISA. However, prior to the enactment of the Multiemployer Act, ERISA allowed PBGC to use its discretion in covering multiemployer plans which terminated before January 1, 1978, and which satisfied certain specified condi-

tions. Mandatory coverage for terminating multiemployer plans was originally deferred until January 1, 1978, to allow additional study of the necessity for and appropriate structure of a mandatory multiemployer plan termination insurance program. (Through a series of amendments to ERISA, the Congress ultimately postponed the mandatory coverage date until August 1, 1980.) In both the single employer and multiemployer plan insurance programs, as originally designed, the event which triggered the application of our guarantees was the termination of the plan.

As early as 1977 PBGC's research and experience with plan terminations indicated that the multiemployer plan insurance program needed substantial restructuring if it was to be effective and financially sound. We found that, rather than encouraging the continuation and maintenance of private pension plans, which was a major purpose of title IV, the original multiemployer plan insurance program could actually have made the termination of a covered plan more attractive than its continuation. Our studies also indicated that the potential costs of the program could range as high as several billion dollars, an amount vastly greater than our projected financial capabilities.

The Congress responded to these problems by passing the Multiemployer Act, which created an entirely new program of multiemployer plan insurance. This new program contains a set of interrelated features which are designed to promote the successful maintenance of existing plans and to discourage plan terminations.

A key element of the Multiemployer Act is to change the insurable event from the termination of a covered plan to the inability of the plan to pay benefits when due. Whether or not the plan has been terminated, PBGC will provide financial assistance to an insolvent multiemployer plan in order to enable the plan to pay guaranteed benefits. The underlying philosophy of this program is that the best way to guarantee the payment of benefits to plan participants is to ensure the continuation of the plans which provide for these benefits.

PBGC is constantly seeking ways to improve its operating procedures in order to minimize the inconvenience which a plan termination can cause to plan sponsors and plan participants. In fiscal year 1980 we instituted two new procedures, and proposed a third, which should be of particular interest to elderly plan participants. The first of these is a process which we call the SHIP (special handling of insufficient plans) transfer. This is an internal procedure, initiated in October 1979, which is designed to expedite our assumption of trusteeship for certain plans which do not possess sufficient assets to pay out at least those benefits which we guarantee. By utilizing the SHIP transfer, we are able to minimize any interruptions in benefit payments which might result from the insufficient funding of a terminated plan.

PBGC has also recently implemented an interagency agreement with the Internal Revenue Service (IRS) whereby we may obtain current addresses for participants of terminated plans who are vested, become eligible to receive benefit payments, and for whom neither PBGC nor the plan administrator (for sufficient plans) has a current address. This new procedure will facilitate the receipt by elderly people of their retirement benefits.

PBGC is also working on a regulation which concerns the allocation of residual plan assets. When PBGC receives notice of the termination of a plan covered by our insurance programs, we review the submitted materials to determine whether the plan has sufficient assets to pay out all guaranteed benefits. If the plan is sufficiently funded, we authorize the plan administrator to distribute the assets to the plan participants. Occasionally, the plan administrator may satisfy all liabilities of the plan to participants and their beneficiaries, and still have assets available for distribution. In such a case, ERISA provides that the residual assets may be distributed to the contributing employer(s) if the distribution is not contrary to any law, and if the plan provides for such a distribution to the employer(s). However, ERISA also requires that any residual assets attributable to employee contributions should be equitably distributed to the employees who made those contributions or to their beneficiaries. PBGC has proposed a regulation which prescribes procedures for properly allocating and distributing such residual assets. We are presently preparing a final regulation based in part on the public comments which we received on the proposal.

With regard to the actual operation of the plan termination insurance program, as of September 30, 1980, PBGC was trustee of approximately 501 plans covering approximately 48,164 vested participants and beneficiaries. Under these plans,

PBGC pays $2,942,961 in monthly benefits to 23,093 individuals. In the absence of PBGC many of these people might not have received any pension benefits at all.

Five of the plans under PBGC trusteeship are multiemployer plans, where PBGC exercised its discretion to guarantee benefits. We currently have 21 additional multiemployer plan termination requests under review.

Finally, ERISA requires PBGC to provide advice and assistance to individuals regarding the establishment of individual retirement accounts (IRA's), and the desirability, in particular cases, of transferring an employee's interest in a qualified retirement plan to such an account upon that person's separation from service with an employer. In fiscal year 1980 we issued an updated booklet on this subject.

Any elderly person may write to Ondrea Gill, Chief, Branch of Coverage and Classification, PBGC, Room 5314, 2020 K Street NW., Washington, D.C. 20006, or may call Ms. Gill at (202) 254-4817, for information on pension protection under our insurance programs.

We hope this information is helpful to you.

Sincerely,

ROBERT E. NAGLE.
Executive Director.

ITEM 31. POSTAL SERVICE

JANUARY 12, 1981.

DEAR MR. CHAIRMAN: This responds to former Chairman Chiles' letters of October 30 and November 26, 1980, requesting information on Postal Service programs affecting the Nation's elderly.

The most significant postal contribution to senior citizens continues to be the existence of an effective, reliable universal postal system, one which operates with the needs of the people it serves in mind. Without such a system enabling the aged and infirm to carry on their family, social, and business activities, the daily lives of millions of Americans would be less enjoyable.

Special efforts are taken by the Postal Service to make the mails easily accessible to the elderly. One such effort is the stamps by mail program. Now in its ninth year of operation, this program enables the elderly to order stamps and stamped envelopes with postage-paid forms. By enclosing a check, including a 40-cent handling fee, the customer receives the order by mail within 3 days. Another service which helps the elderly and others who find it difficult to get to the post office is the consumer service card program, which allows customers to handle problems by mail. Furnished by mail carriers, these cards alert Postal Service headquarters, as well as the local post offices, to customer complaints or requests concerning mail delivery or other services.

In seeking to prevent the mails from being used by unscrupulous operators, the Postal Service performs its second most important service to the elderly. Because they live alone and often have a reduced ability to protect themselves, senior citizens are often perceived to be easy targets by those who seek to use the mails to carry out fraudulent schemes. There are several types of fraudulent promotions, including work-at-home, medical, investment, and insurance schemes, which by their nature tend to focus on senior citizens. Since most elderly Americans live on fixed incomes, senior citizens are most severely hurt by these schemes. Brief summaries of some of the more common schemes which prey upon the elderly are enclosed.

In order to help prevent schemes such as these from succeeding, the Postal Service in 1979 implemented a consumer protection program. Specially trained postal inspectors from the Postal Inspection Service, assigned to major metropolitan areas, are responsible for working with the media, consumer protection groups, investigative agencies, and community groups such as the American Association of Retired Persons to alert the elderly and other consumers to the dangers of fraudulent promotions.

Despite the existence of such preventive efforts, the number and variety of mail fraud schemes insure that some people will continue to become victims of unscrupulous promotions. To deal with this, the Postal Service utilizes two important laws. One of these, the criminal mail fraud statute, 18 U.S.C. § 1341, is the oldest and perhaps the most important consumer protection law. It provides penalties of up to 5 years in prison and a $1,000 fine for the use of the mails

to further any fraudulent scheme. The civil false representation statute enables the Postal Service, after a hearing, to stop the delivery of mail to an address found to be used for a "scheme or device for obtaining money or property through the means of false representations." 39 U.S.C. § 3005. Pending action on the mail stop order, the Postal Service is authorized to go to court to get a temporary restraining order against a person suspected of a violation. The stop order can be an effective way to put some fraudulent schemes out of business short of criminal prosecution.

In addition to protecting the economic well-being of the elderly, the Postal Service continues to help preserve their physical well-being through the "Postal Alert" or "Operation Alert" program. Under this program, which consists of a partnership effort between the Postal Service and local community groups or agencies, letter carriers keep a special watch on mail delivery boxes marked with a bright red or orange sticker given to customers registered in the program. If mail is not picked up from the mailbox in a reasonable time, the Postal Service notifies the participating civic group which then calls a friend or relative who has agreed to follow up in the event of such a warning sign.

In conclusion, I would like to stress again the Postal Service's commitment to helping the Nation's senior citizens. I hope they will continue to take advantage of the special programs we have developed for their benefit. In particular, I hope the elderly, as well as all consumers, will carefully evaluate an offer before purchasing a product or service by mail. If they feel that they have become a victim of a fraud carried out through the mails, they should immediately contact a responsible postal employee. We are here to help them and will assist them in every way possible.

Sincerely,

WILLIAM F. BOLGER.

Enclosure.

DESCRIPTION OF FRAUDULENT SCHEMES

INVESTMENT SCHEMES

Fraudulent schemes soliciting investments in franchises, distributorships, coins, gems, stock, and land have a severe effect on senior citizens seeking to protect their savings from rising inflation. One swindle, typical of investment schemes, was carried out by a Missouri corporation doing business under the name of Progressive Farmers Association (PFA). The stated purpose of the organization was to raise working capital for a new type of cooperative which would bring farmers and consumers together, eliminate the middleman, and result in lower food prices. Six thousand individuals, the majority of whom were retired or semiretired farmers, invested $12 million in PFA before it filed for bankruptcy in 1977. After a 10-month trial, the founder of the corporation and 12 other defendants were found guilty of 175 counts of mail fraud and other violations in August 1980.

INSURANCE SCHEMES

The exploitation of the fears of the elderly with regard to health insurance is another area of concern for the Postal Service. The perpetrators of one such scheme, who were recently successfully prosecuted, defrauded 100 elderly women in Massachusetts and Connecticut. They did this by overcharging for insurance premiums, falsifying health histories, selling life insurance under the pretext of health insurance and duplicating insurance coverage. In one case, maternity insurance was sold to a 93-year-old woman. Some of the victims, who ranged in age from 64 to 95, were paying between $6,000 and $9,000 a year in insurance premiums.

MEDICAL FRAUD

Faced with the ailments of advancing age and rising medical costs, many of the Nation's senior citizens become susceptible to medical quackery schemes. These schemes typically involve allegations that a proffered product can cure such conditions as arthritis, cancer, baldness, obesity, prostatic hypertrophy, sexual dysfunction, or some other degenerative condition. Such false claims have caused the Postal Inspection Service to take action to end approximately 130 medical promotions in the past year.

WORK-AT HOME SCHEMES

With prices consistently on the rise, many older citizens who live on fixed incomes are attempting to augment their incomes by seeking part-time work. Unfortunately, many are attracted to fraudulent work-at-home schemes. For an initial application fee, victims are assured they will be able to earn great sums of money by stuffing envelopes at home or making some simple product, which the promoter promises to purchase. Naturally, once the initial fee is sent, victims never hear from the promoter.

In June 1980, the Postal Service issued a brochure designed to warn people not to get involved in work-at-home schemes. This pamphlet enlists the aid of potential victims by asking consumers to notify the Inspection Service of any suspicious advertisements. To date, approximately 150 responses are being received each week. Hundreds of such schemes have been put out of business through false representation orders or consent agreements.

ITEM 32. RAILROAD RETIREMENT BOARD

JANUARY 6, 1981.

DEAR MR. CHAIRMAN: In response to your letters of October 30, 1980, and November 26, 1980, I am pleased to enclose a statement summarizing major activities of the U.S. Railroad Retirement Board on aging during fiscal 1980. I have also included information on significant legal decisions affecting the elderly under the Board's programs.

I look forward to your committee's 1980 report on developments in aging.

Sincerely yours,

R. F. BUTLER,
Secretary, for the Board.

Enclosures.

U.S. RAILROAD RETIREMENT BOARD

The U.S. Railroad Retirement Board is the Federal agency that administers a comprehensive social insurance and staff retirement system for railroad workers and their families, separate from, but closely coordinated with, the social security system. Programs administered by the Board include the following: (1) old-age, survivor and disability benefits under the Railroad Retirement Act; and (2) unemployment and sickness insurance benefits under the Railroad Unemployment Insurance Act. The Board also performs certain administrative services under the Federal health insurance (medicare) program with respect to aged and disabled railroad workers and eligible members of their families. In addition, the Board has administrative responsibility for certain employee protection measures provided by other Federal railroad legislation, such as the Regional Rail Reorganization Act, the Milwaukee Railroad Restructuring Act and the Rock Island Railroad Transition and Employee Assistance Act.

BENEFITS AND BENEFICIARIES

During fiscal 1980, benefit payments under the railroad retirement and railroad unemployment insurance programs totaled $4.9 billion. Retirement and survivor benefit payments amounted to $4.7 billion, an increase of $456 million over the same period one year earlier. Unemployment and sickness benefit payments totaled $212.3 million, an increase of $70.3 million from the preceding fiscal year.

The number of beneficiaries on the retirement-survivor rolls on September 30, 1980 totaled 1,006,000. The vast majority (80 percent) were age 65 or older. At the end of the fiscal year, 451,000 retired employees were being paid a regular annuity averaging $516, about $64 higher than a year earlier. In addition, 188,000 of these employees were being paid a supplemental railroad retirement annuity averaging $53. Nearly 234,000 spouses of retired employees were receiving an average annuity of $236 at the end of fiscal 1980. Of the 330,000 survivors on the rolls, over 290,000 were aged widow(er)s receiving an average annuity of $361. Some 866,000 individuals who were receiving or were eligible to receive monthly benefits under the Railroad Retirement Act were covered by hospital in-

surance under the medicare program at the end of fiscal 1980. Of these, 848,000 (98 percent) were also enrolled for supplemental medical insurance.

Unemployment and sickness benefits under the Railroad Unemployment Insurance Act were paid to 178,600 railroad employees during the fiscal year. However, only about $0.7 million (less than 1 percent) of the benefits went to individuals age 65 or older.

RAILROAD RETIREMENT LEGISLATION

A primary goal of the Board during recent years has been the passage of legislation which would insure the long-range actuarial soundness of the railroad retirement system.

Actuarial valuations of the railroad retirement system in 1976 and 1979 indicated long-term financing problems, as well as cash-flow problems in the 1980's. Recent projections, taking into account current economic conditions, indicate that the system faces cashflow problems in 1983 unless corrective legislation is enacted in the meantime.

The Board has thoroughly documented these financial conditions and carried on extensive educational activities so as to make all of the concerned parties—railway management, labor, Congress and the administration—fully aware of the extent of the system's financial problems and the necessity for resolving them within certain time frames. In order to expedite legislative assistance, the Board, which is headquartered in Chicago, Ill., established a legislative counsel's office in Washington, D.C., during 1979.

President Carter signed into law in December 1980 a bill directing railroad management and labor representatives to present joint recommendations to Congress for resolving the railroad retirement system's financing problems. Section 2 of the bill H.R. 8195 provides that "No later than March 1, 1981, representatives of employees and representatives of carriers, acting through a group designated by them, shall submit to the Senate Committee on Labor and Human Resources and the House of Representatives Committee on Interstate and Foreign Commerce a report containing their joint recommendations for further restructuring of the railroad retirement system in a manner which will assure the long-term actuarial soundness of such system."

The bill also extends—into 1981 a schedule of cost-of-living increases payable on July 1, which are equal to 32.5 percent of the annual increase in the Consumer Price Index. This increase is applied to the tier II portion of employee and spouse annuities. The tier I portion, which is the equivalent of a social security benefit, and both tiers of survivor annuities increase automatically by 100 percent of annual increases in the Consumer Price Index, without legislation.

MAJOR RAILROAD RETIREMENT COURT DECISIONS

A December 1980 Supreme Court decision in a class-action suit, *U.S. Railroad Retirement Board* v. *Fritz*, upheld certain dual benefit provisions of the 1974 Railroad Retirement Act. The act's dual benefit vesting requirements, which have been in effect since January 1975, consequently remain unchanged. This class-action suit had sought revisions in the vesting requirements so as to provide additional benefits to some of the persons with coverage under both the railroad retirement and social security systems.

The 1974 act coordinated railroad retirement and social security benefit payments so as to eliminate certain duplications, or windfalls, allowed under previous law. However, the act provides a dual benefit windfall payment for those retired before 1975, and for future retirees who were qualified for both benefits before 1975 and meet certain vesting requirements. These vesting requirements call for (1) rail service in 1974, (2) 25 years of rail service by the end of 1974, (3) a current connection with the rail industry in 1974 or at retirement, or (4) being insured for dual benefits before leaving the rail industry prior to 1974.

The class-action suit had maintained that dual benefit windfall payments should be provided for future retirees qualified for both benefits before 1975, without regard to the additional vesting requirements.

The case of *Gebbie et al.* v. *Railroad Retirement Board* was brought before the U.S. Court of Appeals for the Seventh Circuit on a petition for review of a decision by the Board denying petitioners dual benefit windfall payments under the Railroad Retirement Act of 1974.

The plaintiffs, who are retired railroad employees, began receiving auxiliary benefits under the Social Security Act in 1977, in accordance with the 1977 *Califano* v. *Goldfarb* Supreme Court decision and related cases, which held the dependency requirement for widowers' and male spouses' benefits to be unconstitutional. The Board ruled that they were not also entitled to dual benefit windfall payments because nondependent widowers and husbands were not entitled to social security benefits as of December 31, 1974, which was one of the requirements for windfall payments.

In September 1980, the Court reversed the Board's decision and held that the Board had misinterpreted the Railroad Retirement Act in denying the claimed benefits to the petitioners. The case has been submitted to the Solicitor General for a determination as to whether a Petition for a Writ of Certiorari should be filed with the Supreme Court of the United States.

INFORMATIONAL PROGRAMS

Informational conferences for railroad labor union officials are an integral part of the Board's public information program. At these conferences, Board representatives describe and discuss the benefits available under all the Board's programs. Through these conferences, the Board saves the thousands of manhours which would otherwise be required to explain the Board's programs on an individual basis.

Seminars for railroad executives and managers are also conducted by the Board. These meetings are designed to facilitate communications and cooperation between railroads and the Board, as well as acquaint railroad officials with the Board and its programs. At these meetings, Board representatives review the Board's benefit programs, administration and financing, with special attention devoted to those areas in which both the Board and the railroads gain from better coordination.

ARTICLES

The Board's periodical, The RRB Quarterly Review, regularly publishes statistical information and articles on retired employees, their spouses and survivors. During fiscal 1980, the following articles relating to aging were published in the periodical: "Five-Year Experience Under 60/30 [Retirement] Provisions"; "Retirement and Survivor Benefit Operations"; "Legislative and Administrative Developments"; "A Brief Review of 1978–79 [Financial Operations]"; "Legal Rulings"; "Ages of Survivor Annuitants"; and "Characteristics of Employee and Spouse Annuities."

BOARD ASSISTANCE IN UNIVERSITY HEALTH STUDIES

During fiscal 1980, the Board compiled data from its records for a Harvard Medical School research study, funded by the Environmental Protection Agency, on the health effects of diesel exhaust emissions. The Board has also rendered assistance, since 1957, to an ongoing study on heart disease conducted by the University of Minnesota School of Public Health.

ADMINISTRATIVE IMPROVEMENTS

The Board has begun a benefit accuracy study to increase efficiency and improve service to the railroad public by identifying and correcting recurring claims processing problems. Also, the Board and the Treasury Department began processing nonreceipt of check reports and photocopy requests by a magnetic tape exchange, so as to expedite payment of replacement checks in many cases.

The Board has instituted various internal administrative improvements to increase efficiency. In December 1979, the Board initiated a management improvement study to promote more efficient, effective and economic operations of the agency. By implementing some of the recommendations in the study, the backlog of retirement and survivor appeals cases on hand declined from 312 to 224 over the fiscal year, and organizational changes were made in computer operations. The Board also increased its internal audit staff and developed a comprehensive audit plan.

An automated folder control system was put into operation in 1979, with a marked reduction in the number of misplaced folders and related processing problems. Improvements in computer facilities and operations include a back-up computer system, a new direct access storage system and a formal implementation plan identifying security measures the Board can take to reduce the vulnerabilities of its computer records system at a minimum cost.

Other improvements during the 1980 fiscal year included (1) significant progress in reviewing and revising the Board's regulations into clear and simple English, (2) reducing the public information reporting burden by approximately 4,000 hours and (3) the initiation of a pre-retirement counseling program for the Board's own employees.

ITEM 33. SMALL BUSINESS ADMINISTRATION

JANUARY 16, 1981.

DEAR MR. CHAIRMAN: This is in reply to Senator Chiles' request for information on programs for the aging for the Senate Special Committee on Aging's annual report, "Developments in Aging."

During the past year, the Small Business Administration has been very active in promoting programs of interest to the Aging.

In September 1980, our Offices of Advocacy, Management Assistance, and Financial Assistance sponsored a "Conference on Small Business and Senior Citizens: Entrepreneurship, Consulting, and Employment." A copy of the conference announcement is enclosed.[1]

In October 1980, the Small Business Administration Hartford, Conn. District Office joined with the Connecticut State Department of Economic Development, the Connecticut Business and Industry Association, the Chamber of Commerce regional and local organizations, and the State of Connecticut Job Service agencies in supporting the State of Connecticut Department on Aging sponsored "Employment Information Seminar on Older Workers." This seminar was scheduled to assist small business employers to identify, recruit, and effectively utilize abilities of workers over age 55. A copy of the announcement of the seminar is enclosed.[1]

Additionally, SBA's involvement with the problems of the aging has been strengthened by our designating a member of our staff to represent the Small Business Administration on the Interdepartmental Task Force on Statistics on Aging and to assist the Administration on Aging to update their "Inventory on Federal Statistical Programs Relating to Older Persons." We have also designated our representative on the Interdepartmental Task Force to serve as the SBA liaison to the White House Conference on Aging.

The Civil Rights Compliance Division of the Small Business Administration's Office of Equal Employment Opportunity and Compliance assures nondiscrimination on the part of SBA program offices as well as recipients of financial assistance. Complaints of discrimination under the Age Discrimination Act are sent to the Federal Mediation and Conciliation Service for mediation prior to investigation of the complaints.

SBA continues to actively enforce regulation B (12 CFR 202) of the Federal Reserve System and its own requirements under the Equal Credit Opportunity Act, as amended. During fiscal year 1980, SBA monitored 27,619 recipients for nondiscrimination, including compliance with the Equal Credit Opportunity Act's prohibition against discrimination on the basis of age.

In 1964, the Small Business Administration established a volunteer program called the Service Corps of Retired Executives (SCORE). The objective of this program is to provide management assistance service to the small business community. SCORE is comprised of volunteers retired from the active business world who have had a lifetime of business experience and are willing to share this knowledge and experience with others. SCORE provides a business person-to-business person advisory relationship. In addition to the invaluable service that is derived by the small business owner/operator, there is an added benefit to the volunteers. SCORE members know that their aid is needed and their participation provides the retired volunteers with a sense of satisfaction for contributing his or her knowledge to help others.

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[1] Retained in committee files.

SCORE volunteers have counseled over 900,000 small businesses since 1964 and the organization has grown from the initial 1,000 members to its current membership level of 8,000 organized into 380 chapters located throughout the United States. In fiscal year 1980 SCORE volunteers counseled over 150,000 small business owner/operators.

Sincerely,

A. VERNON WEAVER, *Administrator.*

ITEM 34. VETERANS ADMINISTRATION

JANUARY 14, 1981.

DEAR MR. CHAIRMAN: In response to your request of October 30, 1980, I am pleased to forward the enclosed report on the Veterans Administration activities relating to developments in aging for the year 1980.

As you know, this agency has a significant interest in our aging population. Over 2.9 million of the more than 30 million veterans in this country are 65 years of age or older, and more than one-half of all veterans have passed their 47th birthday.

The magnitude of our activity is indicated by the fact that currently the VA provides all or part of the income of more than 1.6 million persons age 65 and over. Also, on a "typical" day in the VA-supported inpatient facilities (i.e., hospitals, nursing homes, and domiciliaries) more than 35 percent of our inpatients, about 37,500 veterans, are age 65 and over.

I hope the enclosed information will be helpful to the committee. Please let us know if we can provide any further aid.

Sincerely,

RUFUS H. WILSON,
Deputy Administrator.

Enclosure.

1. INTRODUCTION

Aging brings with it an increase in the need for acute medical care, outpatient treatment, and many extended nonhospital modes of care such as nursing home, domiciliary, hospital based home care and day care. More VA medical program resources are going to the aging veteran. In 1980 approximately 30 percent of all of the resources—hospital, outpatient, and extended care—went to veterans who are 65 and over. In 1990 the proportion will be about 40 percent.

Extended care bridges full hospital care and independent living with a diversity of programs. The VA had about 51,000 veterans in extended care programs on a typical day in fiscal year 1980, some 45 percent of whom were 65 and over. The increasing number and diversity of extended care programs in the VA parallels that in the Nation.

The VA program for extended care and aging in the 1980's revolves around four major objectives for this area. The first is to improve the quality of care and life for patients of all ages in VA. The second is to improve the utilization of the specific VA programs and their management through lower costs associated with improved staffing, management, patient selection and by the development of alternatives to existing programs. The third is to increase the number of extended care facilities and to improve existing ones. The fourth, which cuts across all of the others, is to provide the Nation with model programs of long-term care, trained personnel in geriatrics and gerontology, and substantial amounts of research in basic and applied gerontology. Education and training are intimately involved in all of these objectives.

2. EXTENDED CARE PROGRAMS

VA NURSING HOME CARE

This program is designed for veterans who are not acutely ill or in need of hospital care, but who require skilled nursing care and related medical services. Typically, a veteran admitted to VA nursing home care is chronically ill, has a permanent or residual disability, is expected to require a long period of nursing supervision, observation and care, and requires special efforts of a long-term rehabilitative nature. All the services required for the comprehensive care of a

veteran in the nursing care unit are available through the resources of the medical center. Nursing home bed increases occurred during the year through replacement of units in Columbia, S.C.; Hampton, Va.; and Miami, Fla. During 1980. there were nursing home care units at 92 VA medical centers with 8,394 average operating beds and an average daily census of 7,933. The number of patients treated was 12,750.

COMMUNITY NURSING HOME CARE

This program is designed for veterans who are not acutely ill and not in need of hospital care, but who require nursing home care and related health care services. The primary purpose of this program is to aid the veteran and his family in making the transition from a hospital to the community by providing time to marshal resources for the veteran's continuing care. Participating facilities are assessed by VA personnel prior to approval and no less than every 2 years thereafter. Followup visits are provided to the veteran in the nursing home by the hospital social worker, nurse, and other members of the treatment team. Under this program, non-service-connected veterans may be placed in community facilities at VA expense for a period not to exceed 6 months. Veterans requiring nursing home care for a service-connected condition may be placed at VA expense for as long as the nursing care need exists.

As of September 30, 1980, 2,979 nursing homes were under contract with the agency, 1,187 of which were skilled homes and 1,792 of which were intermediate care facilities or combined skilled and intermediate care facilities. A total of 28,536 veterans were served by this program during fiscal year 1980 with an average daily census of 8,529.

HOSPITAL BASED HOME CARE

This program allows for an early discharge of veterans with chronic illness to their own homes and reduces readmissions to the hospital. The family provides the necessary personal care under coordinated supervision of a hospital based multidisciplinary treatment team. The team provides the medical, nursing, social, rehabilitation, and dietetic regimens as well as the training of family members and the patient. Thirty VA medical centers are providing hospital based home care services. More acute care beds in hospitals are made available by providing increased days of care in the home.

VA DOMICILIARY CARE

The VA domiciliary program is designed to provide necessary medical treatment and comprehensive professional care for eligible ambulatory veterans in a residential-type setting. The program is directed toward those veterans who are disabled by age, disease, or injury and are in need of care, but do not require hospitalization or the skilled nursing services of a nursing home. To be entitled to domiciliary care, the veteran's disability must be chronic in nature. The veteran must also be incapacitated from earning a living and meet an income limitation criterion.

In fiscal year 1980 the 16 domiciliaries operated 9,217 (average) beds with an average daily census of 7,894. The number of patients treated was 15,180.

New program directions were implemented during the year to create a better quality of life for veterans requiring prolonged domiciliary care and to prepare veterans returning to community living for active participation in various community resources. A survey was initiated during fiscal year 1980 to obtain information about the personal characteristics of domiciliary patients. Survey data will be analyzed and a report prepared during this fiscal year and will be used to further develop and refine domiciliary policies and program directives.

The replacement domiciliary at the VA medical center in Wood, Wis., the first new domiciliary facility since 1953, was activated during fiscal year 1980. A feasibility study was approved by the Office of Management and Budget for the use of instruments to assess change in patients moving from the old to the new facility. The study was initiated and is in process.

Construction is in process on replacement domiciliary facilities at the VA medical centers in Dayton, Ohio; Bay Pines, Fla.; and Martinsburg, W. Va. Activation of these facilities is expected during fiscal year 1981.

PERSONAL CARE HOMES

This program provides personal care and supervision in a homelike setting in the community for veterans who have no homes or whose homes do not provide the care they need. The veteran pays for his care, usually out of the combination of VA pension, supplemental security income, and/or social security disability payments. All veterans with sufficient funds may utilize this service. Homes vary in size from those accommodating 1 veteran in a family setting to homes accommodating 20 or more veterans. Homes are periodically inspected by an interdisciplinary team from the nearest VA hospital. Regular followup visits to the homes are made by members of the VA hospital staff. The social worker is the most frequent visitor, working with relationships between sponsor and veteran, veteran and family, and veteran and the community.

STATE HOME PROGRAM

The State home program has grown from 11 homes in 11 States in 1888 to 43 State homes (one of which has two annexes) in 31 States and the District of Columbia. Currently a total of 16,760 beds are authorized to provide hospital, nursing home, and domiciliary care. The VA relationship to State veterans' homes is based upon two grant programs. One is a per diem program which enables the VA to assist the States in providing care that meets modern standards of quality to veterans requiring domiciliary, nursing home, and hospital care. The other grant program provides VA assistance with 65 percent Federal funding in the construction of new domiciliary and nursing home care facilities, and the expansion and remodeling of existing facilities. The State home per diem program is administered through VA medical facilities which reimburse the States on a quarterly basis. The construction program is administered by central office.

Since the enactment of Public Laws 88–450 in 1964 and 91–178 in 1969, VA grants have been utilized by 31 States.

In 1980 Arkansas established its first State home consisting of 150 domiciliary beds. In addition, new construction resulted in the addition of a 75-bed nursing home at Erie, Pa.; a 51-bed domiciliary at Lisbon, N. Dak.; and an 80-bed nursing home and 10 additional domiciliary beds at Boise, Idaho. The VA also obligated funds in fiscal year 1980 totaling over $8 million in support of constructing an additional 200 nursing home care beds and 60 domiciliary beds. During fiscal year 1980, the average daily census in State veterans' homes was 5,584 nursing home care, 4,888 domiciliary, and 929 hospital patients.

GERIATRIC RESEARCH, EDUCATION, AND CLINICAL CENTERS (GRECC'S)

The GRECC program consists of eight centers and represents another aspect of the multifaceted VA response to the health care needs of aging veterans. It serves as a mechanism for attracting and developing superior staff into the field of gerontology and geriatrics. GRECC activities have been directed toward utilizing and redirecting existing resources for geriatric care and advancing into the VA system clinical research and educational achievement in geriatrics and gerontology. As a part of the program, GRECC's have been developing geriatric evaluation units, usually of 10 to 30 beds, for intensive diagnosis and therapy. Four GRECC's have instituted evaluation units with a broad base in general internal medicine.

Each center typically emphasizes one area of research relevant to aging. For example, one has developed a cardiopulmonary function evaluation unit, and three others, all with neuropsychiatric orientation, are focusing on chronic neurological diseases and organic dementias. GRECC professionals have published or presented over 300 scientific papers. GRECC centers have reported the award of $4.5 million in research funds since the beginning of the program in fiscal year 1975. Over $1.1 million was awarded from the VA through the merit review process in fiscal year 1980. Since fiscal year 1975 the GRECC's have also received awards of more than $3 million from other Federal agencies and private foundations. A formal evaluation of the GRECC program was completed in fiscal year 1980 with site visits made to all of the centers. The site visit team concluded that the GRECC's are making impressive studies in the field of geriatrics and are altering negative perceptions regarding geriatrics in their institutions and communities.

INFORMATION AND REFERRAL PROGRAM

To minimize duplication of effort and to promote efficient use of resources, the VA is actively participating in coordinative endeavors with other Federal agencies on behalf of elderly veterans to provide information and referral services.

During the past year, information and referral liaison representatives from VA medical centers and regional offices continued their liaison with the area agencies on aging (AAA's) within their various jurisdictions. Service to the AAA's is provided in varying degrees depending upon their responses to the VA offer to provide service. Many AAA's are visited regularly; all others are served on an oncall basis. Personnel from the Department of Veterans Benefits have conducted veterans benefits training seminars for AAA's intake counselors in more areas during 1980.

3. Medical Service

The Veterans Administration Central Office Medical Service and the medical services in Veterans Administration medical centers continued to pursue their goal of improving the overall quality of medical care provided veterans during 1980. Once again a large share of these efforts addressed the needs of the aging veterans since this group of patients constitute a significant portion of our patient population both in terms of numbers and professional challenges.

In addition to this general medical interest in the aged patient, several more specific activities in this area were carried out during 1980. The VA has developed policies and procedures for surveillance of patients who have had cardiac pacemakers implanted and a cardiac pacemaker registry has been established. A large proportion of these patients are in older age groups. Two VA medical centers are continuing to survey aging veterans with high systolic blood pressures. This survey will measure mentation in patients on and off treatment. The recently established centers for handling rheumatology-immunology and cardiopulmonary rehabilitation problems continued their growth and development during 1980 with obvious impact on the care of the aging veteran. Medical Service is also collaborating with other professional services to improve clinical nutrition care in the VA system. The potential significance of improved nutrition for aging patients in promoting better quality of life and quality of care is great. It is recognized that the aged and those with degenerative diseases associated with aging are at high risk of developing certain infections. Vaccines are available to prevent influenza and pneumococcal disease and these vaccines are offered to aged veterans in VA medical centers, OPC's, and nursing homes according to nationally accepted recommendations.

4. Mental Health and Behavioral Sciences Service

A focus on the mental health of the aging veteran is an important facet of the VA health care program. The Veterans Administration facilities for the care of older veterans are principally in the extended care programs, the Medical Service and the Psychiatry Service. Many of the patients in the intermediate medical care and the extended care facilities have a psychiatric diagnosis as well as that of some physical disability. On a given day the Medical Service in extended hospital care has about 10,500 patients (about 50 percent of these also contain a psychiatric diagnosis). Of this group 51 percent are 65 years or over and it should also be noted that some of the extended care programs report increasing numbers of admissions for long-term medical care directly from the community and not as transfers from one of the VA medical center wards or clinics.

Of the patients with a psychiatric diagnosis who are age 65 years and older, 76 percent are on a psychiatric ward and 24 percent are on other wards, principally medicine. Many other psychiatric patients are in VA and community nursing home facilities, VA domiciliaries, and residential care homes.

The Veterans Administration supports, through its research program, research on problems in long-term psychiatric disease such as senile dementia and alcoholism, as well as other diseases common among aging individuals.

Psychogeriatric programs are conducted at the VA medical centers in both Little Rock, Ark.; Lyons, N.J.; Northport, N.Y.; and Salisbury, N.C. Many others have units specializing in psychogeriatrics. A large number of aging patients are in various types of community based care. It is believed that some of these pa-

tients will make a better adjustment in the community and many show some improvements in their physical and mental state if kept physically and mentally active. To serve some of these patients geriatric day care programs at VA medical centers in Palo Alto, Calif.; North Chicago, Ill.; Boston (outpatient clinic), Mass.; and Loma Linda, Calif. This number is expected to increase as staff and support become available.

5. Social Work Service

The development of community outreach services to an elderly high-risk veteran population received continuing emphasis in Social Work Service during fiscal year 1980. Although budgetary constraints have been and will continue to affect allocation of resources to this program area, a number of medical centers have been able to maximize the use of scarce professional resources through the initiation of interdisciplinary assessment models tasked with developing a profile of the elderly veteran who is most likely to require social work intervention as a condition of comprehensive health care planning. Factors such as income, severity of illness, and availability of family or "significant other" support systems have been critical elements in identifying those patients most in need of social assessment and discharge planning assistance.

Considerations related to quality of life of our aging veteran population have led to the initiation of intergenerational group experiences involving veterans and young people heretofore unfamiliar with the impact of major social, economic, or cultural influences on the day-to-day existence of those who experienced the events. Hours that might have been spent in superficial activities were thus utilized to enrich the lives of both teachers and students through a productive interchange of ideas between the young and old. Foster grandparent programs have emerged in selected domiciliary settings whereby title XX funds are provided veteran residents who provide companionship or other assistance to needy young people in the community. This has the effect of reducing isolation between the age groups and between the VA and community settings.

During fiscal year 1980 social workers provided placement and followup services to over 67,000 veterans in approved community settings. Approximately 4,700 veterans were placed directly from the community in VA approved nursing homes, residential care homes, and other community facilities. Over 3,100 veterans discharged from community nursing homes were assisted in returning to their homes following a period of VA approved care.

Recognizing that access to a continuum of care is essential to the medical and emotional well-being of the elderly, selected medical centers have initiated inpatient training units to prepare the at-risk elderly for reentry into community living. Such centers also provide a multidisciplinary training base for the health care disciplines through the provision of a team-oriented approach to the assessment of needs and the development of appropriate aftercare services for a patient population.

A number of American Legion posts are hosting adult day care or senior center type activities for elderly veterans in need of supportive services of a preventative and maintenance nature. In one center community agencies have been mobilized to assume a major responsibility for the continuing operation of the program which has permitted Social Work Service and other disciplines to effect a planned withdrawal from the program as primary service providers. The movement of the program from a hospital to a community base not only reduces the required investment of VA staff time but also facilitates the development of a broader base of community support for an expanding program of services to the elderly.

Long-term care patients with potential for independent living are being assisted by social workers to move from structured residential care settings to apartments where, with staff consultation, they will be in charge of their own affairs. Although movement from dependence to a more independent lifestyle requires a significant investment of social work manpower, we believe the benefits achieved in terms of improved quality of life for our older veterans will more than offset the investment required.

The development and coordination of information and referral services and the appointment of liaison staff with areawide agencies on aging at all VA medical centers have facilitated the delivery of services to older veterans. Continuing emphasis on interagency communication has encouraged the development of a more efficient network of services to meet the needs of the elderly.

6. Rehabilitation Medicine Service

The highlight of Rehabilitation Medicine Service's (RMS) involvement in the rehabilitation of the aging veteran in fiscal year 1980 was the May conference in San Antonio, Tex., on this specific theme. A multidisciplinary mix of RMS therapists and physicians from 17 States met to assess the needs of the geriatric veteran to determine what rehabilitation expertise and programing should be incorporated in health care programs throughout the VA system. Speakers from the National Council on Aging, the University of Texas at San Antonio and the VA medical center in San Antonio, discussed attitudes, physiology of aging, and needs of this particular population. A summary report of this conference is planned for distribution to all VA health care facilities to reflect the discussions and recommendations of this conference group. VA–RMS representatives were also an active part of the Third Annual Conference on Aging and Health cosponsored by the University of Virginia School of Medicine and the VA medical center in Salem, Va. This September 1980 conference focused on "coping and caring" for the aging population in their own communities.

RMS has been actively involved in the planning of the new "degenerative and debilitating disease rehabilitation center" in Camden, N.J. Special programs in activities of daily living will be included in this facility to help focus on the needs of the aging hospitalized veteran. New initiatives being planned in Rehabilitation Medicine Service involve the creation of independent living activities programs which will be geared to making the transition between hospital and community a successful venture. Additional plans call for adding compensated work therapy (CWT) programs to the 16 VA domiciliary programs. These CWT's are work programs which involve the patient residents actually working on projects through contracts with community businesses. Further efforts are currently underway to add rehabilitation staffing to the existing VA geriatric research, education, and clinical centers (GRECC's) to utilize the skills and techniques which have previously been developed in these specialized centers.

While all of the above activities have demonstrated relatively new initiatives for RMS in geriatric care, it must be emphasized that, VA-wide, a continuum of programs are in effect and have been reported on in previous documents such as this. One medical center continues the cooperative efforts between the nursing home care program and the local elementary school class. Another center has constructed motorized "go-carts" for use by the older in-hospital patients. Many VA medical center rehabilitation medicine programs are utilizing sensory integration dysfunction techniques for the longer term population; cardiopulmonary and rheumatology rehabilitation programs, and amputee rehabilitation techniques. Physical conditioning and fitness routines for the elderly inpatient have been both beneficial to the patient as well as for nursing staff since exercise oftentimes reduces or delays total bed care needs.

Rehabilitation Medicine Service is committed to becoming even further involved in the planning and implementing of future rehabilitation and followup programs for the geriatric population in the VA health care system. Hopefully, these programs can be used as models for the entire Nation to follow or duplicate in the years ahead.

7. Nursing Service

Nursing care to the elderly veteran is a critical part of the Nursing Service mission and is viewed as comprising the majority of the health services required by this age group. Throughout the year, workshops have been held at five regional medical education centers (RMEC's) to involve nurses from field stations in implementation of the standards of gerontologic nursing care. From these educational efforts, a goal of higher quality nursing care for the aged veteran is anticipated. Nurses have also participated as faculty and participants in RMEC seminars on clinical aspects of aging whenever they could be released from duty. Additional educational efforts are needed, but travel and educational funds for our nursing services are severely limited.

The need for improved community services to the aged veteran and his family still exists, as does the need for preventive care programs. The heavy involvement of nurse practitioner in ambulatory care and in the hospital based home care programs of the VA have helped to meet these needs, but these programs only scratch the surface. Nurses in the Sepulveda and Little Rock VA Geriatric Research, Education, and Clinical Centers (GRECC's) have engineered relationships

with local colleges of nursing for multidisciplinary team training in gerontology funded through the VA or the local university. The Wadsworth and Little Rock VA GRECC's accept masters and baccalaureate nursing students on their clinical units. It is hoped that these educational efforts with young students of all the health professions will enhance the ability of the VA to recruit qualified personnel for care of older veterans.

Nursing Service input was requested and given to the Department of Health and Human Services via the American Nurses Association in establishing the "Guidelines for Skilled Nursing and Intermediate Care Facilities." In addition, Nursing Service is responsible for identification of qualified nurses for the centralized position of supervisor, nursing home care unit. With the construction of new 200-bed nursing home care units, this position becomes as complex as the chief nurse position in some of our smaller hospitals. Executive development training for this group of nurses is a primary goal.

During this fiscal year, Nursing Service recruited and transferred to central office a full-time staff member with program responsibility for gerontologic and geriatric nursing concerns. Since August, this staff member has worked with Extended Care, Rehabilitation, Professional Services, Research, and Academic Affairs at central office to implement title III of Public Law 96–330 and to plan activities to enhance care to older veterans. This employee also testified at Senator Pryor's hearing on "Mental Health Needs of the Elderly" and was a delegate to the White House Miniconference on Mental Health in Aging. Numerous informal consultations have been offered to field stations and individual nurses. Site visits to the geriatric research, education, and clinical centers (GRECC's), as funds permit, have served as a management strategy to increase nursing contributions to these vital centers. Local universities are beginning to request services from this staff member as an occasional consultant or workshop faculty member. These efforts will enhance the ability of Nursing Service to recruit qualified nurses for positions in the VA and to share with others the innovations and programs for care of the elderly currently in progress or under development.

8. Dietetic Service

Nutrition is one facet of health care that impacts daily on the quality of life of older veterans in acute care, extended care, and community care settings. Qualified dietitians assure the accuracy of the prescribed diet provided for aged veterans in VA medical centers. These prescribed diets are translated into foods that are appealing and acceptable to the preference and physical limitations of older veterans and that are not contraindicated by their prescribed medications. Dietitians closely observe the eating habits and food consumed at mealtime by older veterans to assure their intake of a nutritionally adequate diet. The aging process and disease contribute directly to malnutrition. Therefore, dietitians in VA medical centers are particularly vigilant of older veterans' nutritional status. Nursing home care units and domiciliaries, where the resident population is largely older veterans, have dining areas where veterans take their meals rather than receiving a tray at bedside. The stimulation of social interaction at mealtime serves as a positive influence on these veterans' mental attitude and desire to eat.

In coordination with other members of the health team, dietitians help to prepare aged veterans to return to the community. Since many in this age group now live alone, nutrition education is an essential component of discharge planning, particularly for those on fixed incomes trying to cope with an inflationary economy. Meal planning, food budgeting, purchasing, and preparation, and selecting nutritious meals from restaurant menus are included in the counseling given by dietitians. The dietitians' followup in the community for aged veterans in the hospital based home care program and residential care program assures continuity of nutritional care. Family members, caregivers, and community home sponsors are also counseled concerning aged veterans' nutritional care needs to enable them to provide appropriate support.

There is much more to be learned about nutrition in aging. The changes in the older persons' capacity to use nutrients must be researched in order to determine the impact of nutrition in delaying the aging process and preventing the onset of degenerative diseases. As resources become available, dietitians must work with medical investigators to study the nutrition problems that are deteriorating the quality of life for the aged, the very population which is growing most rapidly among the entire country as well as among veterans.

9. Voluntary Service

The continuing commitment of older citizens to their volunteer involvement in Veterans Administration medical facilities was demonstrated dramatically in the 50th anniversary year of the agency. Twelve VA volunteers who have served veteran patients for 50 years or more and are still usefully active were located and received letters of appreciation from President Carter in April 1980. Their individual volunteer service records ranged as high as 67 years and their cumulative total of active involvement was nearly 700 years.

Another statistic useful in defining the commitment of the older volunteers in the average of 40 awards earned each year by the volunteers whose cumulative service has reached 20,000 hours.

These men and women are outstanding examples of thousands of older citizens whose volunteer work in the medical centers contributes to their physical, emotional, and mental well-being. Among the patient and family contact areas which these volunteers find most appealing are escorting patients between wards, clinics, and recreation areas, providing coffee, information, and reassurance to patients and families in admission areas and surgery waiting rooms. Because the already popular escort service has the added advantage of freeing professional and paraprofessional staff for other essential duties, the VA is encouraging its expansion.

The other aspect of VA volunteer involvement with older citizens follows naturally from the rising age level of the average veteran patient. The number of medical facilities with volunteers visiting elderly VA patients in community nursing homes continues to grow. In addition, volunteers are very positively involved in the palliative care, or hospice, programs for terminally ill patients. These carefully selected and trained volunteers are completely assimilated into the medical care teams whose mission is to ease the final weeks and days of the patients, many of them elderly, and lend support to their families.

10. Dentistry

In recognition of the ever increasing commitment that the Veterans Administration has in care of the aging, the Office of Dentistry has continued its emphasis on the preparation of VA dentists for their role in this effort.

As the direct result of an earlier workshop in geriatric dentistry held at VA Central Office in Washington, a needs assessment questionnaire has been developed to provide guidance for future education and training of VA dentists and auxiliary personnel in gerontology and care of the geriatric patient. Because of the overlap in interest and function, this thrust is going forth as a cooperative effort of the Offices of Dentistry, Extended Care, and Academic Affairs. The needs assessment instrument is currently being evaluated by selected consultants from outside the VA system.

Geriatric dentistry and dentistry's role in the care of the geriatric patient were agenda items and received special emphasis at a conference of 98 chiefs of Dental Service held in April 1980.

For a number of years dentists at the Boston VA Outpatient Clinic have been active participants in a long-term, nationwide normative aging study related to age changes in oral health and function. Two of these dentists were principal editors of a recently published book on geriatric dentistry that has received considerable attention and praise from gerontologists and members of the dental profession.

11. Medical Research Service

In 1976 23 million people in the United States (11 percent of the population) were 65 years of age or older, and this number is expected to reach 32 million (14 percent) in the year 2000 and perhaps 45–55 million (20–24 percent) by the year 2020. Moreover, the most rapid growth is expected to be among the extremely aged; that is, in the year 2000 there will be approximately 17 million individuals age 75 and over and 5 million who will be age 85 or older. This marked increase in the proportion of the aged in the population threatens to seriously weaken our capacity to provide care for the elderly through the traditional medical and social systems and, thus, necessitates the development of new methods of health maintenance and social support.

Research on both the medical and psychosocial problems of the elderly are required if the health and social welfare costs generated by this segment of the population are to be reduced. That is, if the physical and mental defects caused

by disease in the aged are diminished, the need for medical and social services will be decreased, and if the socioeconomic status of the elderly is maintained at acceptable levels it may be possible to prevent, stabilize, or partially reverse functional impairments frequently encountered in the aged, again lessening the need for government supported medical and social intervention.

The Veterans Administration has long emphasized the health and social needs of the aging veteran and, as a result, has given strong support to research on the biological, clinical, and psychosocial aspects of aging. These efforts have been manifested in the assignment of high priorities to research on the biology of aging and the development of innovative health care delivery systems. Some results of this research are as follows:

BASIC SCIENCE STUDIES

In the San Francisco VAMC antibodies to normal tissue components are found not uncommonly in the sera of elderly humans. Work with strains of mice which develop similar antibodies has revealed abnormalities of antibody forming cells, immune regulatory cells, scavenger cells, and deficiencies in thymic hormones which, in part, control immune responsiveness. It has also been found that male hormones suppress auto-antibody formation and estrogens enhance antibody formation.

In the San Diego VAMC a marked defect in the maturation of antibody-forming cells has been found in elderly humans.

At the Bedford VAMC an aged-related decrease in the number of dendrite spines (nerve input terminals) was demonstrated in rat brain Basket cells; no changes were noted in Purkinje cells. An aged-related increase in brain-reactive antibodies was found in both the mouse and monkey. The decreased ability of cells from old animals to synthesize new proteins has been found to be due, in part, to a decrease in the proportion of active assembly units, the ribosomes. Chemical studies on lipofuscin, a pigment found in the brains of humans with senile dementia, have shown no changes in proteolipid or basic protein content, but lipid analysis has increased amounts of p-ethanolamine, p-inositides and p-choline.

At the St. Louis VAMC aged rats were found to respond abnormally to calcium deprivation, to a large degree because of their diminished capacity to form the most active vitamin D molecule (i.e., to hydroxylate 25-hydrooxycholecalciferol).

At the Audi Murphy VAMC food restriction markedly increased the median life span of male rats and delayed the age-related increase in the serum concentrations of free fatty acid and cholesterol.

At the Shreveport VAMC the levels of two catecholamine neurotransmitters were found to be diminished in several areas of the brain in middle aged and old rats.

At Bay Pines VAMC the ability of the fruit fly to survive a standard stress was shown to diminish with age, and this was associated with a disorganization of certain temporarily controlled biological activities. Similar results were found in mice.

At the Long Beach VAMC the absorption of vitamin A was found to increase significantly with age in the rat, raising the possibility of similar changes in absorption of other fat soluable nutrients and drugs in the aged human.

At the Ann Arbor VAMC protein synthesis in the salivary glands of old rats was found to be 30 percent less than in young animals.

At the Sepulveda VAMC the frequency of an abnormal form of mitochondrial DNA was found to increase with age in two strains of mice and one rat strain; the highest concentrations were found in the brains of mice and the kidneys of the rat. Studies have demonstrated the appearance of abnormal accumulations of catecholamine neurotransmitters in the brains of old mice. An age-related decrease in myocardial responsiveness to catecholamine stimulation has been shown in the rat; this is thought to be due, in part, to a decrease in total and catecholamine-sensitive adenylate cyclase (second messenger systems).

At the Wadsworth VAMC regeneration of subsets of T-cells following sublethal irradiation is delayed and the pattern abnormal in middle aged and old mice. Loss of immunological vigor in old animals has been correlated with thymic involution. Chronic viral infection has been found to accelerate immunologic aging. A protein which binds IgG auto-antibodies has been detected on the membranes of old red blood cells, and it has been postulated that the binding of

the IgG by this protein triggers selective destruction of old red cells. A simple chemical, 2-mercaptoethanol, has been found effective in restoring impaired immune function in old mice. The bone loss seen in old mice can be prevented or partially reversed by transplants of young bone marrow cells. An age-related loss of marrow stem cells has been demonstrated in mice, and the cellular systems which regulate the rate and pattern of differentiation of these blood cell precursors were shown to be impaired. The maturation of antibody forming cells has been found to be impeded in old mice, in part secondary to impaired T-cell function.

At the Palo Alto VAMC glucose tolerance was shown to deteriorate with age in rats, and this was associated with an increase in circulating insulin. Resistance to the effects of insulin did not appear to increase with age in nonobese men. Plasma triglyceride levels increased with age in rats of both sexes, and this appeared to be caused by an age-related defect in the removal of the triglycerides from the blood. Pancreatic insulin was found to increase with age in the rat; however, the amount secreted following a standard stimulus decreased, perhaps because of a decrease in islet cell cAMP.

CLINICAL STUDIES

At the Minneapolis VAMC it was found that 38 percent of a group of demented elderly patients had potentially reversible causes for their intellectual deterioration; of these, approximately 50 percent improved with treatment. Studies on Parkinson's disease have provided evidence that the muscular rigidity is the result of disordered control in a particular long loop reflex pathway. This finding may provide a basis for more specific therapy of this disease.

At the Boston VA OPC cognitive functioning of the older patient was enhanced by increasing their perception of control with respect to their performance on learning tests. That is, perceived control increases motivation to learn and remember. Cross sectional and longitudinal studies indicated that there is relatively little age-related decline in short-term memory. However, a dramatic decline with age was demonstrated in the acquisition and retrieval of new information from long-term memory. Older patients who have functional memory disorders (not on an organic basis) were found to have difficulties with both motivation and distractibility.

At the Palo Alto VAMC long-term memory improved in six elderly subjects who were given very low doses of physostigmine intravenously in a double blind crossover study. Two other drugs appeared to have no effect on long-term memory.

At the American Lake VAMC normal elderly subjects were found to have mild disturbances of their sleep patterns similar to those observed in senile dementia of the Alzheimer's type.

At the St. Louis VAMC a cardiopulmonary rehabilitation program has drastically reduced hospitalization time for elderly patients with heart and lung disease. Other studies have suggested that anitcoagulation therapy in the acute phase of myocardial infarcation is not beneficial in reducing clot formation.

At the Sepulveda VAMC it has been found that older individuals have more difficulties in tasks requiring recurrent recognition or reproduction of visual or tactual designs but not of auditory patterns.

At the San Francisco VAMC EEG sleep studies performed on normal elderly subjects showed that age per se affects many aspects of brain wave activity. About 10 percent of this apparently normally functioning group was found to have on CAT scan (computer analyzed X-ray studies) a degree of brain atrophy consistent, by present criteria, with that found in dementia.

PSYCHOSOCIAL STUDIES

At the Miami VAMC self-assessed health was found to be more favorable in a group of elderly individuals expressing internal control of their life situation. and more restraints such as poor eyesight, loss of hearing, problems of memory. and needs for outside support were associated with those elderly who were controlled more by external factors. Since self-assessed health relates to level of functioning and to the way the elderly react to an illness, it can be a useful component in evaluation and a means by which behavior can be modified.

At the Columbia VAMC compensatory physiological changes were greater in elderly than in young subjects required to adapt to stresses of psychosocial testing.

At the Buffalo VAMC it was found that, contrary to conventional wisdom, an institution may provide an environment that facilitates and nourishes the self-esteem and satisfaction of a subset of the elderly (male VA domiciliary members).

12. Education

The Office of Academic Affairs continues to emphasize leadership in education and training in geriatrics throughout the Department of Medicine and Surgery. The importance of geriatric education is recognized each day in the increasing number of older veterans seeking care in VA medical centers.

In cooperation with the Offices of Extended Care and Professional Services, the thrust of the educational strategies has been directed toward health care providers, and has emanated from various VA resources, i.e., VA central office (VACO); regional medical education centers (RMEC's); geriatric research, education, and clinical centers (GRECC's); and individual health care facilities. On a continuing cooperative basis these facilities offer training programs which address the multifaceted aspects in the professional and paraprofessional care of the elderly.

SEMINARS ON AGING

Annual national seminars on aging were initiated 5 years ago for D.M. & S. personnel including physicians, nurses, social workers, psychologists, and other therapists. An interdisciplinary approach has thus been incorporated into the educational design. Subsequent to the annual seminar participants develop proposals for educational program efforts to be conducted during the year in their respective facilities.

MANPOWER GRANTS PROGRAM (PUBLIC LAW 541)

The manpower grants program, VA Medical School Assistance and Health Manpower Training Act of 1972, has awarded several grants to academic institutions in support of training in a variety of aspects of geriatrics. These include long-term nursing care of the aging adult, nurse practitioners in geriatric settings, and interdisciplinary training for various types of geriatric services.

PHYSICIAN GERIATRIC FELLOWSHIP PROGRAM

Thirty-two physicians are now enrolled in the geriatric fellowship program which is designed to develop clinical excellence in geriatric/gerontology for inpatient, ambulatory, and long-term care settings. The training program is 2 years in length. Physicians who are board eligible or certified in internal medicine, family practice, psychiatry, or neurology are eligible to apply. Six fellows have participated in a 4-month international experience at a geriatric center in the United Kingdom (St. Pancras Hospital, London; University of Manchester, Manchester and City Hospital, Edinburg). In cooperation with the Office of Research and Development, plans have been developed for a selected group of geriatric fellows to compete for an associate investigator award. This award will provide an additional year of research training in geriatric medicine.

Under a contract to the University of California, Los Angeles, School of Medicine, an education program guide for geriatric medicine is in the final stages of development. The guide will include selected bibliographic references of print and nonprint learning resources and a compendium of behavioral objectives for geriatric medicine. The guide will augment the curriculum materials available to the program directors, fellows, and faculty in affiliated medical schools.

In June 1980, the first group of eight fellows completed their geriatric training. Three are employed in VA medical centers and two are serving as consultants to the VA.

The geriatric fellowship program is conducted at 12 VA medical centers located at Bedford, Mass.; Buffalo, N.Y.; Durham, N.C.; Gainesville, Fla.; Lexington, Ky.; Little Rock, Ark.; Los Angeles (Wadsworth), Calif.; Madison, Wis.; Palo Alto, Calif.; Philadelphia, Pa.; Portland, Oreg.; and Sepulveda, Calif.

INTERDISCIPLINARY TEAM TRAINING PROGRAM

Planning continues for the training of other health professionals in all aspects of gerontology and geriatrics. Three additional VA medical centers have been

designated as training sites for interdisciplinary team training activities in geriatrics for VA staff and health professional students from affiliated colleges and universities: Little Rock, Ark.; Palo Alto, Calif.; and Salt Lake City, Utah. The previously designated sites were Portland, Oreg., and Sepulveda, Calif. This educational effort is based on the concept that health care delivered by a team of health professionals holds promise of more efficient utilization of health personnel and results in better management of elderly patients in need of continuing care. A coordinator directs the educational activity at each site.

The purposes of the team training program are to develop a cadre of health practitioners with the knowledge and competencies required to provide interdisciplinary team care to meet the wide spectrum of health care and service needs of the aged veteran; to provide role models for affiliating students in medical and associated health disciplines; and to provide leadership in interdisciplinary team training for other VA medical centers.

Interdisciplinary team training includes teaching of students and staff about the aging process, instruction in team teaching and group process skills to clinical core staff, and clinical experience in team care for affiliating students with the core team serving as role models.

CLINICAL NURSE, SPECIALIST PROGRAM

A program was initiated in fiscal year 1980 to fund clinical nurse specialist students who receive their clinical training at VA centers. Sixty-four trainee positions will be supported in fiscal year 1981 in three VA priority areas: geriatrics (22), rehabilitation (11), and mental health (31). The clinical training in geriatrics will take place at 15 VA medical centers through academic affiliations with 13 accredited schools of nursing. The nurse specialist training in rehabilitation and mental health will also impact on geriatrics as most elderly patients have need of rehabilitation and mental health services.

CONTINUING EDUCATION PROGRAMS

Continuing education and staff development programs are also directed to geriatric training. Under the sponsorship of central office units and the seven regional medical education centers a large number of workshops and conferences on the subject of geriatrics and gerontology are conducted each year for the staff of VA medical centers, outpatient clinics, nursing homes, and domiciliaries. In fiscal year 1980 programing consisted of approximately 40 different training activities. Examples of subjects included: Rehabilitation of geriatric veterans; geriatric medicine; chronic illness in aging—the social work role; geriatric assessment; clinical geriatrics; VA nursing home care; new directors for domiciliaries; the aging veteran; implementing gerontological nursing standards; personal care homes; and many others. Funds are also used to support continuing education at geriatric research, education, and clinical centers through visitation and lectureships.

LEARNING RESOURCES

This widespread education and training activity in geriatrics has generated a broad spectrum of requirements for learning resources throughout the VA system. Hundreds of online searches of automated bibliographic data bases were performed on all aspects of aging. Library collections at the GRECC's were strengthened to meet research and education needs in geriatrics and gerontology. Thirty copies each of six commercially produced videotapes dealing with the problems of aging were made available to the system through placement in designated medical district software delivery libraries and a videotape production on the VA domiciliary program was initiated at the St. Louis VA Medical Center.

13. Department of Veterans Benefits

COMPENSATION AND PENSION PROGRAMS

Disability and survivor benefits (pension, compensation, and dependency, and indemnity compensation) administered by the Department of Veterans Benefits provide all or part of the income for 1,604,821 persons age 65 or older. This total includes 816,985 veterans, 679,033 widows, 88,545 mothers, and 20,258 fathers. Approximately 115,598 veterans age 78 or older receive a 25-percent differential in addition to their pension benefits under Public Law 86-211, as amended.

The Veterans' and Survivors' Pension Improvement Act of 1978, effective January 1, 1979, provides for a restructured pension program. Under this program eligible veterans will receive a level of support meeting the national standard of need. Pensioners will generally receive benefits equal to the difference between their annual income from all other sources and the appropriate income standard.

This act provides for a $1,006 increase in the applicable income standard for veterans of World War I or the Mexican Border Period. This provision is in acknowledgment of the special needs of our older veterans.

Pensioners receiving benefits under the prior program have the opportunity to elect to receive benefits under this new program.

VETERANS ASSISTANCE SERVICE

Veterans Assistance personnel provided updated information on VA benefits and services to over 600 area agencies on aging (AAA) during fiscal year 1980. Contacts were made by telephone, letter, and in many cases, by personal visits by VA employees to conduct benefit briefings for AAA personnel. VA services to senior centers, nursing homes, and other organizations in the aging community included group discussions with administrators to help them identify potential VA beneficiaries for referral to the VA, and personal interviews with veterans, their dependents and survivors during onsite visits.

A new VA pamphlet, "Veterans Benefits for Older Americans," that highlights VA benefits and services most frequently used by elderly beneficiaries was developed during 1980. It will be widely distributed by Veterans Services Division personnel during outreach visits to the aging community.

EDUCATIONAL ASSISTANCE

There are roughly 320 people age 65 or older receiving VA educational benefits, of whom 220 are training under chapter 34, the Veterans Readjustment Act of 1966, as amended. Widows of veterans who died of service-connected causes, and wives of veterans who are permanently and totally disabled from service-connected disabilities total about 100 of the enrollees in the survivors' and dependents' educational assistance program. Last year there were some 30 veterans 65 years of age or older participating in the vocational rehabitation program. While no education service and no vocational rehabilitation and counseling service programs are specifically designed as a service to the aged, participation in the programs continues to include a small number of aged veterans and eligible dependents.

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