105TH CONGRESS
1st Session

SENATE

REPT. 105–36
Volume 2

DEVELOPMENTS IN AGING: 1996
VOLUME 2—APPENDIXES

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 73, SEC. 19(c), FEBRUARY 13, 1995

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

JUNE 24, 1997.—Ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE
89–806 WASHINGTON : 1997

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING
Washington, DC, 1997.

Hon. ALBERT A. GORE, Jr.,
President, U.S. Senate,
Washington, DC.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 73 agreed to February 13, 1995, I am submitting to you the annual report of the U.S. Senate Special Committee on Aging, Developments in Aging: 1996, volume 2.

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

This report describes actions taken during 1994 by the Congress, the administration, and the U.S. Senate Special Committee on Aging, which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons and their families.

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

Sincerely,

CHARLES E. GRASSLEY, *Chairman.*

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

REPORT

APPENDIXES

APPENDIX 1

ANNUAL REPORT OF THE FEDERAL COUNCIL ON THE AGING

SECTION I. SUMMARY OF ACTIVITIES DURING 1994

A. OVERVIEW OF STRATEGIC PLAN AND ISSUE PRIORITIES

To meet its mandate of comprehensively reviewing and evaluating Federal policies and programs affecting older Americans, the Federal Council on the Aging (FCoA) developed a multiyear strategic plan focusing on five priority issue areas:

(1) Health care, with a concentration on long-term care;

(2) Mental health and aging, with an emphasis on identifying and providing preventive assistance to at-risk, isolated older individuals in their homes and communities;

(3) The Older Americans Act, with a focus on nutrition and elder abuse;

(4) Income security, particularly Social Security; and

(5) The 1995 White House Conference on Aging, with an emphasis on playing a leadership role in developing productive recommendations prior to and during the Conference, and working to generate a strategy and set of mechanisms for following through on priority recommendations arising from the Conference.

A major guiding principle for the Council in developing these issue priorities is to provide a voice for older Americans and their families who are particularly vulnerable so that they are better able to help themselves lead productive and dignified lives.

During 1994, the Council's plan was formulated around the following major activities:

Listening to the concerns and recommendations of older individuals in their local communities and advocating for policies which preserve the dignity, independence, and productivity of persons across generations and over time.

Reviewing Federal policies and programs, identifying duplication and gaps among services, and evaluating their value and impact on the lives of older Americans.

Convening quarterly public meetings designed to gather information and discussing specific policy recommendations pertaining to the Council's priority issue areas.

Developing a series of informational materials and policy recommendations pertaining to long-term care, mental health and aging, the Older Americans Act, and the 1995 White House Conference on Aging.

Providing leadership, guidance, and recommendations for the 1995 White House Conference on Aging by attending more than two dozen regional, State local, and mini-conference events.

Forming cooperative partnerships with other agencies and professionals in the field of aging to develop and disseminate information to older consumers and their families.

Beginning to generate strategies for assisting certain at-risk older individuals and their families, with an emphasis on persons who are the victims of crime and elder abuse, older persons living alone, economically vulnerable older Americans, minorities, and older women.

Preparing and disseminating an annual report of activities and recommendations to the President.

B. Quarterly Meetings

Under the Chairmanship of the Honorable John E. Lyle from Houston, Texas, the primary goal of the Council's meetings was to seek to develop and advocate for a set of targeted policy recommendations to provide to the President, Members of Congress, the Secretary of Health and Human Services, the Office of the Assistant Secretary for Aging, the White House Conference on Aging, and Federal and State agencies.

JANUARY 24TH AND 25TH MEETING

The Council met in Washington, D.C. on January 24 and 25, 1994, to participate in the Administration on Aging's "Health Care University." During this meeting the Council discussed health care reform in general, and particularly the growing need for long-term care assistance. It was noted that many families are having to assume increased responsibilities associated with caring for older parents and relatives, but that supports for these families and caregivers are often lacking or inconsistent from community to community. In addition, Medicare does not provide coverage for long-term care. The discussions during this first quarterly meeting helped to lay the foundation for the development of an issue brief and a series of policy recommendations on long-term care later in the year.

The Council also met with the Assistant Secretary for Aging to share their thoughts and concerns on a number of issues related to the Older Americans Act, and to hold a constructive dialogue on possible future joint initiatives of the Administration on Aging and the Federal Council on the Aging. It was noted that the national aging network, through the framework of the State and area agencies on aging, is doing an excellent job of providing comprehensive assistance to older consumers and their families. However, resources are very strained. There is particularly a great need in local communities for nutrition home- and community-based care, and ombudsman assistance to better protect persons against elder abuse.

APRIL 27TH AND 28TH MEETING

Mental Health and Aging

One of the major outcomes of this meeting was the unanimous approval of a project to help produce and disseminate a book on mental health and aging to be done in conjunction with the National Institute of Mental Health. The purpose of the publication is to help to better inform health, behavioral, and social service practitioners in community mental health centers who have limited training in gerontology or mental health and aging. The publication will also include specific recommendations from the FC–A concerning national and local strategies for better addressing mental health and aging.

The Council discussed participating in a mini-conference to the White House Conference on Aging sponsored by the Mental Health and Aging Consortium. The mini-conference is to be held on February 24–26, 1995 in Washington, D.C. and will focus on four general themes: (1) strengths and weaknesses in current research; (2) positive looks at mental health: (3) services and training needs; and (4) the question of parity between physical health and mental health. The Mental Health and Aging Consortium anticipates that outcomes from the mini-conference will include a series

of research topics, recommendations, and a set of video tapes that would be shared with individuals and families throughout the country. The Council subsequently agreed to join the Mental Health and Aging Consortium and to actively participate in the mini-conference.

Discussion with the Assistant Secretary for Aging

The Council members met with the Assistant Secretary for Aging, Dr. Fernando Torres-Gil, to discuss a number of topics, including health care reform, long-term care, the upcoming reauthorization of the Older Americans Act, Social Security as an independent agency, activities related to Older Americans Month, and the priority initiatives of the Administration on Aging.

The FCoA also discussed and passed a strategic plan for 1994 and 1995 designed to play a leadership role in: (1) preparing for the 1995 White House Conference on Aging; (2) improving the effectiveness of mental health assistance for older persons and their families; (3) advocating for long-term care with a focus on home and community-based care; and (4) making recommendations related to the reauthorization of the Older Americans Act.

SEPTEMBER 13TH & 14TH MEETING

The FCoA convened under the newly appointed Chairman, John E. Lyle, for the purpose of discussing activities related to the White House Conference on Aging. Other major topics included the Older Americans Act, Social Security, and the needs of special populations of older persons, including older women, urban Indian elders, and Filipino veterans.

The Chairman appointed Raymond Raschko, of Spokane, Washington, to serve as the Council's Vice Chairman. The position of Vice Chair will be alternated on a rotating basis to provide opportunities for other members to serve in this capacity.

White House Conference on Aging

Council members reported on the local, State, and regional pre-conference activities they had participated in that were held in their States and communities. These activities demonstrated that there is a substantial grass roots enthusiasm for trying to address the many challenges associated with an aging society.

The Chairman noted that members of the FCoA are in touch with older persons in their communities of a daily basis, and that as statutorily mandated advisors to the President on aging matters, have a unique and important role to play as delegates to the WHCoA. Discussions were held on a series of leadership options for the Council to propose to the WHCoA to be initiated both during and after the Conference.

The WHCoA itself will be an outgrowth of the grass roots recommendations of Americans throughout the country. The Council members unanimously expressed a strong desire to build on this effort by helping to develop a framework and strategy for following through after the Conference by working for enactment of key recommendations that the delegates deem to be particular priorities.

Older Americans Act

Also on the agenda was a discussion with the Assistant Secretary for Aging, Dr. Fernando Torres-Gil, pertaining to the Older Americans Act. The Council raised several issues concerning proposed changes in the intrastate funding formula. The Assistant Secretary reported that the Administration on Aging (AoA) received over 2,500 comments to the proposed regulations for the intrastate funding formula and that the agency is reviewing these comments carefully.

The Assistant Secretary for Aging noted that there are many competing factors that must be balanced and taken into consideration in approving any formula. For instance, it needs to reflect the intent of the Older Americans Act to serve all persons aged 60 and over, but it also needs to be targeted to persons with the greatest social and economic needs. It must also account for the reality that the money the Administration on Aging has to work with does not meet all of the needs for assistance in our communities. The formula must also reflect the President's commitment to allow States maximum flexibility. Finally, it must have a component which will provide an ability to rely on an outcome measurement. The Assistant Secretary stated that he will ultimately make a decision on the formula based on an attempt to balance all of the above considerations.

Dr. Torres-Gil emphasized that regardless of the outcome of the formula, one of the important factors to keep in mind is that States have used Older Americans Act dollars to leverage substantial numbers of other dollars. As the aging network strug-

gles with limited sources of revenue, supporters of aging programs should keep in mind the need to continue to work to leverage other funding sources in States.

The Council members also reported hearing in their communities a number of concerns about the amount of data collection being imposed on States and area agencies by AoA. The Assistant Secretary was asked what the agency expected to get out of this process, and how far States, area agencies, and providers were expected to go in gathering the data.

The Assistant Secretary said that NAPIS, the National Aging Programs Information System, is an effort to collect hard data on persons being served. Increasingly the Congress and the Office of Management and Budget are saying that unless an agency can document how the money will be spent and what will be gained from each newly appropriated dollar, then additional resources may not be provided. In addition, during the last reauthorization of the Older Americans Act, the Congress inserted into the statute a requirement that AoA must improve its data collection.

Consequently, AoA is setting new requirements in order to better measure what the benefits will be of additional dollars and to provide a clear basis for appropriations requests. While the Assistant Secretary noted that many States are strapped for additional resources to do this data collection, he said he believes this data collection is vitally necessary as an investment in the future.

Social Security

The Council received an update of the work of the Social Security Advisory Council from its executive director, David Lindeman. This particular Advisory Council has been given three major charges by the Secretary of Health and Human Services, the Honorable Donna Shalala:

Develop recommendations that deal with the long-term actuarial shortfalls of the Social Security program.

Examine issues related to how the system interacts with the work patterns of women, including coverage, family structure issues, dual entitlement, and other matters.

Examine retirement policy and develop recommendations concerning the way in which Social Security fits or does not fit within the framework of pensions, savings, and income.

The FCoA received an overview of the status of the trust funds and the many factors that need to be taken into consideration by the Advisory Council in carrying out its mandates. Mr. Lindeman stated that the earlier these Social Security issues are addressed, the more options there are available that can be phased in over time, and the better opportunity persons will have to appropriately plan for their retirement.

Mr. Lindeman also stated that even though the number of workers per beneficiary is going down, that factor in and of itself would not be a big problem if there were lots of national savings and productivity gains. Unfortunately, since 1973, productivity gains have been essentially flat and national savings rates extremely low.

Special Populations, Including Older Women, Filipino Veterans, and Urban Indian Elders

Based on Census data which reveals that approximately three-quarters of all elderly persons living below poverty are women, the FCoA and its staff worked in cooperation with the Administration on Aging in helping to launch its "Initiative on Older Women." One of the major purposes of this venture is to assist the Assistant Secretary for Aging and AoA to better educate and inform women of all ages about the importance of planning for a long lifespan.

The Council is concerned by projections which indicate that, despite greater participation in the labor force, in the year 2020 the median income of single elderly women is likely to be only three-fifths that of single elderly men. In addition, two out of five women aged 65 and over who are living alone will have incomes below 150 percent of the poverty level. The FCoA is working in conjunction with AoA's Initiative on Older Women to develop strategies for optimizing the contributions of women to society, inform women at the grass roots level, and promote public and private sector partnerships that will better address issues related to income security, caregiving, health, housing, domestic violence, employment, and other issues.

The Council also discussed a resolution pertaining to the special characteristics of Filipino veterans. Despite the great sacrifices and contributions made by Filipino veterans during World War II, these older persons now face many problems including inadequate living arrangements, no health benefits, no financial assistance, and other concerns that affect their basic quality of life. Yet, the U.S. Government has denied Filipino World War II veterans the same status accorded other U.S. veterans

by denying them veterans benefits. The Council subsequently passed a resolution calling for a coordinated effort by related agencies to develop strategies for addressing the problems of Filipino veterans.

Finally, the Council examined the status and characteristics of urban Indian elders. A 1990 report written by Dr. Josea Kramer and funded in part by the Administration on Aging revealed a number of serious problems faced by urban Indian elders. While this report proposed a series of recommendations, there seems to have been little or no follow-up by the appropriate government agencies to consider or implement these proposals. The Council subsequently passed a resolution to seek to determine what efforts have been made by the various agencies to implement any of the report's recommendations.

DECEMBER 8TH & 9TH MEETING

The meeting focused particular attention on issues related to long-term care, mental health and aging, the reauthorization of the Older Americans Act, and the White House Conference on Aging. Speakers included the Assistant Secretary for Aging, the Executive Director of the White House Conference on Aging, and representatives from the Congressional Budget Office, the National Association of State Units on Aging, the National Association of Area Agencies on Aging, and the Administration on Aging.

Long-Term Care

Given the lack of passage of health care reform legislation during 1994, the Council discussed the increasing burdens that could be placed on families, older persons, States, and local communities trying to provide adequate and appropriate long-term care assistance. Concern was expressed by a number of Council members that many older persons are released from hospitals "sicker and quicker" to their homes and communities, and families are ill-prepared and often lack appropriate home and community-based supports to assist them with caregiving responsibilities. It is estimated that nearly four-fifths of care is provided by family members. The Council began to examine how innovative home- and community-based support programs can provide caregivers with appropriate supports so that they are better able to help themselves and family members receive the care they need.

In addition, discussions were undertaken about ways to better identify and reach isolated individuals who might be in need of assistance, particularly given the lack of a cohesive and comprehensive long-term care policy. Among the options examined was a report from a representative of the Congressional Budget Office on the status and characteristics of various pieces of health reform legislation that were being discussed by Congress at the end of the 103rd Congress. Other options included focusing more on various state initiatives and activities, as well as community-based programs and assistance provided through the Older Americans Act.

The Council voted to continue to play a leadership role in informing the public and policymakers about the need for long-term care coverage, particularly home and community-based options.

Mental Health and Aging

The Council received an update from Dr. Mary Harper of the National Institute of Mental Health on the status of the book which is being prepared for the FCoA entitled, "Community-Based Mental Health Services/Behavioral Healthcare for the Elderly." Several prominent professionals in the field of mental health and aging have prepared, or are in the process of completing, chapters for the book. The book is scheduled for release in the spring of 1995 and will be provided as a resource to community mental health centers and for the 1995 White House Conference on Aging. Included in the publication will be a series of focused policy recommendations discussed and approved by the Federal Council members.

Dr. Harper noted that persons aged 65 and over account for approximately 13 percent of the population and received nearly half of the medications prescribed by physicians. Yet, older Americans are rarely used in clinical trials designed to test for side effects. The Council voted to send a letter to Dr. David Kessler of the Food and Drug Administration and to Pharmaceutical and Pharmacist Associations urging better testing of the side effects of pharmaceuticals and combinations of drugs on older persons.

Discussion was also undertaken about the great need for systems and strategies which reach out into the community to older persons who may be in need of mental health assistance, but who are isolated from families and friends. The Council noted that very often our system of mental health supports relies first on an individual

contacting an agency for assistance. However, the problem is that most at-risk older persons do not seek this type of assistance themselves. Rather, it is usually a family member or friend who helps them get assistance. There are increasing numbers of older persons living alone who are not fortunate enough to have someone they can count on for these types of referrals. The Council subsequently discussed and passed a series of recommendations urging States and localities to develop early identification strategies, as well as great coordination between the area agency on aging system and the mental health system.

The Council voted that its first issue brief for 1995 be prepared on the subject of mental health and aging. The Chairman and the Vice Chairman will participate in the White House Conference on Aging Mini-Conference on Mental Health and Aging scheduled for February 1995.

Older Americans Act

The Council received an update from the Assistant Secretary for Aging, staff from the Administration on Aging, and representatives from the National Association of State Units on Aging and the National Association of Area Agencies on Aging regarding issues related to the reauthorization of the Older Americans Act.

Background information was received concerning the substantial leveraging federal Older Americans Act dollars creates from communities and older persons themselves. The Council expressed serious concern that proposals to block grant senior nutrition programs with welfare programs would destroy the partnership that exists between older persons and their families with Federal, State, and county funding resources. In many localities, monetary and in-kind contributions from older persons to the senior nutrition program provide 40–50 percent of the funding provided by the Federal Government, and many times more than is provided through county governments.

In addition, these nutrition programs often serve as a point of contact and entry to other forms of assistance for vulnerable and at-risk older persons. They provide an important function by identifying and reaching out to older persons so that they may be assessed and assisted in a more comprehensive way, enabling them to live more independently in their communities.

The Council subsequently passed a resolution opposing the block granting of the senior nutrition programs or other titles under the Older Americans Act.

C. Reports

1993 Annual Report to the President

The Council distributed its twentieth annual report to the President. The report detailed information along two major themes. The first was examining issues and characteristics within the Nation's diverse older population that are particularly critical to the most vulnerable and at-risk older persons. The second was to begin to develop background information on issues related to planning for the aging of the "baby boom" cohort and the next generation of older Americans. Issues covered in the report include: income security; health care; housing and living arrangements; older women; minority elders; mental health; and intergenerational perspectives.

Mental Health and Aging

In conjunction with the National Institute of Mental Health and the Center for Mental Disorders and Aging Research, the FCoA worked to prepare a book entitled: "Community-Based Mental Health Services/Behavioral Health Care for Older Persons." The purpose of this book is to help educate practitioners in community mental health centers and to provide a wide range of specific recommendations as to what should be occurring in the country regarding mental health and aging.

Chapters include: (1) an overview of aging and mental health; (2) psychopathology and treatment of the elderly; (3) assessment of the elderly; (4) psychopharmacology and the elderly; (5) health promotion; (6) dementia and the elderly; (7) caregiving; (8) ethics; (9) religion; (10) suicide; (11) special populations; (12) cost and financing of mental health services to the elderly; and (13) depression in the elderly.

D. Issue Briefs

"The Need for Home and Community-Based Long-Term Care: A Rural Perspective"

This issue brief continues the Council's 20-year history of focusing on matters associated with the provision and delivery of long-term care. Its purpose is to provide

planners, policy makers, legislators, and delegates to the White House Conference on Aging with a summary overview of some key characteristics and factors surrounding the need for long-term care assistance in rural areas, to develop a series of policy recommendations, and to highlight areas where more information is needed.

Its major conclusion is that rural elders and their families are significantly less likely than their urban counterparts to have access to a range of community-based, long-term care assistance. This lack of options not only tends to place increased burdens on rural families and caregivers, but it also has serious implications for taxpayers. Rural elders were found to be more likely to reside in nursing homes when they may not need 24-hour nursing. Medicaid picks up the tab for this assistance once an individual's resources are depleted.

With the aging of the nation's rural population, consideration will need to be given to developing a comprehensive strategy for addressing this growing need before it increasingly overburdens families, caregivers, and taxpayers. Its major policy recommendations include: (1) health care reform which includes long-term care assistance is crucial; (2) the long-term care system must support a comprehensive range of choices and alternatives in rural as well as urban areas; (3) this system needs to recognize the dignity of persons in need, promote independence in the least restrictive settings whenever possible, and recognize the diversity of states and communities by allowing flexibility of development.

Mental Health and Aging

The Council gathered background information for an issue brief to be released in early 1995 on the special mental health characteristics and needs of older persons. Specific policy recommendations are being developed to inform and assist professionals in community mental health centers, policymakers, and the general public.

E. Joint Partnerships

White House Conference on Aging

Council members participated in more than two dozen local events officially sanctioned by the White House Conference on Aging. The Council also: provided significant recommendations regarding the theme, structure, and issue priorities for the Conference; provided recommendations as a representative to the Advisory Committee; developed a proposal for a leadership role at the Conference in May; and urged the formation of a structure and the action plan for working to implement and enact priority recommendations arising from the Conference. The Council developed a strategy for helping to assist with this process and provided specific policy recommendations to the President.

Background materials on long-term care, mental health and aging, and the Older Americans Act were prepared in order to be distributed to delegates at the Conference, as well as policymakers, the press, and other interested individuals.

Coalition on Mental Health and Aging

The FCoA joined in partnership with the Mental Health and Aging Consortium to participate in a mini-conference to the White House Conference on Aging pertaining to mental health and aging issues. The mini-conference is scheduled to take place in February 1995, and will focus on four general themes: (1) strengths and weaknesses in current research; (2) positive looks at mental health; (3) services and training needs; and (4) the question of parity between physical health and mental health. Outcomes are expected to include a series of research topics, a series of recommendations, and a set of video tapes that will be shared with people throughout the country.

Developments in Aging

The FCoA provided a section on issues and activities for the Senate Special Committee on Aging publication, "Developments in Aging." This report describes actions taken by the Congress, the administration, and the Senate Committee on Aging which are of particular relevance to older Americans. It also summarizes and analyzes Federal policies and programs that are of importance to older individuals and their families.

SECTION II. MAJOR FINDINGS, RESOLUTIONS AND RECOMMENDATIONS

A. Health and Long-Term Care

MAJOR FINDINGS

A combination of factors work to place rural elders at a higher risk of poor health outcomes and with a smaller number and range of home- and community-based alternatives that is available for older Americans residing in other areas.

While there are many innovative and excellent sources of long-term care assistance in rural communities, these systems are uneven in terms of availability. Many areas do not have the resources to adequately meet the growing need. In general, home and community-based care for rural elders and their families are often less comprehensive, offered less frequently, and are not as accessible as they are in suburban and urban areas.

Transportation is vital for providing access to and from the array of home and community-based services. In rural areas, both geographic and social isolation limit older individuals' access to services.

Despite the nearly universal coverage by Medicare of persons aged 65 and over, older Americans pay significant percentages of their incomes for medical expenses. On average, Medicare pays only around half of the elderly's health care bills, with out-of-pocket costs (inflation adjusted) doubling since Medicare was enacted.

Shortly after the year 2000, the projected need for long-term care, particularly community-based care, is projected to increase exponentially. By the year 2040, nearly 14 million Americans will likely need some form of long-term care assistance, including 10 million who will need home and community-based care.

The date and research gathered by the FCoA indicate that if the growing numbers of older Americans and their families are to have access to a range of long-term care choices, policies and resources need to be developed which cost-effectively increase the availability, accessibility, affordability, and coordination of community-based care, particularly in rural areas.

The vast majority of older Americans prefers to stay in their homes and communities when the appropriation supports are available. Home and community-based services can permit impaired elders to remain in the community and live as independently as possible provide a better quality of life for impaired elders; reduce institution care and related subsidy costs; maximize the options available to impaired elders and their caregivers; provide needed support and relief for family caregivers; and serve to prevent or delay further health problems.

Given the rapid growth of persons aged 85 and over, the lack of a cohesive long-term care strategy could end up causing significant burdens for families and the Nation's health care expenditures. At the very least, the data indicate compelling reasons for gathering more information on this issue so that effective strategies and polices can be developed to address the growing needs.

RESOLUTIONS AND RECOMMENDATIONS

The FCoA recognizes that health care reform is critically necessary for America. Long-term care needs to be included in any health care reform strategy.

A long-term care program must recognize the dignity of persons in need. To the extent feasible, it should promote independence in the least restrictive setting. It must recognize the diversity of states and communities and allow flexibility of development.

Rural long-term care delivery and accessibility issues are growing national problems that need to be addressed in a comprehensive manner given the rapid growth of persons aged 85 and over.

Consideration should be given to strategies which encourage the use of modern technology, such as telecommunications and telemedicine. Such systems have the potential for linking information and care between a patient, primary care physician, and a specialist, even when they are miles apart.

Communication should be enhanced between states, area agencies on aging, and related service providers which encourage information sharing on innovative and cost-effective programs.

Policies and programs should be encouraged which assist in the formation of informal support groups designed to help alleviate the individual stress of family caregivers and which help to share caregiving responsibilities.

The Council reviewed a recent report of the Special Committee on Aging which reveals that the current policies of Medicare, Medicaid, and private insurers have left their doors wide open to fraud, costing the health care system more than $100 billion yearly. The Council urged that immediate action be taken to strengthen the

criminal laws and enforcement tools to stop fraud and abuse of the Nation's health care system, and that tough anti-fraud and anti-abuse provisions be built into the foundation of any health care reform enacted by the Congress.

B. Mental Health and Aging

MAJOR FINDINGS

An estimated 20 percent of all persons aged 65 and over experience problems serious enough to put them at risk of premature psychiatric and/or nursing home placement. Their ability to maintain themselves in the community becomes compromised as they experience serious mental, emotional, physical, social, and environmental problems.

At-risk older persons do not refer themselves for help or assistance, including persons with Alzheimer's disease. The disease itself leads to denial, projection of blame, and renders the majority of persons incapable of understanding and acting on their own behalf. If these individuals receive help, it is because somebody else—usually a family member—identified them and sought assistance. There are increasing numbers of at-risk elderly, including those with Alzheimer's disease, who have no one to perform this invaluable function.

One of the problems with many of our community delivery systems is that they are passive and generally wait to be contacted. For isolated older persons, a major challenge is locating and delivering assistance to persons who most need assistance. In almost all urban and rural areas of the United States, persons with Alzheimer's disease who live alone and have no family support become progressively worse until their lack of self-care and/or behavior makes them visible enough to be removed from their home and placed in an institution.

"Gatekeepers," or nontraditional referral sources who are trained to identify high-risk older persons, can be an important first step in helping to refer these individuals to appropriate assistance. Gatekeepers can include such professionals as meter readers and customer contact personnel from utility companies, cable television installers, fire, police and sheriff department staff, resident apartment managers, postal carriers, ambulance company staff, bank personnel, and others.

Approximately one-fourth of all suicides in the United States are estimated to be by persons over the age of 60. Elderly white males have the highest rate of suicide of this group.

When older persons attempt suicide, they are more often successful than are younger persons. Clinical experience suggests that as suicide moves from the stage of being a passive idea to more of an actual attempt, persons become progressively more resistant to seek and/or accept assistance. Consequently, an important factor for effective intervention is early identification and referral.

RESOLUTIONS AND RECOMMENDATIONS

Isolated older persons, both urban and rural, who live alone and have mental health problems such as Alzheimer's diseases and depression, are especially at-risk for suffering, hospitalization, and nursing home placement. The Council strongly urges States and localities to develop and implement specialized early identification strategies and in-home delivery systems for assisting these particularly vulnerable older Americans.

In most States, the area agency on aging system and the mental health system do not integrate their activities and programs, let alone coordinate or cooperate with their delivery of assistance. The Council strongly urges greater integration of these systems, particularly as they relate to high risk home-dwelling older persons who have a high interrelationship between physical, mental, self-care, emotional, and support problems.

Age integrated subsidized housing has led to much suffering for older persons because of violence, drugs, and crime. The Council recommends that representatives from the aging and disability communities work with the Department of Housing and Urban Development to form a special task force designed to assist public housing authorities develop guidelines about who they house, particularly in terms of protecting older residents from abusive residents with substance abuse problems.

As health care reform progresses, the Council strongly recommends the inclusion of long-term care assistance, including a mental health benefit that takes into account the low utilization rates of older persons and which targets benefits to overcome access problems.

Older persons make up 13 percent of the population and receive 45 percent of the medications prescribed by physicians. Yet, older Americans are rarely used in clinical trials of pharmaceuticals that are designed to determine the drug's efficacy and

side effects. The Council strongly recommends using a more representative sampling of older persons in clinical trials and pharmaceuticals.

C. Older Americans Act

MAJOR FINDINGS

Health and nutrition studies indicate that 85 percent of older persons have a nutrition-related condition or chronic disease and that nutritional status is a risk factor for and predictor of visits to the physician, hospital emergency room, and hospital admission and readmission.

The Senior Nutrition Program under the Older Americans Act maintains the dignity of hundreds of thousands of nutritionally at-risk older persons and provides mechanisms for participants to contribute according to their ability to pay. According to the most recent 1993 figures, over 225 million meals were served through a nationwide network of more than 15,000 community nutrition sites.

Approximately 127 million meals were provided at congregate settings such as senior centers (27 percent of the recipients were frail and disabled, 45 percent were low income, 41 percent were rural residents, and 17 percent were minority). Another 103 million meals were provided to older persons who are homebound due to illness, disability or geographic isolation.

Older persons make significant contributions through volunteerism and financial support to substantially defray the cost of the meals. In Fiscal Year 1993, older Americans contributed over $180,000,000 of their own money to the Senior Nutrition programs. These contributions were used to expand services. Additionally, older individuals contribute substantial amounts of in-kind contributions by volunteering at nutrition sites and delivering meals to homebound seniors.

In San Diego County, for instance, elderly participants contributed over $1.8 million in fiscal year 1993–94 under the Older Americans Act Senior Nutrition Program, which was four and a half times more money than was provided by the County of San Diego. In addition, San Diego County senior nutrition volunteers donated over 250,000 hours of service. These monetary and in-kind contributions are typical of the valuable nationwide partnerships that exist between funding through the Older Americans Act, the local aging network, and older individuals and their families.

The Senior Nutrition Program is a fundamental part of a comprehensive service system aimed at keeping older persons in their home. It provides support for family caregivers, is consumer-focused, and has widespread support due to its flexibility and its role as a point of contact and link to the wider aging service system.

The establishment and development of services through the Older Americans Act and its 57 State Units on Aging, 670 area agencies on aging, and more than 25,000 related service providers throughout the country, provides an effective community-based infrastructure which can increasingly address some of the continuum of care needs of older Americans. Out of this network and through a wide variety of State-assisted mechanisms, a number of creative and innovative programs have been established. However, the resources provided through this network are presently able to assist only a small proportion of those in need today, and is falling behind the projected need to assist the increasing numbers of older persons in the future.

Data for Fiscal Year 1993 indicate that approximately 6½ million individuals aged 60 and over received supportive services under the supportive services and senior center activities of the Older Americans Act. These services represent the cornerstone of the nationwide aging network effort to assist older persons to live independently in their homes and communities for as long as possible. Two out of five of those persons assisted were low income, and one out of five were minority older persons.

There is mounting evidence that abuse, neglect, and exploitation of older persons is a serious national problem. Many older persons experience social isolation and debilitating illnesses that increase their susceptibility to abuse and criminal victimization. More needs to be done to examine this problem, and to examine the ability of resources provided under Title VII of the Older Americans Act and other sources to adequately address this problem.

RESOLUTIONS AND RECOMMENDATIONS

The Council is particularly concerned about draft proposals contained in the "Contract With America" that would likely break up the comprehensive services provided under the Older Americans Act into many separate functions and block grants. The Council strongly believes that one of the great strengths of the Older Americans Act has been its ability to assist older persons and their families in a comprehensive

manner through a national aging network, and opposes any effort to block the senior nutrition programs with welfare programs, such as food stamps.

The FCoA supports the continuation of the Older Americans Act as a categorical program and strongly opposes the block granting of any titles, responsibilities, programs, and services under the Act.

In order to have the benefit of the recommendations from the 1995 White House Conference on Aging, and because many programs arising from the last reauthorization have not had sufficient time to be implemented and evaluated, the FCoA supports a simple 1-year extension of the Older Americans Act.

D. Special Populations

MAJOR FINDINGS

By the year 2030, minority populations will comprise one in four persons aged 65 and over, as compared to approximately one in eight today.

Nearly three out of five persons over the age of 60 are women. Data gathered by the FCoA and the AoA reveal that:

> Compared to men, elderly women live longer, are three times more likely to be widowed or living alone, spend more years and a larger percentage of their lifetime disabled, are nearly twice as likely to reside in a nursing home, and are more than twice as likely to be living in poverty.
>
> Almost three-quarters of all elderly persons living below poverty are women. Three of five Black women aged 65 and over living alone, and two of five Hispanic women aged 65 and over living alone have incomes below the poverty level.
>
> Women provide 80 percent of the informal care that their families receive.
>
> Seven out of ten "baby boom" women will outlive their husbands. Many can expect to be widows for 15–20 years. In the year 2020, two out of five women aged 65 and over living alone are likely to have incomes which are less than 150 percent of the poverty level. The median income of single elderly women at that time is projected to be 63 percent that of single elderly men.

Urban American Indians have been called the "invisible minority" because their conditions and needs are not generally recognized in comparison to other older populations. A study of elderly urban Native Americans living in Los Angeles by Dr. Josea Kramer found that:

> Monthly incomes were not sufficient to cover basic living expenses of nearly two out of five older American Indians surveyed.
>
> One out of nine is homeless.
>
> Three out of five report having health problems.
>
> Diabetes occurs at almost five times the expected rate.
>
> One in four have impairment in at least one activity of daily life.
>
> 58 government agencies received a copy of these findings and a series of recommendations, but it is not clear whether there has been any follow-up seeking to address this situation.

The Council found that many Filipino veterans face critical problems such as a lack of adequate living arrangements, no health benefits, poor physical and mental conditions, no financial assistance, a greater susceptibility to crime victimization, and increased separation anxieties from family members. In addition, the U.S. Government has denied Filipino World War II veterans the same status accorded to other U.S. veterans by denying them veterans benefits.

RESOLUTIONS AND RECOMMENDATIONS

Greater attention and resources need to be focused on gathering data and initiating outreach to particularly vulnerable subgroups of rural elders, such as persons living alone, individuals with health or mobility problems, the "old old," racial and ethnic minorities, and older women.

The FCoA strongly supports the efforts of the Administration on Aging, the Social Security Administration, and the Pension and Welfare Benefits Administration of the U.S. Department of Labor to better inform persons of all ages about the need to plan early for retirement and for a long lifespan. The FCoA urges these agencies, the President, and the Congress to develop policies which pay particular attention to the special needs and characteristics of older women, who are much more likely to be living in poverty, both now and in the future, than are older men.

By a unanimous vote during its quarterly meeting on September 13, 1994, the FCoA recommends that the Assistant Secretary for Aging assume a leadership role in coordinating the efforts of government agencies to pool their resources for serving the unmet needs of urban American Indian elders.

By a unanimous vote during its quarterly meeting in Washington, D.C., on September 13, 1994, the FCoA recommended that a meeting be convened consisting of representatives from the Federal Council on the Aging, the Veterans Administration, the Immigration and Naturalization Service, and the Administration on Aging in order to seek coordinated strategies for addressing the problems of Filipino veterans.

E. White House Conference on Aging

RESOLUTIONS AND RECOMMENDATIONS

Based primarily on the Council Members' participation in many local WHCoA events, as well as some of the experiences arising from the 1981 WHCoA, the Council submitted the following recommendations to the Conference's executive director.

There is widespread enthusiasm for this WHCoA at the grass roots level. Every effort must be made to continue the President's intention to make this very much a "people's conference." Budget permitting, the President and the WHCoA should utilize advancements in telecommunications since the 1981 Conference to give this Conference more of a town hall focus. Many thousands of persons are personally invested in the pre-conference activities. At the very least, methods should be in place to have the public plugged in as observes.

The Conference agenda must focus on at most six to eight priority categories of issues. Two and a half days is simply not enough time to adequately discuss and pass meaningful recommendations on dozens of issues. We urge the Policy Committee to prioritize some key issues going into the Conference so that discussions will not be all over the board. Given that these conferences occur at best only once every 10 years, we simply cannot afford to have proposals passed in a haphazard way. We strongly believe that more targeted discussions around a few key issues will lead to more significant and productive recommendations.

Regardless of the theme or agenda, it is crucial that a strategy be devised which is designed to follow through on key recommendations arising from the Conference. The FCoA intends to play a strong leadership role in our communities and with the President and the Congress to work for enactment of major WHCoA recommendations.

III. FUTURE DEVELOPMENTS

In carrying out its mandate to comprehensively review and evaluate Federal policies and programs affecting older Americans, the FCoA has developed an action plan designed to advocate for the needs of older Americans who are particularly vulnerable so that they and their families are better able to lead productive and dignified lives.

The Council's plan has been formulated on two major principles:

Provide a voice for older persons and their families, with particular sensitivity to individuals who often do not have the resources to be heard, including: Frail persons in need of long-term care assistance, persons with mental health needs, individuals who are the victims of elder abuse, persons living alone, and economically vulnerable individuals.

Seek to focus on three or four major issues and follow through with a multi-year action plan designed to develop a targeted series of informational materials and policy recommendations.

A. Goals and Objectives

Every activity of the Council will have as its ultimate goal to provide productive recommendations to the President and policymakers on ways to improve programs and policies affecting older Americans.

Serve as ombudsmen and spokespersons for the most vulnerable and at-risk older Americans, and play an important outreach role between older persons in their communities, the White House, and Federal agencies.

Promote preventive assistance, better intergenerational understanding and highlight the positive contributions of older persons.

Study, develop, and advocate for policy recommendations within the Council's priority issue areas. These priority issues are:

Long-Term Care (Within an Emphasis on Home and Community-based Care);

Mental Health and Aging;

Older Americans Act (With an Emphasis on Reauthorization, Nutrition, and Elder Abuse); and

Providing Leadership Regarding the White House Conference on Aging.

B. Action Plan

DEVELOP AND ADVOCATE FOR KEY POLICY RECOMMENDATIONS

Each quarterly meeting of the Council will have as its objective providing to the President a summary interim report of recommendations.

The Council will prepare and publish three issue briefs annually on topics within its priority areas. These issue briefs will conclude with policy recommendations.

The first issue brief for 1995 will be on mental health and aging.

As mandated by the Older Americans Act, the Council will provide an annual report to the President of findings and recommendations.

Each of the reports and issue briefs will be transmitted to policymakers, government agencies, and interested parties.

Council members will play a leadership role in events related to the White House Conference on Aging.

Members participate in local, regional and mini-conferences, as well as contributing information, perspectives, and recommendations to the Conference.

Advocate for priority policy recommendations post-WHCoA. Work for enactment of productive policies.

SPOKESPERSONS FOR AT-RISK OLDER AMERICANS

Council members will reach out into their local communities to determine the major concerns and contributions of older persons, and communicate this information to Federal agencies and the White House. Council members will in turn provide information about Federal programs to persons at the local level.

The Council will issue statements and press releases and provide editorials and public comments on key issues, particularly as they affect vulnerable and at-risk older persons.

Hold at least one of the Council's quarterly meetings outside of Washington, providing an opportunity for studying local issues and obtaining citizen input.

PREVENTIVE ASSISTANCE AND OLDER PERSONS AS A VALUABLE RESOURCE

The Chairman in particular will seek opportunities for speaking on ways older persons can continue to serve as valuable resources in their communities and on the importance of preventive care. The Council's informational materials will also include an emphasis on these topics. Efforts will be made to disseminate this information through a variety of public-private, cooperative efforts.

The Council will continue to utilize the media, through statements, press releases, and editorials to better inform the public about these matters.

FOCUS PARTICULAR ATTENTION ON PRIORITY ISSUE AREAS

Long-Term Care

Develop and disseminate an issue brief on rural long-term care, including policy recommendations.

Support the inclusion of long-term care in any health care reform. Push for principles as contained in the long-term care resolution passed by the Council.

Examine and develop recommendations regarding the role of the aging network in the provision of home and community-based care.

Mental Health and Aging

Publish and disseminate a book on mental health and aging designed to assist providers of mental health services with a better understanding of the special characteristics and needs of older persons. The book will also include recommendations to improve the quantity and quality of community-based mental health services for the elderly.

Prepare and disseminate an issue brief on mental health and aging.

Join in partnership with the Coalition on Mental Health and Aging in developing and advocating for policy recommendations.

Participate in the White House Conference on Aging Mini-Conference on Mental Health and Aging. Advocate for increased attention and visibility of mental health issues at the WHCoA, and work for the enactment of productive policies following the Conference.

Older Americans Act

Focus on issues related to the Act's authorization.

Study and make specific recommendations regarding Title VII of the Act, including the ombudsman programs, programs on elder abuse, neglect and exploitation, and outreach, counseling and assistance programs.

Develop an issue brief on elder abuse and examine ways to improve assistance and protections under the Act.

Examine the role of the aging network in the provision of home- and community-based long-term care.

White House Conference on Aging

Council members will continue to play a leadership role in pre-conference activities by serving as delegates, participants, and presenters in State, local, regional, and mini-WHCoA events.

The Chairman will serve on the Advisory Committee for the Conference and the Council will provide guidance on the structure, background materials, and development of resolutions and recommendations.

Members of the Council will help to serve as facilitators and moderators during the Conference in May.

The FCoA will play a leadership role in helping to develop and advocate for key recommendations passed by the delegates at the Conference.

APPENDIX A—BACKGROUND OF THE FEDERAL COUNCIL ON THE AGING

Authorized under Section 204 of the Older Americans Act, the Federal Council on the Aging (FCoA) is the bi-partisan citizen advisory agency within the executive branch of the Federal Government charged with advising and assisting the President on the special needs and characteristics of older Americans.

Created under the 1973 amendments to the Act, the FCoA is comprised of 15 members, 5 of whom are appointed by the President, 5 by the U.S. Senate, and 5 by the U.S. House of Representatives. Council members are appointed to serve 3-year terms and are chosen from among individuals with expertise and experience in the field of aging who represent a diverse cross-section of rural and urban communities, national organizations with an interest in aging, business, labor, Indian tribes, minorities, and the general public. By statute, at least 9 of the members must themselves be older persons.

FUNCTIONS OF THE FCOA INCLUDE

Serving as spokespersons on behalf of older persons by making recommendations about Federal policies and programs;

Reviewing and evaluating policies to assess their effectiveness and to promote better coordination between and across Government agencies;

Directly advising the Assistant Secretary for Aging on matters pertaining to services and assistance under the Older Americans Act;

Informing the public about the problems and needs of the aging by collecting and disseminating information, conducting or commissioning studies, and by issuing reports;

Holding public hearings and conducting or sponsoring conferences, workshops, and meetings;

Serving on the Advisory Committee of the White House Conference on Aging; and

Issuing an annual report to the President on key findings and priority recommendations.

BIOGRAPHIES OF COUNCIL MEMBERS

John E. Lyle, Chairman, of Houston, TX, is appointed by President Clinton to a term ending March 31, 1996. Mr. Lyle has been an attorney for 60 years and is presently director of Falcon Seaboard Resources, Inc., of Houston, Texas and is "of counsel" to the Houston law firm of Harris and Quinn. At the age of 33, while serving his country overseas during World War II, Mr. Lyle was elected to represent the citizens of the 14th Congressional district of Texas in the U.S. House of Representatives. Congressman Lyle served for 10 years (1944–55) as a powerful ally of Speaker Sam Rayburn and worked as a member of the House Rules Committee which guided legislation through the Congress. Mr. Lyle's many accomplishments and affiliations include serving two terms in Corpus Christi, serving as director of the State Bar of Texas, being elected president of the Law Enforcement Foundation for the Texas Attorney General, and serving on the board of St. Luke's Hospital and Foundation.

Alice B. Bulos, of San Francisco, CA, is appointed by President Clinton to a term ending on March 31, 1997. Ms. Bulos is a community activist from South San Francisco who is active in a variety of civic organizations. She holds leadership positions as California chair of the Filipino-American Democratic Caucus, chair of the Sacramento Asian/Pacific Women's Network, and the northern California chair of the National Filipino-American Women's Network. Ms. Bulos formerly served as the Health Commissioner of San Mateo County (1986–94) and as a board member of the regional center for Mental Disabilities. A naturalized American citizen, she holds a B.A. and M.A. from the University of Santo Tomas in Manila, where she taught and served as the chairman of the Department of Sociology.

Eugene S. Callender, of New York, NY, is a reappointee of the U.S. House of Representatives to a term ending March 31, 1995. Dr. Callender is a clergyman and an attorney. He is the former director of the New York State Office on Aging, from 1983–89. Presently he is a vice-chairperson of the National Caucus and Center on the Black Aged and is the President of the SYDA Foundation in New York.

William B. Cashin, of Manchester, NH, is appointed by President Clinton to a term ending on March 31, 1995. Mr. Cashin is a vice president of the Catholic Medical Center in Manchester, and Dean of the City of Manchester's Board of Mayor and Alderman. As a hospital administrator, he directs the day-to-day operations of all non-clinical support services for a 330-bed institution. He also worked at Notre Dame Hospital in a similar posi

Rudolph Cleghorn, of El Reno, OK, is a reappointee by the U.S. Senate to a term ending March 31, 1997. Following his retirement as a case manager with the U.S. Department of Justice, Mr. Cleghorn served for 10 years as program manager of a Title VI program, and was instrumental in the formation of the National Association of Title VI Directors. He was a staff member of Three Feathers Associates which administered a grant to train Title VI directors. In 1984, he was appointed to AARP's ad-hoc Committee on Minority Affairs, and in 1988 to the Minority Concerns Committee of the National Council on the Aging. He is a member of numerous aging and Indian Organizations, and is a member of the Otoe-Missouria and Cherokee-Delaware Indian Tribes.

Stephen Farnham, of Presque Isle, ME, is a reappointee by the U.S. Senate to a term ending March 31, 1997. Mr. Farnham is the executive director of the Aroostook Area Agency on Aging, Inc., and voluntarily directs the operation of the Caribou Congregate House Development Corporation. He is a strong advocate for the needs of vulnerable older people in Maine and has served 3 years as a board member of the National Association of Area Agencies on Aging (NAAAA).

Max L. Friedersdorf, of Sanibel, FL, is appointed by the U.S. House of Representatives to a term ending March 31, 1996. Prior to the House appointment, Mr. Friedersdorf served as Chairman of the FCoA under former President Bush. His nearly 28 years of experience in high level positions in the Federal Government includes 8 years in the White House as Assistant to the President for Congressional Liaison under Presidents Nixon, Ford, and Reagan. He is Senior Vice President with Neill and Company in Washington, D.C. and serves as Chairman of the Advisory Board for the Association of Retired Americans. A native of Indiana, he attended Franklin College, where he was awarded a B.A. in Journalism and an Honorary Doctorate of Law. He also earned an M.A. in Communications from American University in Washington, D.C.

Robert L. Goldman, of Oklahoma City, OK, is a reappointee by the U.S. Senate to a term ending on March 31, 1995. Since retiring from the Bell System in 1979, Mr. Goldman has been an active advocate for improving the quality of life for older Americans. He is a member of the boards of numerous senior advocacy and service organizations, and maintains an intergenerational interest by serving on the city's Educational Round Table, and by working with handicapped school children. Mr. Goldman has served as Chairman of the Oklahoma State Council on Aging and as Vice President of the Oklahoma State Board of Nursing Homes. Currently, he is an active member of the Oklahoma State Commission on Health Care

Connie Hadley, of Kansas City, KS, is a reappointee by the U.S. Senate to a term ending on March 31, 1996. She is an active senior with a long involvement in community programs. A respected and influential voice in the community, she is especially active in promoting programs to help low-income and minority older persons. She is a former Executive Director of the Economic Opportunity Foundation, Inc., in Kansas City, and is a member of Senior Organized Citizens of Kansas. She also serves on the Board for Foster Grandparents in Wyandotte County, and was the first County Senior Citizens Coordinator.

Olivia P. Maynard, of Flint, MI, is appointed by President Clinton to a term ending March 31, 1997. Ms. Maynard is the president and founder of Michigan Prospect for Renewed Citizenship, and is a visiting professor at the University of Michigan

School of Social Work. She is the former director of the Michigan State Agency on Aging, Office of Services to the Aging, and was also a candidate for Lt. Governor. She taught adult education at C.S. Mott Community College. Ms. Maynard hold a B.A. from George Washington University and an M.S.W. from the University of Michigan School of Social Work.

Myrtle B. Pickering, of Shreveport, LA, is appointed by President Clinton to a term ending on March 31, 1995. Ms. Pickering has served for 16 years as the Executive Director of the Caddo Council on Aging. She also serves on the National Council on the Aging, Louisiana State Citizens Committee on Mental Health, and the Louisiana Elderly Health Care Council. She is President of the Louisiana Senior Citizens Trust Fund, and former President Pro Tempore of the Louisiana Silver Haired Legislature.

Josephine K. Oblinger, of Springfield, IL, is a reappointee by the U.S. House of Representatives to a term ending on March 31, 1997. Mrs. Oblinger has served 3 year terms upon the recommendation of former House Minority Leader Robert Michel. Mrs. Oblinger has an extensive career as a State Legislator and is a longstanding advocate for older people in Illinois. She is the former Director of the Illinois Department on Aging.

Raymond Raschko, of Spokane, WA, is a reappointee by the U.S. House of Representatives to a term ending on March 31, 1996. Mr. Raschko serves as Director of Elderly Services with the Spokane Community Mental Health Agency, and as a member of the Washington State Long-Term Care Commission. He also serves as Director of the Greater Spokane Chapter of the Alzheimer's Association.

Romaine M. Turyn, of Readfield, ME, is appointed by the U.S. Senate to a term ending on March 31, 1996. Ms. Turyn is currently Project Director for the Maine Alzheimer's Project, and employed by the Muskie Institute of Public Affairs at the University of South Maine. She served as the Executive Director to the Maine Committee on Aging. She also served as special assistant to the Senate Majority Office of the Maine Legislature. Recently, she was elected as Vice Chair of the Senior Legislative Advocacy Coalition.

E. Don Yoak, of Spencer, WV is a reappointee by the U.S. House of Representatives to a term ending on March 31, 1995. He is retired from the West Virginia Department to Highways and has been active in the West Virginia Legislature for the last 54 years. Mr. Yoak currently serves as Doorkeeper of the West Virginia House of Delegates. He serves as Chairman of the Ford Motor Company Dispute Settlement Board in West Virginia; also as a State Coordinator for AARP, and on the board of directors for the West Virginia Assistive Technology Systems.

APPENDIX 2

REPORT FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1. DEPARTMENT OF AGRICULTURE

AGRICULTURAL RESEARCH SERVICE

TITLE AND PURPOSE STATEMENT OF EACH PROGRAM OR ACTIVITY WHICH AFFECTS OLDER AMERICANS

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

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

In addition, studies are performed at the Beltsville Human Nutrition Research Center (BHNRC), the Grand Forks Human Nutrition Research Center (GFHNRC), and the Western Human Nutrition Research Center (WHNRC) on the role of nutrition in the maintenance of health and prevention of age-related conditions, including cancer, coronary heart disease, hypertension, diabetes, neurological disorders, osteoporosis, and immunocompetence. Summaries of human nutrition research progress and a list of projects related to nutrition and the elderly are attached.

BRIEF DESCRIPTION OF ACCOMPLISHMENTS

Reduced ability to regulate energy balance is associated with aging. Investigations of the effects of aging on mechanisms of body energy regulation and the control of food intake were conducted at the HNRCA. The subjects were 35 healthy young and elderly men of normal body weight leading unrestricted lives and consuming a diet of typical composition. The results demonstrate that human aging is associated with a substantially reduced ability to regulate energy balance and control energy intake even in apparently very healthy individuals. This knowledge can be used to promote weight stability among the elderly and should thereby encourage the important goal of reducing preventable disability and disease late in life.

Strength training has positive effects on glucose and chromium metabolism in older men (53–63 years old). Aging has been associated with a progressive impairment of carbohydrate metabolism, characterized by impaired glucose tolerance and insulin sensitivity. At the Beltsville Human Nutrition Research Center, strength training was investigated in older individuals. This training resulted in significant increases in strength and muscle mass, and decreases in body fat. Insulin's action was found to improve, and this may be due to the observed differences in metabolism of the essential trace element chromium. Chromium metabolism was followed using stable (non-radioactive) isotopes of the element. This research will benefit scientists in the fields of nutrition, exercise physiology, kinesiology, gerontology, and diabetology.

Exercise is an effective means to counter physical frailty in the oldest old. Muscle weakness and atrophy have been linked to physical frailty in the elderly. Although disuse of skeletal muscle and undernutrition have been often cited as potentially reversible etiologies of this frailty, the efficacy of interventions targeted specifically toward these deficits has not been previously evaluated in a large controlled trial. A randomized, placebo-controlled clinical trial of high-intensity progressive resistance training and/or multi-nutrient supplementation in 100 nursing home residents was

conducted at the HNRCA. Results showed high-intensity resistance training is a feasible and effective means to counter muscle weakness and physical frailty in the oldest old. Multi-nutrient supplementation without concomitant exercise may reduce ad libitum food consumption and does not further improve outcomes.

Older women can offset an undesirable hereditary effect on bone loss by raising their calcium intake. It is well known that osteoporosis has an inherited component. Recently the gene regulating the vitamin D receptor (VDR) was linked to bone mineral density in adults. Vitamin D and its intestinal receptor are important in the process of calcium absorption, particularly in those on low-calcium diets. A study was conducted at HNRCA to determine whether genetic VDR status is related to rates on bone loss in postmenopausal women and, if so, whether calcium intake influences the association. Genetic VDR status was determined in 229 women who had participated in an earlier 2-year calcium supplement trial. Those with the reportedly undesirable VDR status lost bone mineral more rapidly from the hip, spine, and whole body. At the hip, this genetic influence was present only in women with calcium intakes under 650 mg per day (average 400 mg per day). We conclude that genetic VDR status influences rates of bone loss in postmenopausal women and that individuals with the undesirable status can offset this hereditary effect by raising their calcium intake.

Nitrogen balance data suggest elderly adults require intakes of protein higher than the current Recommended Dietary Allowance. There have been insufficient data available to determine the protein requirements of the elderly. This population differs from younger populations in body composition, physical activity, food intake, and disease incidence, factors which may affect protein requirements. The dietary protein requirements of the elderly were determined in 12 men and women, aged 56 to 80 years, using the short-term nitrogen balance technique which measures the difference between the amount of nitrogen ingested and excreted by the body. Volunteers were randomly assigned to groups that consumed protein intakes equivalent to the Recommended Dietary Allowance (RDA) or twice the RDA. The nitrogen balance data suggest that a safe protein allowance for essentially all elderly adults would require intakes of protein considerably higher than the current RDA. These results are of direct benefit to scientists, agencies providing for the nutrition of elderly populations, and, even more so, to the elderly consumers by providing evidence of higher protein requirements in this population.

Cataract development may be slowed by a diet that increases glutathione. In the eye, glutathione appears to provide a critical defense mechanism against the onset of cataract. Low levels of forms of glutathione are found in many cataractous lenses. In cataract induced by galactose, a decrease in stores of a substance necessary to regenerate glutathione has been observed and may contribute to the progression of cataract. At HNRCA the dose-response relationship between dietary galactose and cataract formation was established by feeding rats various amounts of galactose. The anti-cataract potential of glutathione monoethyl ester was tested on rats fed 15 percent galactose. Progression of cataract development during the early stage was significantly slower than those not treated with glutathione monoethyl ester indicating that a diet that increases glutathione and thus antioxidant potential may delay cataracts in the elderly.

Patients with Alzheimer disease exhibit altered plasma concentration of selected amino acids. Amino acids provide the building blocks for proteins within the body. Diseases of the liver and kidney are known to cause abnormalities in amino acid metabolism and amino acid concentration in blood. In normal healthy individuals, age, sex, and exercise have been shown to affect blood amino acid concentrations. Thus, characterization of the normal ranges for fasting amino acids is important for interpreting results from dietary and metabolic experiments and for diagnostic purposes in conditions where changes in amino acid profile are expected. At HNRCA, a study using fasting samples from several elderly populations provided the opportunity to evaluate normal fasting amino acid concentration in healthy elderly female subjects and a group of elderly patients diagnosed with Alzheimer disease. Results included: (1) Fasting amino acid concentrations do not reflect levels of dietary protein intake when the dietary amino acid composition is similar, and (2) Patients with Alzheimer disease exhibited altered plasma concentration of a few selected amino acids relative to active or sedentary control subjects.

Small intestinal permeability is not diminished with aging. The effect of aging on the small intestine is a controversial topic, and it is unknown whether the aging process itself results in altered small intestinal permeability. Intestinal permeability or "leakiness" can be assessed by a test which compares the relative absorption and excretion of a large sugar, lactulose (absorbed in the spaces between cells) to a small sugar, mannitol (absorbed through cell membranes). At HNRCA, small intestinal integrity and permeability with advancing age as measured by the lactulose and

mannitol absorption test were evaluated in 56 healthy subjects in three age groups: 20 to 39 years, 40 to 50 years, and >60 years. Subjects were all healthy, community-dwelling volunteers. With increasing age, both the percentage of lactulose excreted and the percentaged of mannitol excreted progressively decreased.

However, the lactulose-to-mannitol ratio did not change with increasing age. Thus, there is a progressive decline in the ability to excrete lactulose and mannitol with age due to a decline in kidney function with advancing age. However, small intestinal permeability, as indicated by this lactulose-to-mannitol ratio, does not change with aging. Thus, small intestinal permeability is not diminished with aging measured by the lactulose/mannitol absorption test.

The effect of beta-carotene supplementation on the distribution of carotenoids, vitamin E, vitamin A, and cholesterol in plasma lipoprotein fractions of healthy older women. Compounds present in fruits and vegetables called carotenoids have been shown to reduce the risk of certain types of cancer and of heart disease. To delineate the mechanisms by which beta-carotene acts in these disease states, an understanding of its effects on the distribution of other antioxidants and of fat molecules in the various compartments of blood is necessary. At HNRCA, the effects of taking large amounts of beta-carotene supplements on the concentrations of beta-carotene, other carotenoids, vitamin E, and cholesterol in the various fat compartments of blood were investigated. Also effects of taking beta-carotene supplements on the levels of two form of vitamin A (retinol and retinyl palmitate) were studied. Ten healthy older women were assigned to experimental and control groups. They ingested either 90 mg of beta-carotene or a placebo daily. Three weeks of beta-carotene supplementation resulted in about a 10-fold enrichment of all the lipoprotein fractions with beta-carotene. There was no effect of beta-carotene on plasma and lipoprotein concentrations of other carotenoids, vitamin A, and fat molecules (cholesterol and triglycerides). However, there was an increase in vitamin E levels in plasma and in high-density lipoproteins. These results indicate beta-carotene may have a sparing effect on vitamin E and beta-carotene supplementation may protect vitamin E from destruction.

Elderly may be deficient in cobalamin. A study was conducted at HNRCA to determine vitamin B12 deficiency in a healthy elderly group using measures of vitamin B12-dependent metabolism as indices. At least 12 percent in a large sample of free-living elderly Americans (the Framingham Study) are cobalamin (a chemical complex associated with the vitamin B12 group) deficient. Many elderly persons with seemingly normal vitamin concentrations are, in fact, deficient by these newer and more sensitive criteria.

Agricultural Research Service—Research Projects Related to Nutrition and the Elderly

	Funding Level fiscal year 1994 dollars
Effect of Fiber or Amylose on Metabolic Parameters—BHNRC, 05/01/90–04/30/95. Objective: To determine the effects of high amylose foods or purified versus food fiber on blood parameters associated with chronic diseases and mineral bioavailability	308,426
Newly Available Carbohydrates in the Development of Diet for Control of Risk for Disease—BHNRC, 02/03/95–02/02/97. Objective: To examine use of carbohydrate to maximize physical performance in humans. To examine effects of soluble fibers on cholesterol metabolism and disease risk in humans and animals. To examine long-term effects of carbohydrate intake on disease development or prevention	660,711
Dietary Carbohydrates and Etiology or Prevention of Degenerative Diseases and Their Complication—BHNRC, 04/01/91–03/31/96. Objective: To investigate the underlying mechanisms of how dietary carbohydrates induce biochemical, cellular, molecular and structural changes that either increase or decrease the risk of degenerative diseases that occur during the aging process	344,578
Nutritional and Biochemical Role of Chromium in Health and Disease—BHNRC, 01/23/90–01/22/95. Objective: Determine effects of low Cr intakes of humans on variables associated with sugar and fat metabolism. Determine the effects of physical performance on trace metal metabolism. Develop sensitive methods to detect marginal signs of chromium deficiency. Determine and define the role of chromium in selected abnormalities in glucose metabolism. Determine the bioavailability of various forms of chromium	354,518

	Funding Level fiscal year 1994 dollars
Effect of Dietary Fat on Biochemical and Physiological Markers of Risk for Thrombosis—BHNRC, 05/29/92–05/28/97. Objective: Determine the ability of specific dietary fatty acids to (a) influence eicosanoid metabolism and derivative consequence on blood clotting tendency, and (b) modulate platelet activity and other hemostatic factors that are major determinants of thrombotic risk	558,714
Relation Between Nutrition and Aging: Cholesterol, Bile Acid, Sterol Metabolism and Fecal Mutagenicity—BHNRC, 04/08/94–04/07/99. Objective: To investigate the relationship of fat and other nutrients or components of the human diet to age-related disorders such as cancer and coronary heart disease, as reflected by change in bile acid metabolism, fecal mutageus hormones, serum cholesterol, platelet aggregation, and other parameters affected by diet and suspected of involvement in aging disorders	289,809
Effects of Copper Deficiency and its Modifiers on Cardiovascular Metabolism and Function—GFHNRC, 03/04/91–03/03/96. Objective: Copper deficiency produces a host of adverse anatomical, chemical, and physiological changes in the cardiovascular system in several species including man. Chemical factors that affect blood coagulation and clot lysis and neuroendocrine mechanisms that affect blood pressure will be studied. Modifying factors such as commonly eaten chemicals or food will be studied occasionally. These studies will provide information useful in definition of copper requirements	395,972
Human Mineral Element Requirements and Their Modification by Stressors—GFHNRC, 05/13/91–05/12/96. Objective: Determine the dietary requirements of humans for magnesium, copper, and boron, and whether these requirements are affected by nutritional, physiological, hormonal, or metabolic stressors. Specifically, for humans, to demonstrate that copper is of nutritional concern and that its nutritional need is enhanced by oxidant stress; to demonstrate that inadequate dietary magnesium can have pathological consequences; and to confirm that dietary boron affects measures of macromineral metabolism	1,489,999
Dietary Trace Elements and Physiology of the Cardiovascular and Related Systems—GFHNRC, 02/11/91–02/10/96. Objective: The physiological consequences, especially to the cardiovascular system, of trace element deficiencies, emphasizing copper, will be determined; the effect of copper deficiency on microcirculation, platelet-blood vessel wall interactions, vascular smooth muscle responses, and heart mechanical function will be examined. Whether oxygen-derived free radical damage is the cause of any of the physiological deficits seen in trace element (particularly copper) deficiencies will be determined	409,571
Gastrointestinal function and Metabolism in Aging—HNRC, 12/11/89–12/10/94. Objective: (1) Determine how aging affects the human dietary requirements for vitamin B2 and vitamin B6. (2) To study the effects of small intestinal bacterial over-growth on ethanol metabolism, vitamin bioavailability, lactose intolerance, and fecal enzyme concentration. (3) To determine how aging affects carotene and vitamin A metabolism in the human and in animal models. (4) To delineate the pathways of intestinal carotene metabolism	1,610,494
Function and Metabolism of Vitamin K and Vitamin K Dependent Proteins During Aging—HNRC, 12/11/89–12/10/94. Objective: Molecular, biochemical, and functional assays of vitamin K nutritional status will be developed. These methods will help determine human dietary vitamin K requirements and establish criteria for determining subclinical vitamin K deficiency in human and experimental animals. The vitamin K content and bioavailability of a variety of foods common to the American diet will be determined. Enzymes responsible for the metabolic recycling of vitamin K will be identified, isolated, purified, and characterized	921,775

	Funding Level fiscal year 1994 dollars
Bioavailability of Nutrients in the Elderly—HNRC, 12/11/89–12/10/94. Objective: (1) To determine the bioavailability of food folate and the impact of aging on this process. (2) To define the mechanism of body folate conservation and effect of aging. (3) To assess the folate/vitamin B12 status in the elderly with respect to cardiovascular and neuropsychiatric functions. (4) To define the mechanism of age related decreases in intestinal absorption of calcium. (5) To study the factors that influence the bioavailability of zinc and magnesium	1,635,339
Role of Nutritional Factors in Maintaining Bone Health in the Elderly—HNRC, 12/11/89–12/10/94. Objective: The objective of this lab is to improve the scientific basis for understanding and setting the intake requirements of calcium and vitamin D in aging adults. Specifically, we will define the intake of calcium and vitamin D above which skeletal mineral is maximally spared. This requires an understanding of how demographic, endocrine, and physical factors (e.g. race, sex, age, years since menopause, weight, activity level, and the ability to absorb calcium) affect the requirement of these nutrients	1,007,419
Relationships Between Aging, Functional Capacity, Body Composition and Substrate Metabolism and Need—HNRC, 12/11/89–12/10/94. Objective: To examine the effects of increased physical activity, body composition, and diet on the following: (1) Peripheral insulin sensitivity and glucose metabolism; (2) functional capacity and nutritional status of the frail, institutionalized elderly; (3) cytokine production and whole body and skeletal muscle protein metabolism; and (4) total energy expenditure and its relationship to protein metabolism and requirements	1,447,031
Lipproteins Nutrition and Aging—HNRC, 12/11/89–12/10/94. Objective: Research objectives are: (1) to test the efficiency of a low saturated fat, low cholesterol diet in lowering density lipoprotein (LDL) cholesterol levels in elderly normal and hyperlowlipidemic subjects; (2) to study effects of dietary fatty acids on the production of liver lipoproteins in monkeys; (3) to study the interrelationships of diet and lipoproteins in the population; and (4) to study the regulation of intestinal lipoprotein production by fatty acids and cholesterol in vitro in Caco-2 cells	1,910,688
Effect of Nutrition and Aging on Eye Lens Proteins, Proteases, and Cataract—HNRC, 12/11/89–12/11/94. Objective: One-half of the eye lens cataract operations and savings of over $1 billion would be realized if we could delay cataract by 10 years. We are attempting to use enhancement of dietary antioxidants, such as vitamin C, and other nutrients such as carotenes and folacin to delay damage to lens proteins and proteases and to maintain visual function in elderly populations. This should delay (1) cataract-like lesions in eye lens preparations and (2) cataracts in vivo	772,124
Epidemiology applied to Problems of Aging and Nutrition—HNRCA, 12/11/89–12/10/94. Objective: (1) To define diet and nutritional needs of older Americans. (2) To advance methods in nutritional epidemiology. (3) To relate nutrition to cataract formation and to the function of the aging kidney, skeletal system, and cardiovascular system. (4) To define the changes in body composition associated with aging. (5) To interrelate physical activity and diet with the aging process. (6) To relate low levels of vitamin B12 with neurobehavioral and cognitive function	1,192,600
Aging Nutrition and Immune Response—HNRCA, 12/24/92–12/23/94. Objective: Investigate the role of nutrients and their interactions with other environmental factors in age-associated changes of the immune response, to reverse and/or delay the onset of these immunological changes by dietary modifications, and to use the immune response as an index in determining the specific dietary requirements for older adults	708,019
Amino Acid Metabolism, Aging and Risk of Chronic Disease—HNRCA, 02/10/93–02/09/96. Objective: Determine (1) if impaired polyamine synthesis in lymphocytes of aged individuals accompanies the observed age-related decline in immune responsiveness, (2) if in vivo and in vitro NO/NO2 production and interorgan metabolism of agrinine is altered by aging, and (3) if these processes can be modulated and the effect on host immune function by manipulation of dietary amino acid levels	378,952

	Funding Level fiscal year 1994 dollars
Energy Regulation and Body Composition in Aging—HNRCA, 12/24/92–12/23/95. Objective: To explore the extent and causes of changes in body fat and protein with aging and to investigate optimal values for dietary energy intake and expenditure in the aging population	1,190,934
Dietary Antioxidants, Aging, and Oxidative Stress Status—HNRCA, 12/11/89–12/10/94. Objective: To determine the effect of (1) long-term vitamin E and/or fish oil supplementation in healthy subjects, lipid peroxidation, immune function, and drug metabolism; (2) lowering total fat in the diet in older adults on immune response and eicosanoid metabolism; and, (3) vitamin E on exercise-induced lipid peroxidation in young and old men and the effect of vitamin E and (carotenoids, vitamin C, etc.), and their interactions with polyunsaturated dietary fatty acids, including fish, oils, or immune function and aging	906,221
Mechanisms involved in altered Neurotransmitter Receptor Responsiveness in Senescence—HNRCA, 05–29–93–05–28–96. Objective: To determine: (1) the factors involved in neuronal loss and phosphoinsositide mediated signal transduction (ST) deficits in senescence; (2) nutritional, pharmacological, or molecular methods that will reduce, retard, or reverse these deficits; and (3) if amelioration of these declines will translate into improvements in motor and/or cognitive behaviors	409,481
Regulation of Gene Expression in Nutrient Metabolism—HNRCA, 06/18/93–04/17/95. Objective: Several new areas will be explored aimed at defining the regulatory processes controlling lipogenesis ad fatty acid homeostasis in the mammalian liver. (1) What are the DNA sequence elements and critical protein factors that regulate lipogenic gene transcription in vitro and in vivo in response to diet and metabolic hormones? (2) How does development of the hepatic architecture influence homeostasis of lipogenic gene expression. (3) How aging and genetic factors alter lipogenic gene expression	484,693

ECONOMIC RESEARCH SERVICE

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

The Economic Research Service conducts research and identifies policy issues relevant to the elderly population from the perspectives of rural development and of food spending, safety, nutrition, and food assistance.

Brief description of accomplishments

The ongoing rural development research examine demographic and socioeconomic characteristics of the elderly, as well as their health status and living arrangements, by metro-nonmetro residence. Research based on the 1990 decennial census has focused on retirement areas and changes in the concentration of the older population by residential area. ERS participates in the Interagency Forum of Aging-Related Statistics at the National Institutes of Health and is currently represented on the Forum's work group on Population and Vital Statistics.

RURAL DEVELOPMENT RESEARCH REPORTS

Beale, Calvin L. and Glenn V. Fuguitt, "The Changing Concentration of the Older Population, 1960–90," *Journal of Gerontology,* Vol. 48, No. 6, S278–S288, 1993.

Beale, Calvin L. and Kenneth M. Johnson, "Post-1990 Demographic Trends in Nonmetropolitan America," Working Paper No. 5, Loyola University, Chicago, 1994.

Rogers, Carolyn C., "Social and Physical Context of Rural Aging," Book review of C. Neil Bull's "Aging in Rural America," to be published in forthcoming issue of *Rural Development Perspectives.*

Rogers, Carolyn C., "Health Status of the Older Population in Nonmetro Areas," an article in forthcoming issue of *Rural Development Perspectives.*

Rogers, Carolyn C., "Increasing Disability among the Nonmetro Elderly as They Grow Older," article in forthcoming issue of *Rural Conditions and Trends.*

Brief description of accomplishments

By the year 2030, those over are age 65 will comprise 20–25 percent of the population—that is, 1 out of every 4–5 people. In 1900, only 1 out of 25 people were over age 65. Many physical and physiological changes occur during the aging process. Some of the changes observed among the elderly may be the result of lifelong pat-

terns of food consumption and physical activity. Therefore, improvements in dietary patterns and physical activity could prevent, delay, or even reverse some of these changes. In 1992, annual per person spending increased with age of the household head up to age 64, then declined. However, the share of food expenditure spent away from home tended to decline with age of the household head.

The elderly participate in a number of USDA food assistance programs. In January 1992, the participation rate in the Food Stamp Program by elderly persons was one-third, compared to an overall rate of 74 percent.

FOOD ISSUE RESEARCH REPORTS

Blisard, Noel, and James Blaylock. "Slow Growth in Food Spending Expected." *Food Review,* Vol. 16, No. 2, pp. 2–5, May-Aug. 1993.

Kramer, Tim R. "Nutrition and a Robust Immune System." *Nutrition: Eating for Good Health.* U.S. Department of Agriculture, AIB–685, 1994.

Rosenberg, Irwin H. "Nutritional Needs of the Elderly." *Nutrition: Eating for Good Health.* U.S. Department of Agriculture, AIB–685, 1994.

Smallwood, David M. and James R. Blaylock. "Fiber: Not Enough of a Good Thing?" *FoodReview,* Vol. 17, No. 1, pp. 23–29, Jan.-Apr. 1994.

Smallwood, David M., Noel Blisard, James R. Blaylock, and Steven M. Lutz. *Food Spending in American Households, 1980–92.* Econ. Res. Serv., U.S. Dept. of Agriculture, Statistical Bulletin No. 888. October 1994.

Weaver, Connie M. "Maintaining a Strong Skeleton." *Nutrition: Eating for Good Health.* U.S. Department of Agriculture, AIB–685, 1994.

EXTENSION SERVICE, USDA, AND STATE COOPERATIVE EXTENSION SERVICE EDUCATION PROGRAMS AND ACCOMPLISHMENTS

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

Extension in its lead role as the educational arm of USDA has conducted programs based on research findings that have benefitted older persons, their adult children and caregivers. The vision is for older persons to: maintain and continue a quality lifestyle while aging in place; have a greater opportunity to be financially secure; experience positive human relations; and to have available and know how to access health care options.

In an effort to realize this vision, Extension is networking with national, State, and local organizations and agencies such as: the Administration on Aging, the National Rural Health Associations, the American Association of Retired Persons, the American Society on Aging, the National Council on Aging, the National Council of Negro Women, the White House Conference on Aging staff (WHCOA). A National program leader (NPL) is functioning as a member of the WHCOA Federal Liaison Committee. States and counties have been encouraged and provided information on how to conduct Mini-WHCOA sessions and to submit recommendations to the WHCOA staff. This NPL functions as a member of the National Council of Negro Women's Eldercare Institute Advisory committee. The National office has provided special needs funding to a three-State consortium to "Assess Behavior Changes and Influences on Eating Behaviors in Older Adults' from Food Guide Pyramid Lessons".

State Extension Administrators and Specialists in 74 Land-Grant institutions and county agents in 3,150 local offices have networked, initiated, and conducted many programs. Below are some highlights of these efforts.

Brief description of accomplishments

ALABAMA

Alabama A&M University.—The Extension Program at Alabama A&M University implemented a number of programs designed to respond to the needs of the elderly population in North Alabama. Over 3,000 senior citizens in the University's 12 county service area received practical information applicable to critical issues which they confront daily.

Collaborative efforts with community service agencies such as the Top of Alabama Regional Council of Governments (TARCOG), senior centers, Community Action Agencies (CAA), NACOLG/Area Agency on Aging, and other organizations facilitated the University's rural and urban programs outreach efforts. Specifically, programs were offered in nutrition and health, food safety, consumer fraud, housing, and home maintenance.

Realizing the importance of the home environment to the physical, social, and psychological well being of citizens, particularly the elderly, a large percentage of

programs efforts in the area of elderly housing focused on home care and maintenance. One hundred and forty-one home visits were made and 50 home demonstrations were conducted to address specific housing needs of senior citizens. Thirty-three related radio programs were aired and a number of newsletters were distributed.

A Youth Elderly Service (YES) program was implemented in two counties. Through the program, 77 seniors received assistance with lawn care and general home maintenance from youth volunteers. The YES program seeks to improve the relationship between participating elderly and youth clientele. As a collaborative effort with the Juvenile Courts, the program also seeks to promote the rehabilitation of juvenile offenders, while benefiting the community and elderly citizens. Youth serve under careful supervision.

Under the Decisions for Health Initiative, 1,400 elderly citizens participated in basic nutrition education programs including meal planning and use of the Food Guide Pyramid. Forty-three percent or 604 of the participants reported eating more fruits, vegetables, and grain products as a result of the training.

Under this same initiative, 1,200 individuals received training relative to dietary fat intake. Follow-up evaluations of program efforts indicated that 286 (23%) of those involved in training adopted recommended practices for reducing fat in the diet, and actually lowered their intake.

Additionally, the Urban Component of the Cooperative Extension Program at Alabama A&M conducted a 15 lesson series with senior citizens in Madison County. Clients received information in the fundamental areas of nutrition and health (53 trained), food safety (63 trained) and consumer fraud (69 trained). The participants rated the content of these lessons as being very good and useful.

COLORADO

Thirteen Extension Service faculty members and six other agency representatives form the Gerontology Team that has provided leadership, resources and staff development workshops for county staff and volunteers since 1991. The team published 11 newsletters on Caregiving, Alzheimer's Disease, Parkinson's Disease, Prevention of Falls, Grandparenting etc. These were provided to 100 Extension County offices and aging network personnel in Colorado and others in the Rocky Mountain region. More than 1,700 customers have attended sessions on "Healthwise for Life" which teaches people healthy life styles and health promotion and wellness practices. The team produced 36 news releases that were published in 15 papers. A series of 12 Nutrition Newsletters were provided to county offices on discs so local items and identification could be added. The content included research based information on the Dietary Guidelines and information on the how and where of participating in the Food Stamp and Congregate Mealsite programs. Currently, the newsletter method of the teaching older people is being evaluated to see if behavior changes result in older Coloradans improving their nutrition status as a result of increased nutrition knowledge and knowing how to participate in mealsite, food stamp, and other social service nutrition programs.

FLORIDA

In Florida 1862 and 1890 Extension Service faculty expended a total of 516 days and reached 94,000 aged Whites, 27,000 Blacks, 16,000 Hispanics, and 500 Asians. Over 4,500 seniors attended nutrition and health programs offered at congregate meal sites and health fairs throughout the State. Also, over 41,000 newsletters about nutrition and health concerns reached older adults; these were mailed to their homes, distributed to nursing homes, received in CES offices, or passed out at meal sites in Pasco, Lake, Jackson, and Leon Counties.

Other programs emphasized other aspects of well-being. In Jackson county, over 130 older adults learned how to better manage stress. In Martin, over 100 seniors learned to protect themselves from crime. In Broward, 1,800 seniors in focus groups discussed changes associated with the aging process. In Lake, older adults (139) were helped to find information on community services.

Over 600 seniors attended programs that provided information related to caregiving such as home care, personal care of the elderly, and caregiver stress (Brevard, Lake, Flagler).

Volunteer networks enabled older adults to assist their peers with common concerns. Trained volunteers with the Widowed Persons Service in Lake County reached 235 bereaved persons, providing needed support to ease grief and lift depression, and guidance to assist in avoiding hasty decisions at a difficult time.

In addition, older volunteers in intergenerational programs have assisted many families. In one county (Suwannee) 10 volunteers mailed newsletters on child devel-

opment to over 200 parents of young children and read to 130 children in schools and libraries. In Orange County volunteers made 2,800 "ouch dolls" for children getting immunizations. In Broward County, 50 English-speaking seniors tutored 85 immigrant families; 96 percent of recipients said they learned a great deal. Older volunteers also offered educational programs on consumer fraud, personal safety, financial management, exercising for fitness, stress management, and the aging process (Martin, Jackson, Lake, Volusia).

Through programs on financial management, nearly 600 older adults in Lake, Volusia, Jackson, and Martin Counties increased their ability to make sound financial decisions. In Lake County, over three-fourths of 139 persons attending the program increased their financial knowledge, developed knowledge and confidence in their financial decisions, and gained greater control of their money. In Volusia, almost all who attended workshops (200) said they had improved their knowledge "much" or "very much" and most were taking steps to plan their finances and organize records. In Jackson County, 92 percent started keeping a record of where their money was going and changes they needed to make, and 84 percent had changed their spending habits.

In Jackson County, a 5 part program, "Using Medicines Wisely" was presented to 6 different senior groups with 110 participants. Prior to the program, 93 percent did not have a complete record of medicines taken in their medical record; 68 percent used more than one pharmacy so there was not a complete patient profile for the pharmacist; and 89 percent were not storing their medicines safely. At a 6 month follow-up of 55 participants, 75 percent had prepared a medicines log, 53 percent were using just one pharmacist, and 82 percent were storing medicines properly.

In Osceola County, congregate meal site managers reported changes in their clients' nutritional practices. They indicated that 75 percent of clients (n=1,680) have started trying to add fiber to their diets; 95 percent improved knowledge of healthy bladder and bowel habits; 75 percent now understand food labels.

County extension faculty supported services delivery to Florida's elderly by assisting providers. County faculty saved senior centers money by making food safety and temperature checks of foods prepared for congregate and home-delivered meals. In addition, congregate meal sites are required by law to offer educational programs to their clients. County Extension faculty provided useful information on current topics (such as food labeling and the food guide pyramid) at the centers. Extension extended the reach of services to older adults by offering information on community services available to assist the elderly, through Extension publications, displays, and programs.

County faculty worked with Senior Centers or Older Americans Councils, and most also worked with AARP. Other organizational linkages included Area Agencies on Aging, volunteer agencies such as VISTA and RSVP, hospitals, civil groups, schools, libraries, churches, technical and community colleges, HRS, Hospice, Widowed Person's Service, Social Security Administration, banks, businesses, food banks, Red Cross, the public health department, consumer credit counseling, and city, county, and federal government.

KENTUCKY

Small Group Learning Sessions. Using materials prepared by Cooperative Extension, 3,100 Kentuckians participated in group learning sessions on the topic of Depression in Later Life. An additional 2,000 Kentuckians participated in similar programs on Grandparenting. A variety of other educational sessions on aging, which reached smaller numbers, were conducted across the Commonwealth of Kentucky. Separate from these sessions, a number of new releases on aging were disseminated statewide.

The 2nd Symposium on Aging: Design of Healthcare Environments. This symposium, targeted primarily to a diverse group of aging network professionals, drew an attendance of 250 and was a tremendous success. Both written evaluations and informal feedback reflected an appreciation for the range, depth, and practicality of the information presented during this three day event. Many found that the rich diversity of participants afforded refreshing and valuable networking opportunities. Among those attending were interior designers, nurses, Cooperative Extension professionals, architects, Kentucky Extension Homemaker Association members, University administrators, and a variety of other professionals, including representatives from twelve states outside of Kentucky. This event was particularly timely in that it addressed three areas of current national concern: aging, healthcare, and Americans with disabilities.

Mini White House Conference on Aging. The Fayette County Cooperative Extension Service, in cooperation with the Association of Older Kentuckians, the Division of Aging Services, and Central Kentucky Area Agencies on Aging, conducted a regional White House Conference on Aging in Lexington, Kentucky on July 26, 1994. One-hundred-ninety-nine seniors attended this public forum, including 29 African-Americans and 38 males. High priority issues identified by this energetic and outspoken group included intergenerational concerns, housings, health, taxes, social security, and transportation. The specific concerns raised were conveyed to those planning the Governor's White House Conference on Aging.

GriefWork Project. During 1993, approximately 29,800 Kentuckians over 55 died, leaving behind a far greater number of bereaved loved ones. In addition to the maze of probate, Social Security settlements, and other financial matters bereaved individuals undergo a complicated and intense sequence of mental, emotional, and physical adjustment to the loss of a loved one. Based upon a needs assessment that included numerous individual interviews with key informants and community focus groups, the GriefWork Committee is in the process of developing 20 fact sheets and accompanying support materials. Volunteers will be trained to use these resources and will have available to them a library of books, pamphlets, and videotapes.

New Video Series. An excellent collection of 13 one-hour PBS videotapes, which reflect the latest gerontology research and knowledge base, are now available statewide for special interest sessions. Study guides, developed by Washington State University Cooperative Extension Service, accompany each of the videotapes.

MARYLAND

In Maryland, a Memorandum of Understanding was signed in August, 1992, between the Maryland Office on Aging (MOA) and the Cooperative Extension (CES). The focus of this is to develop and deliver the Nutrition Screening Initiative (NSI) through a concerted, statewide effort, combining State, regional and local resources. Improving the health and well-being of seniors by helping them develop and maintain beneficial nutrition practices is the overall goal. The Project is directed by a program management team, composed of the MOA Director of the NSI and two CES Nutrition Specialists. In addition, a task force comprised of county staff from both agencies advises the management team and helps implement the NSI at the local level, through the State's 19 area agencies on aging.

To execute this program, specific goals, objectives, and guidelines have been established. A training manual for local staff conducting screenings in a variety of settings, such as congregate meals sites, home delivered meals, and health fairs has been developed. This manual describes the screening instrument, lists responsibilities of all participating staff, and suggests ways to plan, promote, and set up for the screening. Effective interviewing and nutrition education strategies are included, as well as guidelines for referral. Extension agents have also listed a variety of ways they can be involved, such as helping to develop projects at the local level, providing educational programs to seniors, setting up display tables, offering food demonstrations and computerized dietary analysis, and developing educational videotapes.

A series of brochures, called "Check it Out," has been developed by the MNSI program management team. Each brochure is focused on a different NSI risk factor, and contains practical tips to motivate seniors to make behavioral changes. The nutrition screening procedures have been pilot tested in four counties with a diverse group of senior citizens. A system for collecting and analyzing statewide data is being established.

In Ann Arundel county, six "You and Your Aging Relative" classes were conducted for 60 caregivers with focus on caregiving, health, nutrition, financial concerns, and community resources. One participant, a RN, shared information and community resource information with patients and caregivers she has contact with at her position at a local medical center. Ten reported using community resource information to meet family needs. Twelve reported taking more time for personal needs when caregiving so as not to burn out.

Three "Grief/Loss and Depression" classes reached 139—a day care group, a retired group and a church group dealing with grief and loss. Participants through class involvement set new goals, practiced coping techniques, and planned activities to focus attention on the positive.

In Frederick County, CES and the wellness center of Frederick Memorial Hospital sponsored "Senior Healthscope" fairs at three Senior Centers.

Another county conducted the Women's Financial Information Program for 65 persons in one of the 8 week series and 82 in the second series. This home economist

also presents a 1 hour call-in radio program weekly on such topics as housing for seniors, estate planning, wills, nutrition etc.

An Extension Specialist has updated and revised five publications for mature children of aging parents to increase their understanding of changing relationships, physical changes, emotional changes, mental changes, and dementia and Alzheimer disease. This specialist served as a resource person for a regional conference of the clergy who were developing a 5-year program for the elderly in their congregations.

"Preventing Foodborne Illness in Elderly Receiving Meal Assistance" is a project that has been funded by Extension Service, USDA because foodborne illness is a widespread and expensive public health problem that is especially hazardous to the elderly. The staff at congregate sites receives minimal training in food safety principles, and many elderly individuals do not practice safe food handling at home. They propose to offer on-site education programs to the staff and recipients of congregate meals and home delivered meals, emphasizing fundamental food safety principles. They expect to see positive changes in knowledge and behavior as a result of the education intervention.

An 1890 Extension home economists will conduct a Mini White House Conference on Aging Forum in which older African American Women will dialogue and make recommendations to the White House Conference on Aging.

MICHIGAN

The AARP and Extension sponsored "Women's Financial Information Program" entered the distance learning arena when Michigan Cooperative Extension Service presented the seven-session program via satellite in March and April 1994. The audience: 32 participants in the campus studio classroom and almost 1,000 participants at 43 locations across the State. Each of the two-and-one-half hour sessions had three components; an introduction, a lecture with a question-and-answer period (questions were phoned in from downlink sites during a break) and small group discussions led by trained facilitators. One Michigan participant drove 124 miles round trip each week to attend the WFIP sessions. Another participant said, "The satellite broadcasts give me the confidence to organize my finances."

MISSOURI

Lincoln University.—Lincoln University Cooperative Extension was one of five Historically Black Colleges and Universities (HBCU's) selected to participate in the National Black Leadership Initiative on Cancer (NBLIC) Rural Intervention and Evaluation Program (RIEP). Lincoln joined four other (HBCU's) in this effort. NBLIC has provided an opportunity for Extension to expand its capacity to deliver culturally sensitive cancer education, prevention, and control programs for limited resource, older Black women and their families in rural Bootheel communities. One of the committee's major responsibilities is to maximize community participation and involvement in the NPLIC program. NBLIC served as the host for one of five press conferences held around the State on National Mammography Day.

A knowledge, attitudes, and practices pilot survey was conducted in two Bootheel counties in order to gain a better understanding of rural Blacks' perceptions about cancer risks, prevention, and treatment and to obtain baseline data regarding the delivery of culturally appropriate public education and outreach activities designed to increase cancer survival rates. A women's breast cancer health pilot survey was conducted as part of the NBLIC outreach program. Both surveys confirmed national survey data that rural Blacks tend to accept common cancer myths more readily (i.e., birth control pills, X-rays, drinking coffee, and eating foods that contain fiber cause cancer), and that they have a more pessimistic attitude toward their chances of getting cancer. An assessment of responses indicates the following: the lack of knowledge, the lack of culturally appropriate data, and the lack of access to rural health services impede the development and implementation of successful cancer prevention and control programs. As a direct result of the success of the first two years of the NBLIC RIEP, Lincoln University Cooperative Extension has been awarded a $183,000 grant entitled, "Cancer Screening Outreach Project for Older African American Women in Southeast Missouri (The Bootheel)." This project has been funded as of November 1, 1994, by the Missouri Department of Health, Breast and Cervical Cancer Control Program (MDOH/BCCCP). Under this grant Lincoln Cooperative Extension will: Plan and conduct a comprehensive outreach breast and cervical cancer intervention program for rural, low-income African American women, 50 years of age and older, who live in the rural Southeast region of Missouri. The objective is to reduce the incidence, morbidity, and mortality of breast and cervical cancer among the target population.

University of Missouri.—The Women's Financial Information Program (WFIP), a national program co-sponsored by AARP and the Extension System, has reached over 2000 Missouri women since the program started in 1990. WFIP covers the basic tools of financial literacy—from getting organized to investing for retirement. The seven part in-depth course includes lectures by experts as well as small group activities and independent assignments. Significant behavior changes have resulted in new or revised wills being made, financial records have been organized and open discussions around financial status and the future have occurred in the family unit. One 63-year-old participant learned that she did not have enough investments or capital for retirement; therefore, she converted a lifelong gardening hobby into a lawn care and gardening business employing three people to increase her retirment resources.

OHIO

Wood County Extension involved 24 retirement village residents and fifth graders in an intergenerational pen-pal project. After months of corresponding the class visited the retirement village and met their pen pals. The program is on-going and students are changing their stereotypes of "poor old people". The pen-pal project was a pilot program of the Senior Series, a compilation of programs for older adults adapted from University of Missouri Extension resources. The Senior Series goal is to help Ohio's elderly residents improve their quality of life and share their experiences with other seniors and younger generations. Over 4,000 Ohio seniors in 19 counties have participated.

NEVADA

In collaboration with AARP and a variety of service and professional organizations, State and Area Resource Management Extension Specialists have presented the Women's Financial Information Program to six groups in five cities and towns in Nevada. The program is designed to empower participants to take control of their finances with confidence. The seven session series have been attended by more than 200 people in the past year and additional sessions are planned for 1995. A follow-up study of participants is in progress and will assess changes in financial management satisfaction with financial situation, and implementation of recommended financial practices (e.g., developing a spending plan, reviewing insurance coverage, setting up a financial record keeping system, etc.)

With funding from the Nevada Division for Aging Services, faculty and staff from the University of Nevada, Reno are currently implementing the Nutrition Screening Initiative (NSI), a national effort to promote routine nutrition screening and improved nutritional care for the elderly. Efforts to date have included nutritional screening of over 2,000 elderly residents. Through educational efforts, dietitians also encouraged elders to take steps to improve their nutritional health. To complement these efforts, dietitians worked with other allied health professionals to enhance their knowledge and skill related to improving the nutritional health of their elderly patients. The next phase of this project will focus on enhancing elders' compliance and understanding of prescribed therapeutic (modified) diets.

NORTH CAROLINA

N.C. A&T State University.—Forty-three Extension Agents across the State have received training on the Senior Wellness Series. The purpose of the Series is to provide information to help senior adults improve the quality of their physical and mental health, and strengthen their independence. Programming efforts are focused on enhancing self-care for the elderly. The programs deal with three important topics of interest to a large number of senior adults-(1) Food and Nutrition; (2) Elimination: Bowel and Bladder; (3) Using Medicines Wisely. A major emphasis for these outreach programs has been to reach the rural minority seniors. Networking with other organizations; having volunteers assist with transportation, and conducting programs at convenient locations such as nutrition meal sites have helped us to reach the targeted audience.

Other group programs for senior citizens provide information on budgeting/money management, home/personal safety, estate planning and health insurance. Senior citizens also receive one-to-one assistance in budgeting and money management for those on fixed incomes. Volunteers receive training through the Senior Health Information Program to assist senior citizens with questions related to Medicare and Medicare Supplement policies and long-term care insurance.

N.C. State University.—North Carolina is moving ahead in addressing the elder care information needs of aging and older adults and caregivers, with maintenance-level programs continuing on (1) elder care awareness, (2) planning ahead for elder

care decisions, (3) volunteer information provider programs, and (4) training family caregiver programs. Over 16,000 older adults and elder care providers were involved.

Networking among agencies to organize and conduct elder care programs have benefitted family caregivers, who report reduction of stress as a result of the information and emotional support they have received. These new partnerships have resulted in staffs understanding each other's programs better and in many counties they meet regularly to maintain better coordination among agencies. Five agents in 1993–94 reported working with 229 members of their local aging networks, and many other agents reported such contacts without quantifying them. Extension involvement in interagency aging activities has been of value in many counties as they make the transition to the new way to fund county aging services through the Home and Community Care Block Grant (HCCBG). Of special note is Halifax County, where CES houses a county-funded coordinator of aging services who monitors county use of $403,000 in HCCBG funds. Halifax and Northampton provide leadership for the annual Roanoke Valley Aging Conference, and the Unifour Counties this year organized an Older Families Forum, attended by 176, with requests that it be an annual event. A foundation funded NE Regional Elder Care Project is an exemplary program is which $10,000 per year (a 3-year grant) has permitted the poorest region of the State to motivate professionals and volunteers to reach family caregivers with directories of aging services and provide emotional support to the people carrying out this major family responsibility.

The Medicare Myths training for pre-retirement audiences was delivered in September 1994 in an attempt to reduce/avoid some of the financial and emotional problems of today's older adults, whose planning was based on misinformation. This packaged program is expected to reach many new audiences and to promote the use of Extension's interrelated financial management, elder care, estate planning, and retirement planning programs.

FARMERS HOME ADMINISTRATION

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

Currently FmHA has two programs that directly affect older Americans:

Federal Domestic Assistance (FDA) Catalog Number 10.415 Rural Rental Housing (RRH) Loans empowers the agency authorized under the Housing Act of 1949, as amended, Section 515 and 521, Public Law 89–117, 42 U.S.C. 1485, 1490a, to make RRH loans. The objectives of this program are to provide and construct rental and cooperative housing and related facilities suited for independent living for rural residents. Occupants must be low-to-moderate income families, and, in some cases, elderly (62 years or older) or disabled.

Funds obligated for fiscal year 1994 for the 515 programs totaled $512,394,227.

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

For fiscal year 1994, appropriations were (loans) $35,000,000; (grants) $25,000,000.

FOOD AND CONSUMER SERVICE (FCS)

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

The Food Stamp Program provides monthly benefits to help low-income families and individuals purchase a more nutritious diet. In fiscal year 1994 $22 billion in food stamps were provided to a monthly average of 27 million persons.

Households with elderly members accounted for approximately 16 percent of the total food stamp caseload. However, since these households were smaller on average and had relatively higher net income, they received only 6 percent of all benefits issued.

Brief description of accomplishments

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

In response to the recommendations of recent GAO audit report, FCS and SSA have formed a workgroup to address the failures and inadequacies of the current joint processing system. FCS published a Federal Register notice soliciting recommendations for joint processing improvements.

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

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

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

Brief description of accomplishments

In 1993, total distributions for the program were valued at about $90 million.

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

The Commodity Supplemental Food Program provides supplemental foods, in the form of commodities, and nutrition to infants and children up to age 6, pregnant, postpartum or breastfeeding women, and elderly who have low incomes and reside in approved project areas.

Service to the elderly began in 1982 with pilot projects. In 1985, legislation allowed the participation of older Americans outside the pilot sites if available resources exceed those needed to serve women, infants and children. In fiscal year 1993, $30 million was spent on the elderly component.

Brief description of accomplishments

About 33 percent of total program spending provides supplemental food to approximately 140,000 elderly participants a month. Older Americans are served by 18 of 20 State agencies.

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

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

Approximately $18 million of total costs went to households with at least one elderly person. (This figure was estimated using a 1990 study that found that approximately 39 percent of FDPIR households had at least one elderly individual.)

Brief description of accomplishments

This program serves approximately 44,000 households with elderly participants per month.

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

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

The adult day care component permits adult day care centers to receive reimbursement of meals and supplements served to functionally impaired adults and to persons 60 years or older. An adult day care center is any public or private nonprofit organization or any proprietary Title XIX or Title XX center licensed or approved by Federal, State, or local authorities to provide nonresidential adult day care services to functionally impaired adults and persons 60 years or older. In fiscal year 1993, $18 million was spent on the adult day care component.

Brief description of accomplishments

The adult day care component of CACFP served approximately 17 million meals and supplements to over 36,000 participants a day.

In 1993, the National Study of the Adult Component of CACFP was completed. Some of the major findings of the study include: overall, about 31 percent of all adult day care centers participate in CACFP; about 43 percent of centers eligible for the program participate. CACFP adult day care clients have low incomes; 84 percent have incomes of less than 130 percent of poverty. Many participants consume more than one reimbursable meal daily; CACFP meals contribute just under 50 percent of a typical participant's total daily intake of most nutrients.

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

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

Approximately $100 million in commodities were distributed to households including an elderly person. (This figure is estimated using a 1986 survey indicating that about 38 percent of TEFAP households have members 60 years of age or older.)

Brief description of accomplishments

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

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

The Nutrition Program for the Elderly (NPE) provides cash and commodities to States for distribution to local organizations that prepare meals served to elderly persons in congregate settings or delivered to their homes. The program promotes good health through nutrition assistance and by reducing the isolation of old age. USDA supplements the Department of Health and Human Services' Administration on Aging with approximately $152 million worth of cash and commodities.

Brief description of accomplishments

In fiscal year 1993 over 245 million meals were reimbursed at a cost of almost $145 million. On an average day approximately 925,000 meals were provided at over 14,000 sites.

FOOD SAFETY AND INSPECTION SERVICE (FSIS)

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

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

Brief description of accomplishments

FSIS continues to distribute food safety information to this group through direct mail of publications and liaison work with the Administration on Aging.

In addition, exhibits were presented and food safety information was distributed through the annual meeting of the American Society on Aging.

FOREST SERVICE

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

This program year, July 1, 1993–June 30, 1994, the USDA Forest Service's Senior Community Service Employment Program (SCSEP) provided an opportunity for 5,476 participants, age 55 years and above, to upgrade their work skills by receiving employment and training opportunities while providing community service to the general public.

Volunteers continue to contribute to the management of the Nation's natural resources that are administered by the USDA Forest Service. During fiscal year 1994, 93,725 participants assisted in the management of the National Forest System, including 13,898 participants age 55 years and above. Volunteers participate in resource protection and management, cooperative/international forestry, and research. Typical positions include campground host; information specialist; fire lookouts; and recreation, wildlife, and fisheries assistants.

Brief description of accomplishments

As a result of this training, 703 of our participants received full or part-time employment.

RURAL DEVELOPMENT ADMINISTRATION

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

The Rural Development Administration's (RDA) Community Facilities program directly affects older Americans.

Federal Domestic Assistance Catalog number 10.766, Community Facilities (CF) Loans, empowers the agency authorized under the Consolidated Farm and Rural Development Act, as amended, Section 306, Public Law 92–419, 7 U.S.C. 1926, to make CF loans. The objective of this program is to provide essential community services to rural residents. Loan funds can be used to construct new facilities. Under this program, RDA makes loans for the following type facilities that directly affect older Americans:

Physicians and Dental Clinics
Nursing Home
Boarding Home for Elderly (Ambulatory Care)
Hospital (General and Surgical)
Outpatient Care
Visiting Nurses (In Home Health Care)
Rescue and Ambulance Service
Senior Citizens Retirement Home
Senior Citizens Community Center
Adult Day Care Center
Food Perpetration Center
Public Transportation

For the fiscal year ending September 30, 1994, RDA made Community Facility loans as follows:

234 Direct Loans for $163,000,000
40 Guaranteed Loans for $30,000,000

Federal Domestic Assistance Catalog number 10.768, Business and Industrial (B&I) Loans, empowers the Agency authorized under the Consolidated Farm and Rural Development Act, as amended, Section 310B, Public Law 92–419, 7 U.S.C. 1932. The Rural Development Administration (RDA) B&I Loan Program provides guarantees on loans obtained through private lenders for business and industry located outside the boundary of a city of 50,000 or more and its immediately adjacent urbanized area. These loans are made for purposes of developing and financing business and industry, increasing employment and controlling pollution, or other facilities that directly affect older Americans.

Hospitals
Nursing Homes
Doctor's Offices
Physicians and Dental Clinics
Outpatient Care Facilities

For the fiscal year ending September 30, 1994, RDA made B&I loans as follows:

106 Guaranteed Loans for $129,342,519.

ITEM 2. DEPARTMENT OF COMMERCE

ORGANIZATION OF THIS REPORT

This report includes a listing of reports from the Census Bureau that contain demographic and socioeconomic information on the elderly population, and five sections describing other reports, papers, data bases, and continuing work from the Census Bureau relating to the elderly population 65 years and older. The following describes the contents of each component of the report.

1. Listing of reports.—Provides a listing of the reports that contain data on the elderly population 65 years and over from the Current Population Reports series, the Current Housing Reports series, the International Population Reports series, and the Special Studies Reports series. The Current Population Reports series is an important source of demographic information on a wide variety of population-related topics. Much of the current population data from the Census Bureau are derived from the Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP). The Current Housing Reports series presents housing data primarily from The American Housing Survey, a biennial national sample survey of approximately 55,000 housing units. The International Population Reports series includes demographic and socioeconomic data reported by various national statistical offices, several agencies of the United Nations (UN), and the Organization for Economic Cooperation and Development. Most of the projected data come from data files of the Census Bureau. The Special Studies Reports series provides information pertaining to methods, concepts, or specialized data. The Census Bureau publishes reports on youth, women, the older population, and other topics in this series.

2. Bureau of the Census Decennial Products and Projects.—Provides a summary of 1990 Census Printed Reports, Computer Tape Files, CD–ROMs, Summary Tape Files, Population Subject Summary Tape Files and Housing Subject Summary Tape Files that contain characteristics of persons 65 years and over.

3. Bureau of the Census International Research on Aging.—Provides a summary of analytical studies and other ongoing international aging projects. Reports are based on compilations of data obtained from individual country statistical offices, various international organizations, and estimates and projections prepared at the Census Bureau and included in the International Data Base on Aging.

4. The Federal Interagency Forum on Aging-Related Statistics.—Provides a summary of the activities of the Federal Interagency Forum on Aging-Related Statistics (The Forum) for which the Census Bureau is one of the lead agencies. The Forum encourages cooperation, analysis, and dissemination of data pertaining to the older population.

5. Projects Between the Census Bureau and the Administration on Aging.—Provides a summary of projects between the Census Bureau and the Administration on Aging relating to the older population.

6. Projects Between the Census Bureau and the National Institute on Aging.—Provides a summary of the projects between the Census Bureau and the National Institute on Aging relating to the older population.

BUREAU OF THE CENSUS—CURRENT POPULATION REPORTS—1994

Series P–20 (Population Characteristics):

	No.
Regularly recurring reports in this series contain data from the Current Population Survey on geographical mobility, fertility, school enrollment, educational attainment, marital status, households and families, persons of Hispanic origin, voter registration and participation, and various other topics for the general population as well as the elderly population 65 years and older.	
School Enrollment—Social and Economic Characteristics of Students: October 1993	479
Marital Status and Living Arrangements: March 1993	478
Household and Family Characteristics: March 1993	477
Educational Attainment in the United States: March 1993 and 1992	476
The Hispanic Population in the United States: March 1993	475
School Enrollment—Social and Economic Characteristics of Students: October 1992	474
Geographical Mobility: March 1991 to March 1992	473
Residents of Farms and Rural Areas: 1991	472
The Black Population in the United States: March 1992	471
Fertility of American Women: June 1992	470
Voting and Registration in the Election of November 1992	466

	No.
The Asian and Pacific Islanders Population in the United States: March 1991 and 1990	459
Series P–23 (Special Studies):	
Information pertaining to methods, concepts, or specialized data is furnished in these publications. The reports in this series contain data on mobility rates, homeownership rates, and Hispanic population for the general population and the older population. The report "Sixty-Five Plus in America," focuses on analyses of demographic, social and economic trends among the older population.	
How We're Changing: Demographic State of the Nation: 1994	187
Population Profile of the United States: 1993	185
How We're Changing: Demographic State of the Nation: 1993	184
Hispanic Americans Today	183
Households, Families, and Children: A 30-Year Perspective	181
Sixty-Five Plus in America	178RV
How We're Changing: Demographic State of the Nation: 1992	177
Series P–25 (Population Estimates and Projections):	
This series includes monthly estimates of the total United States population, annual midyear estimates of the U.S. population by age, sex, race, and Hispanic origin, and State estimates by age and sex, and projections for the United States and States.	
State Housing Unit and Household Estimates: April 1, 1980 to July 1, 1993	1123
Projections of the Voting-Age Population for States: November 1994	1117
Population Projections for States, by Age, Sex, Race, and Hispanic Origin: 1993 to 2020	1111
State Population Estimates by Age and Sex: 1980 to 1992	1106
Population Projections of the United States, by Age, Sex, Race, and Hispanic Origin: 1993 to 2050	1104
U.S. Population Estimates, by Age, Sex, Race, and Hispanic Origin: 1980 to 1991	1095
Projections of the Voting-Age Population, for States: November 1992	1085
Series P–60 (Consumer Income):	
This report presents data on the income and poverty status of households, families, and persons in the United States for the calendar year 1993. These data were derived from information collected in the March 1994 Current Population Survey.	
Income, Poverty, and Valuation of Noncash Benefits: 1993	188
Series P–70 (Household Economic Studies):	
These data are from The Survey of Income and Program Participation (SIPP) which is a national survey conducted by the Census Bureau. Its principal purpose is to provide better estimates of the economic situation of families and individuals. These reports include data on the elderly population 65 years and older.	
Dynamics of Economic Well Being: Poverty, 1990–1992	42
Dynamics of Economic Well-Being: Program Participation, 1990–1992	41
Dynamics of Economic Well-Being: Labor Force and Income, 1990–1992	40
Dynamics of Economic Well-Being: Health Insurance, 1990–1992	37
Household Wealth and Asset Ownership: 1991	34
Americans with Disabilities: 1991–1992	33
Statistical Briefs:	
The Earnings Ladder: Who's at the Bottom? Who's at the Top?	SB/94–3RV
Preparing for Retirement: Who Had Pension Coverage in 1991?	SB/93–6

CURRENT HOUSING REPORTS

Series H–111:	
These reports provide statistics on occupied and vacant housing units for the third quarter of 1994, 1993 and selected years from 1960 to 1992. The statistics in this report are based on data collected in two different sample surveys conducted by the Census Bureau. Estimates and characteristics of occupied and vacant housing units are based on data obtained in the monthly Current Population Survey/Housing Vacancy Survey (CPS/HVS).	
Housing Vacancies and Homeownership: Third Quarter, 1994	94/Q3
Housing Vacancies and Homeownership: Annual Statistics: 1993	93–A

Series H–121:

No.

These reports present data from the American Housing Survey. Some characteristics shown in these reports include socioeconomic status of household, physical condition of the housing unit and affordability of housing in relation to income.

America's Racial and Ethnic Groups: Their Housing in the Early Nineties 94–3
Households at Risk: Their Housing Situation 94–2
Tracking the American Dream: 50 Years of Housing History from the Census Bureau: 1940 to 1990 94–1
Housing Characteristics of Rural Households: 1991 93–5
Homeowners, Home Maintenance, and Home Improvements: 1991 93–4
Who Can Afford to Buy a House in 1991? 93–3
Our Nation's Housing in 1991 92–2
First Time Homeowners 93–1

Series H–123:

This report includes housing related data from the Census Bureau; the Bureau of Labor Statistics; the Federal Housing Finance Board; and the National Association of Realtors. The Census Bureau data were collected primarily from the American Housing Survey, decennial census, and from current construction statistics. This report describes selected characteristics of the Nation's housing and its occupants, housing costs, income of homeowners and renters and other related topics.

Housing in America: 1989/90 91–1

Series H–150:

This book presents data on apartments; single-family homes; mobile homes; vacant housing units; age, sex, and race of householders; income; housing and neighborhood quality; housing costs; equipment and fuels; and size of housing units. The book also presents data on homeowner's repairs and mortgages, rent control, rent subsidies, previous unit of recent mover, and reasons for moving.

American Housing Survey of the United States in 1991 91

Series H–170:

This book presents data for selected metropolitan statistical areas for the same characteristics shown above in Series H–150.

American Housing Survey for Selected Metropolitan Statistical Areas (Eleven Metro Areas per year are produced on a 4-year rotation for a total of 44 metro areas) .....92– (MSA)

International Population Reports

Series P–95:

The reports in this series contain demographic and socioeconomic data on the older population as estimated or projected by the Census Bureau or published by various national statistical offices, several agencies of the United Nations (UN), and the Organization for Economic Cooperation and Development.

Aging in Eastern Europe and the Former Soviet Union 93–1
An Aging World II 92–3
Population and Health Transitions 92–2
Aging in the Third World 79
An Aging World 78

Wallchart: "Global Aging Comparative Indicators and Future Trends" was issued in September 1991. The statistics shown in the wall chart are based largely on information from the International Data Base on Aging. The multicolored chart includes demographic and social statistics for 100 countries. It also features tables and graphs that highlight important research topics in the field of aging.

Special Series

Profiles of America's Elderly:

Growth of America's Elderly in the 1980's (Number 1)
Growth of America's Oldest-Old Population (Number 2)
Racial and Ethnic Diversity of America's Elderly Population (Number 3) 93–1
Living Arrangements of the Elderly (Number 4) 93–2

Wallchart: "Elderly in the United States" was issued in September 1992. The statistics shown in the wall chart are intended to highlight dimensions of aging in American states. Data are primarily from the 1990 Census of Population. Projections for the United States and States are from Series A issued in 1990 and are available through 2010.

OTHER REPORTS, PAPERS, DATA BASES, AND CONTINUING WORK

I. Bureau of the Census Decennial Products and Projects

A. 1990 CENSUS PRINTED REPORTS

The Census Bureau released 1990 Census of Population, General Population Characteristics (CP–1) and General Housing Characteristics (CH–1). These volumes contain demographic data and basic housing data collected from all households and group quarters. There is an individual report for each State, a summary volume for the United States, a summary report for metropolitan areas, a separate summary report for urbanized areas, and data for individual areas below the state level.

The General Population Characteristics report includes an age distribution to "105 years and over" by sex, race, and Hispanic origin; household and group quarters population; marital status; and household relationships. The General Housing Characteristics reports have information on age of householders. Data are available for households with elderly householders on the number of one-person households, persons per room, tenure, value and rent, number of units in structure, and whether meals are included in rent.

The Census Bureau released reports containing social and economic information from a sample of households and persons in group quarters. One report, Social and Economic Characteristics (1990 CP–2), contains information on language, educational attainment, living arrangements, labor force status, and income and poverty status in 1989 by age. The Detailed Housing Characteristics (1990 CH–2), reports have information for householders 65 years and over in occupied housing units by selected characteristics (for example, mean household income in (1989) dollars, one-person households, lacking complete plumbing, and no telephone in unit).

The Population and Housing Characteristics for Census Tracts and Block Numbering Areas (1990 CPH–3) report includes an age distribution to "85 years and over" by sex; and household type and group quarters information for persons "65 years and over." The report also contains data on disability, poverty status in 1989, and selected housing characteristics for occupied housing units with a householder 65 years and over by race and Hispanic origin in selected census tracts/BNAs.

The Population and Housing Characteristics for Congressional Districts of the 103rd Congress (1990 CPH–4) report includes an age distribution to "85 years and over" by sex; household type and relationship; and householder 65 years and over living alone. The report also provides information for persons 65 years and over on disability, poverty status by race, and Hispanic origin, and the number of civilian veterans. Poverty data also are shown for persons 75 years and over. Selected housing characteristics are shown for occupied housing units with a householder 65 years and older.

The Census Bureau released six population subject reports that contain data on the older population. These reports include The Foreign-Born Population in the United States (1990 CP–31); Ancestry of the Population in the United States (1990 CP–3–2); and Persons of Hispanic Origin in the United States (1990 CP–3–3); Education in the U.S. (1990 CP–3–4); Asians and Pacific Islanders in the United States (1990 CP–3–5); Characteristics of American Indians by Tribe and Language (1990 CP–3–7). The Census Bureau also released the housing subject report, Metropolitan Housing Characteristics, which contains data on the older population.

The Census Bureau issued tabulations from the 1990 census on the nursing home population. The report, Nursing Home Population: 1990 (CPH–L–137), provides state-by-state information on the nursing home population, by age, sex, and marital status. Do You Know Which 1990 Products Contain Data on the Older Populations? describes how census data are obtained, how age is defined, and which census products show information on the older population. We, the American Elderly uses data from the 1990 census to profile the Nation's older population.

B. Computer Tape Files and CD–ROMs

Public-Use Microdata Samples (PUMS)

The Census Bureau released the 5-percent and 1-percent Public-Use Microdata Samples (PUMS) for the 1990 census. These PUMS files show most population and

housing characteristics. The PUMS files are available for the Nation, each State, the District of Columbia, and Puerto Rico.

The Public-Use Microdata Sample on the Older Population (PUMSO)

The Census Bureau released the 3-percent elderly PUMSO file. The file contains data for all household members in households occupied by a person 60 years and over. The file provides data users the capability to produce their own tabulations not available in general-purpose census data products. Data users also have the capability to analyze data on the older population, including the very old (85 years and over) such as living arrangements, income in 1989, and sources of household income from which older members may benefit.

The Census Bureau also released the 10-percent samples for Guam and the U.S. Virgin Islands. The 5-percent sample for the United States is available on CD–ROM.

The PUMS and PUMSO files for the United States may be combined to obtain a larger sample of elderly records.

Summary Tape Files

The Census Bureau released four main data files on computer tape form the 1990 census. These are Summary Tape Files (STFs) 1, 2, 3, and 4. STF 1 and STF 2 contain complete-count data, and STF 3 and STF 4 contain sample data ("long-form" data collected from about 1 in 6 households).

STF 1 and STF 3 data are also available on CD–ROM for those who use microcomputers. Software for finding the data is included with each CD–ROM; the software (called "GO") is menu-driven and user-friendly.

Population Subject Summary Tape Files

Characteristics of Adults With Work Disabilities, Mobility Limitations, or Self-Care Limitations (SSTF) 4

This file contains both 100-percent and sample data for the United States, States, the District of Columbia, counties with 50,000 or more persons, and Metropolitan Statistical Areas with 250,000 or more persons. The B Record of the file has 70 population tables. This record presents data for civilian noninstitutionalized persons 16 years and over with work disabilities and without work disabilities. Some of the characteristics shown in this file include age, educational attainment, group quarters, Hispanic origin, household type and relationship, income in 1989, tenure, race, ratio of income in 1989 to poverty level, units in structure, vehicles available, and veteran status. Age as presented in this file has an upper category of 75 years and over in most tables.

Education in the United States (SSTF) 6

This file contains population items for the United States, States, and the District of Columbia. Two tables in this file provide data on the older population. Educational attainment data are shown by sex and age (upper category of 85 years and over). The School Enrollment table includes an age distribution to "75 years and over" by type of school and sex.

Employment Status, Work Experience, and Veteran Status (SSTF) 12

This file contains both 100-percent and sample data for the United States, States, the District of Columbia and each metropolitan area. The population items include age, class of worker, educational attainment, employment status, group quarters, household type and relationship, income in 1989, marital status, occupation, period of military service, residence in 1989, school enrollment, sex, veteran status, work status in 1989, and year last worked. Age as presented in this file has an upper category of 75 years and over or 85 years and over.

Fertility (SSTF) 16

This file contains both 100-percent and sample data for the United States, States, and the District of Columbia. The population items include children ever born, children ever born per 1,000 women, citizenship, educational attainment, employment status, Hispanic origin, income in 1989, marital status, place of birth, poverty status in 1989, school enrollment, type of residence, and year of entry to the United States. Age as presented in this file has an upper category of 75 years and over.

Journey to Work in the United States (SSTF) 20

This file includes summary characteristics of economic, social, and housing data for the United States; metropolitan areas, central cities, and balance of metropolitan areas in the aggregate; nonmetropolitan areas in the aggregate; individual metropolitan areas, central cities and balance of each metropolitan area. Characteristics

related to journey-to-work include place of work, means of transportation to work, travel time to work, time leaving home to go to work, and private vehicle occupancy for workers 16 years and over. Age as presented in this file has an upper category of 75 years and over.

Earnings by Education and Occupation (SSTF) 22

This file contains earnings by education and occupation for the United States, States and the District of Columbia, and metropolitan statistical areas of 500,000 or more population. Earnings for detailed occupations are shown by age, sex, and education. Earnings for occupation groups are shown by race, age, education.

Housing Subject Summary Tape Files

Housing of the Elderly (SSTF) 8

This file contains both 100-percent and sample data housing items for the United States, States and District of Columbia, inside and outside metropolitan areas, and Metropolitan Statistical Areas. Housing data are given by age of householder. The most detailed age groups show 5-year age groups from "60 to 64" years of age up to "90 years of age or older." The file also provides housing data for persons 60 years of age or older who live in a housing unit with a householder who is under 60 years of age. Housing characteristics are repeated by race, Hispanic origin, and household type. Data by household income are incorporated in some of the tables, particularly ones for financial characteristics such as housing costs.

Housing Characteristics of New Units (SSTF) 9

This file contains characteristics of persons by age living in new housing units. Data are available for the United States, regions, States, all metropolitan areas (MA), and central cities within the MAs.

Mobile Homes (SSTF) 10

This file contains data on persons by age living in mobile homes. Data are available for the United States, regions, States, all MAs, and central cities within the MAs.

Condominium Housing Units (SSTF) 18

This file contains data on persons by age living in condominium housing units. Data are available for the United States, regions, States, all MAs, and central cities within the MAs.

II. Bureau of the Census International Research on Aging

A. Studies from the International Data Base on Aging

1. A brief article on "An Aging World Population" (by Kevin Kinsella) appeared in the bimonthly World Health Organization magazine "World Health" (July-August 1994).

2. A chapter discussing the demography of aging worldwide was prepared for publication in a forthcoming 1995 British Medical Journal volume entitled "Epidemiology of Old Age."

3. The Census Bureau updated the 1987 publication, "An Aging World." The new report, "An Aging World II", Series P95/92–3 was issued in February 1993, and assesses demographic, social, economic, and health trends from recent population censuses and surveys. The report also emphasizes a number of additional topics: the oldest old; aging in Eastern Europe; health and disability-free life expectancy; and institutionalization and other living arrangements.

4. The Census Bureau released in November 1993, "Aging in Eastern Europe and the Former Soviet Union", Series P95/93–1. The report includes topics on basic demographic trends, health status, and various socioeconomic dimensions of the elderly in this region of the world.

5. The Census Bureau completed updates in 1994 for the original 42 countries in the International Data Base on Aging, and added 43 countries to the data base. Additional countries are being incorporated on a flow basis (1994).

6. An updated version of the paper, "Living Arrangements of the Elderly and Social Policy: A Cross-National Perspective," by Kevin Kinsella of the Census Bureau was published in the proceedings of the International Conference on Population Aging in San Diego, September 17–19, 1992. The paper examines family and household structure, changes over time, and potential implications for social support and expenditures.

7. A revised version of an earlier Census Bureau report entitled "Population Aging in Southern Africa" was prepared for the National Institute on Aging in June 1994.

8. A paper on "The Demography of Aging: Essentials of Short-Term Training" was prepared by Kevin Kinsella for the International Institute on Aging Expert Group Meeting on Short-Term Training in the Demographic Aspect of Population Aging and its Implications for Socioeconomic Development, Policies and Plans, held in Malta in December 1993.

9. "Aging and the Family: Present and Future Demographic Issues" is a chapter by Kevin Kinsella in the forthcoming "Handbook on Aging and the Family", to be published by Greenwood Press in January 1995. The chapter considers the effects of reduced fertility, lengthening life expectancy, the epidemiologic transition, and altered living arrangements on family and household structures.

10. "China's Aging Population: Implications in Rural and Urban Areas," a paper by Christina Harbaugh and Judith Banister, was presented at the annual meeting of the Association of Asian Studies in Los Angeles in March 1993.

11. The Census Bureau issued in December 1992, "Population and Health Transitions", Series P95/92–2. This report looks at aspects of the demographic and epidemiologic transitions in Eastern Europe and the developing world, and discusses several implications for health policy. An excerpt of this report was presented at the United Nations Expert Group Meeting on Population Growth and Demographic Structure in Paris, November 16–20, 1992.

12. "Population Aging in Africa: The Case of Zimbabwe" appeared in "Changing Population Age Structures. Demographic and Economic Consequences and Implications", published by the United Nations Economic Commission for Europe (Geneva) in 1992. Kevin Kinsella is the author.

13. A chapter entitled "Dimensiones demograficas y de salud en America Latina y el Caribe" (Demographic and health dimensions in Latin America and the Caribbean), by Kevin Kinsella, was included in a 1994 Pan American Health Organization volume "La atencion de los ancianos: undesafio para los anos noventa" (Scientific Publication No. 546). This chapter examines demographic and socioeconomic characteristics of the elderly in developing countries of the Western Hemisphere.

14. "Research on the Demography of Aging in Developing Countries," by Kevin Kinsella of the Census Bureau, and Linda Martin of the National Academy of Sciences, was presented at the Workshop on the Demography of Aging, Committee on Population, National Academy of Sciences, Washington, DC, December 10–11, 1992, and subsequently was published as a chapter in Demography of Aging (National Academy Press, 1994).

15. The "Journal of Cross-Cultural Gerontology" began in 1992 to include an "Aging Trends" report in each of its issues. Reports appearing in 1994 included Indonesia (by Arjun Adlakha and David Rudolph of the Census Bureau), Southern Africa (by Yvonne Gist of the Census Bureau), and Taiwan (by Rose Li of the National Institute on Aging).

16. "Demographic Dimension of Population Aging in Developing Countries," by Kevin Kinsella of the Census Bureau and Richard Suzman of the National Institute on Aging, is an article in the "Journal of Human Biology", Vol. 4, pages 3–8, 1992. In this article, several demographic aspects of population aging in developing countries are considered: the oldest old, median population age; life expectancy and mortality; functional status and disability, and sex differences. While our understanding of the demographic impact of population aging is becoming better appreciated, research on the descriptive epidemiology of age-related changes in health and physical functioning in developing countries is still at an early stage.

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

18. "Changes in Life Expectancy—1900 to 1990" was prepared by Kevin Kinsella of the Census Bureau for presentation at an International Conference on Aging: Nutrition and the Quality of Life in Marbella, Spain, and later published in the American Journal of Clinical Nutrition (Vol. 55, 1992). The paper summarizes levels of and changes in life expectancy at birth and at older ages in industrialized countries during the 20th century. Trends in mortality and morbidity are summarized in the context of the historic epidemiological transition from infectious to chronic diseases. Cause-specific mortality and decomposition of life expectancy into active and inactive components are examined. There is also an initial attempt to correlate life expectancy with physical attributes that may reflect differences in nutrition.

19. "Demography of Older Populations in Developed Countries" was published as a chapter in the Oxford Textbook of Geriatric Medicine in 1992. Richard Suzman of the National Institute on Aging, Kevin Kinsella of the Census Bureau, and George C. Myers of Duke University are the authors. The chapter explores dif-

ferences and similarities in the aging process and among the elderly populations of 34 industrialized nations. The chapter reviews past and projected trajectories of the growth of older populations, socioeconomic characteristics, and current and expected health status.

20. "The Paradox of the Oldest Old in the United States: An International Comparison" was published as a chapter in "The Oldest Old", ed. by Richard Suzman, David Willis, and Kenneth Martin, Oxford University Press publication, 1992. Barbara Boyle Torrey and Kevin Kinsella of the Census Bureau and George C. Myers of Duke University are the authors. The paper focuses on demographic trends, marital status and living arrangements, and income, related to the oldest old (80+) in eight countries. Data are shown from 1985 to 2025.

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

22. A software version of the International Data Base on Aging was created for use on microcomputers and is being distributed by the Interuniversity Consortium for Political and Social Research at the University of Michigan.

23. A wall chart on Global Aging was prepared by the Census Bureau for distribution in September 1991. It is based largely on information from the International Data Base on Aging. The multicolored chart includes demographic and social statistics for 100 countries. It also features tables and graphs that highlight important research topics in the field of aging.

24. "A Comparative Study of the Economics of the Aged" was presented at the Conference on Aged Populations and the Gray Revolution in Louvain, Belgium in 1986. Barbara Boyle Torrey and Kevin Kinsella of the Census Bureau and Timothy Smeeding of Vanderbilt University are the authors. The paper presents estimates of how social insurance programs for the elderly have grown as a percentage of gross domestic product in several countries partly as a result of lowering retirement age and an increase in real benefits. It then discusses how the labor force participation of the elderly in these countries has uniformly declined. Finally, it examines what contribution the Social Security benefit makes to the total income of the elderly and how the average income of the elderly compares with the average national income in each country.

25. "Aging in Eastern Europe and the Former Soviet Union" was published in "International Population Reports", Series P–95, No. 93–1 (1993).

26. "An Aging World II" was published in "International Population Reports", Series P–95, No. 92–3 (1993).

27. "Population and Health Transitions" was published in "International Population Reports", Series P–95, No. 92–2 (1992).

28. "Aging in the Third World" was published in "International Population Reports", Series P–95, No. 79 (1988).

29. "An Aging World" was published in "International Population Reports", series P–95, No. 78 (1987).

30. The Director of the Census Bureau serves as one of the Commissioners for the U.S.-Japan Joint Commission on Aging.

31. Staff of the International Programs Center assisted in the design, provision of materials for, and teaching of a short-term training course on the Demography of Aging, sponsored by the United Nations International Institute on Aging and held in Malta in November/December 1994.

III. The Federal Interagency Forum on Aging-Related Statistics

The Census Bureau is one of the lead agencies in The Federal Interagency Forum on Aging-Related Statistics (The Forum), a first-of-its-kind effort. The Forum encourages cooperation among Federal agencies in the development, collection, analysis, and dissemination of data pertaining to the older population. Through cooperation and coordinated approaches, The Forum extends the use of limited resources among agencies through joint problem solving, identification of data gaps, and improvement of the statistical information bases on the older population that are used to set the priorities of the work of individual agencies. The participants are appointed by the directors of the agencies and have broad policymaking authority within the agency. Senior subject-matter specialists from the agencies are also involved in the activities of The Forum. The Forum was cochaired in 1994 by Harry A. Scarr, Deputy Director, Bureau of the Census; Manning Feinleib, Director, National Center for Health Statistics; and Richard J. Hodes, Director, National Institute on Aging.

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

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

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

The Census Bureau released "Federal Forum Report 1989–90" (March of 1992). It reviews the activities of the Forum and its member agencies during 1989–1990. We expect to release the "Federal Forum Report 1991–1993" in early 1995. Various sections of the report summarize Forum work and accomplishments, cooperative efforts of members, publications by member agencies, and activities planned for the near future. An interagency telephone contact list of specialists on subjects related to aging is also included.

Census Bureau staff cochair the Working Group on Data on Minority Aging. The group is making an inventory of Federal and other large data sets to identify the extent to which data are available on minority groups in the older population. Census Bureau staff also cochair the Working Group on Administrative Data on Aging. This group is identifying and evaluating some of the administrative data that could be used to develop demographic estimates of the elderly.

IV. Projects Between the Census Bureau and the Administration on Aging

From the 1990 Census of Population and Housing, the Census Bureau produced a special tabulation of 1990 census data on older Americans. This file is titled "The 1990 Census of Population and Housing Special Tabulation on Aging (STP 14). The file contains data on ability to speak English, mobility and self-care limitations, marital status, living arrangements, earnings, educational attainment, employment status, poverty status, veteran status, condo status, meals included in rent, mortgage status, year householder moved into unit, and so forth. Most tables are for persons 60 and over, 65 and over, 75 and over, and 85 and over. There is an "A" file for each state and a "C" file with U.S. data. The file is available on computer tape or on CD–ROM from Customer Services, Census Bureau, 301–457–4100.

From the 1990 census, the Census Bureau produced special tabulations particularly useful to local Area Agencies on Aging for administering programs under the Older Americans Act. The Census Bureau prepared a 1990 census public-use microdata file on the older population (PUMSO) with individual questionnaire information (to protect respondents' confidentiality, the records contain no identifying information) for 3 percent of persons aged 60 and over and members of their households.

V. Projects Between the Census Bureau and the National Institute on Aging

A. The Census Bureau published an updated version of the report titled, "Sixty-Five Plus in America", Series P–23, No. 178RV. This report is a chartbook and analysis of demographic, social, and economic trends among the older population. The data used in this report are primarily from the 1990 Census of Population and Housing and national surveys such as the Current Population Survey, the Survey of Income and Program Participation (SIPP), the Health Interview Survey, and the Longitudinal Survey on Aging. This reports summarizes numerous reports prepared by statisticians from the Census Bureau and other Federal agencies with information about the elderly. This report expands on information in "Diversity: the Dramatic Reality" by Cynthia M. Taueber, Chapter 1 of "Diversity in Aging" Scott A. Bass, Elizabeth A. Kutza, Fernando M. Torres-Gil, eds. (Glenview, IL, Scott, Foresman and Co., 1990).

B. The Census Bureau published a wall chart, "Elderly in the United States ." This wall chart was produced by Cynthia Taeuber and Barry Ocker with the support of the Office of the Demography of Aging of the National Institutes on Aging.

The statistics shown in the wall chart are intended to highlight dimensions of aging in American states. Data are primarily from the 1990 Census of Population. Projections for the United States and states are from Series A issued in 1990 and are available only through 2010.

C. The Census Bureau published the first four of a series of "Profiles of America's Elderly." They are: "Growth of America's Elderly in the 1980's"; "Growth of America's Oldest-Old Population"; "Racial and Ethnic Diversity of America's Elderly Population (93–1)"; and "Living Arrangements of the Elderly (93–2)." These profiles include demographic, social, and economic trends among the elderly as well as topics on demographic changes during the 1980's. Additional profiles will be published in this series (for example, one on centenarians).

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

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

F. Cynthia M. Taeuber wrote a chapter on the quality of census data on the elderly that includes an evaluation of coverage, age misreporting, estimates, and projections of centenarians, and so forth. It is "Types and Quality of Data Available on the Elderly in the 1990 Census," in "Epidemiology Study of the Elderly", ed. Robert B. Wallace, New York: Oxford University Press, 1992.

G. The Census Bureau prepared a file from the SIPP on the health, wealth, and economic status of the older population. The SIPP file is archived at the University of Michigan (Nancy Fultz, 313–763–5010).

H. Cynthia M. Taeuber (with Jessie Allen) wrote "Women in our Aging Society: The Demographic Outlook," in "Women in the Frontline: Meeting the Challenge of an Aging America", ed. Alan Pifer and Jessie Allen, Washington, DC: The Urban Institute Press, 1993. The chapter looks at the demographics of population aging and its present and future intersection with various aspects of the experience of American women.

I. Cynthia M. Taeuber wrote "Women in our Aging Society: Golden Years or Increased Dependency" in "USA Today" (1993). The article discusses the diversity of the Nation's female elderly population and how the experiences of younger women may affect them as they age.

J. "A Demographic Portrait of America's Oldest Old" was prepared by Cynthia M. Taeuber, Bureau of the Census, and Ira Rosenwaike, University of Pennsylvania, in "The Oldest Old," ed. by Richard Suzman and David Willis, Oxford University Press, 1992. This chapter looks at the rapid growth of the oldest old population, those 85 years and over and the reasons for that growth. This chapter also: (1) compares the oldest old's demographic, social, and economic characteristics with those of the younger old; (2) describes the characteristics of the centenarian population; (3) examines the quality of census data on the oldest old; and (4) discusses the implications of the growth and characteristics of this unique and important group.

K. The Census Bureau reprogrammed the regularly published tabulations of the Current Population Survey to include data for the population "65 to 74 years" and "75 years and over" in annual reports (see especially P–20, Nos. 461 and 458, P–60, Nos. 181 and 180). The report on marital status includes data for the population 85 years and over.

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

M. Nampeo McKenney and Cynthia M. Taeuber prepared a paper on "Coverage Improvement and Sampling Strategies in Censuses and Surveys: Improving Data on Minority Elderly," for the 1993 Conference of The Gerontological Society of America.

ITEM 3. DEPARTMENT OF DEFENSE

DEPARTMENT OF DEFENSE 1994 ELDERCARE INITIATIVES

The Department of Defense has undertaken several initiatives in support of the elderly during this past year. This is part of a continuum of efforts over the past years to bring eldercare resources and assistance to members, families, and eligible beneficiaries.

RESEARCH

In order to obtain a clearer understanding of the scope of eldercare responsibilities within the military, several questions were included in a comprehensive survey of military personnel and spouses in late 1992. The survey was completed this past year and provided some important information. The survey showed that 10,720 military personnel had elderly dependents. That is, the elderly person resided with the military member and the member was responsible for over one-half of the elderly person's support. Survey respondents were also queried about other responsibilities for elderly relatives. This included those who had some type of responsibility for an elderly person, but he elderly person did not live with the member. Nine percent of the force (n=160,899) indicated that they had responsibilities in this category. In most cases, this means long-distance care on the part of the military member/family.

A follow-on survey is planned to track those respondents responding in the affirmative to the eldercare questions from the 1992 survey. This survey will attempt to identify those resources military members and families may need in order to attend better to their eldercare responsibilities. As with other family responsibilities, eldercare is a readiness issue. Worries and concerns about eldercare impact personnel readiness, job performance, and retention. In order to meet this growing need, the Department has undertaken several initiatives.

RESOURCES

The Family Support Coordinating Subcommittee recently approved the WISE Workplace Information Seminars on Eldercare. These seminars, which will be conducted at the installation level, provide a wide range of valuable information on eldercare. Seminar topics include community resources, living arrangements options, caregiver burnout, financial concerns, legal safeguards and long-distance caregiving. The seminars are designed to enable caregivers and potential caregivers to deal with the numerous and complex issues of eldercare. This kind of information is particularly valuable for military families who, normally, are geographically separated from aging parents and family members. At the installation level, the seminars can be provided by Family Center staff, chaplains, and civilian personnel offices.

The delivery of eldercare seminars is the logical next step of previous Departmental efforts to expand the information and resources available for Departmental personnel. Previous resources disseminated worldwide include the "DoD Eldercare Handbook," "Eldercare Guide for Professionals," and a "Caregiver's Guide."

HEALTH CARE

The Department of Defense has begun its implementation of its new regionally managed care program for members of the uniformed services and their families, and survivors and retired members and their families. Retirees and their families will find that this new program will increase their access to high quality health care.

TRICARE introduces to beneficiaries three choices for their health care delivery; TRICARE Standard, a fee-for-service option which is the same as standard CHAMPUS; TRICARE Extra, which offers preferred provider option with discounts; and TRICARE Prime, an enrolled health maintenance organization (HMO) option. All active-duty members will be enrolled in TRICARE Prime. Those CHAMPUS-eligible beneficiaries who elect not to enroll in TRICARE Prime, and Medicare-eligible DoD beneficiaries will remain eligible for care in military medical facilities on a space-available basis.

TRICARE Standard.—This option is the same as the standard CHAMPUS program.

TRICARE Extra.—In the TRICARE Extra program, when a CHAMPUS-eligible beneficiary uses a preferred network provider, he/she receives an out-of-pocket discount and usually does not have to file any claim forms. CHAMPUS beneficiaries

do not enroll in TRICARE Extra, but may participate in Extra on a case-by-case basis just by using the network providers.

TRICARE Prime.—This voluntary enrollment option offers patients the advantages of managed health care, such as primary care manager, assistance in making specialty appointments, and someone else to do their claims filing. The Prime option offers the scope of coverage available today under CHAMPUS, plus additional preventive and primary care services. For Prime enrollees, the new cost sharing provisions do away with the usual standard CHAMPUS cost sharing. Of particular note, families of active duty personnel will have no enrollment fees. CHAMPUS-eligible retirees who enroll in Prime will pay an enrollment fee, but will pay only $11 per day for civilian inpatient care in comparison to the $323 per day plus 25 percent of professional fees charge faced by those retirees who use TRICARE Standard. For Prime enrollees, there will be copayments for care received from civilian providers. These copayments are significantly less than the other two options. Enrollees in TRICARE Prime obtain most of their care within the integrated military and civilian network of TRICARE providers. Additionally, under a new point of service option, Prime enrollees may retain freedom of choice to use non-network providers but at significantly higher cost sharing than TRICARE Standard.

A major component of TRICARE is the series of managed care support contracts that supplement the capabilities of regional military health care delivery networks. There are to be seven fixed-price, at-risk contracts supporting the 12 Regions, competitively awarded prior to the end of Fiscal Year 1996. The new TRICARE Prime cost sharing provision will be phased in as each regional TRICARE contract begins operations. TRICARE Prime will first be offered to beneficiaries living in Washington and Oregon when the new regional TRICARE contact begins health care delivery services on March 1, 1995.

ITEM 4. DEPARTMENT OF EDUCATION

POSTSECONDARY EDUCATION

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

In fiscal year 1994, an estimated $28 billion was made available to students through the student financial assistance programs authorized by Title IV of the Higher Education Act of 1965, as amended. In fiscal year 1994, an estimated 5 percent of all Title IV recipients were over age 40.

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

In addition to these programs, the Office of Postsecondary Education supports innovative approaches to meeting the needs of older Americans through the Fund for the Improvement of Postsecondary Education (FIPSE). In fiscal year 1994, FIPSE funded two projects dealing specifically with our aging population. These projects are:

Center for Intergenerational Learning (Temple University, Philadelphia, PA): Asian, Latino, and Eastern European students will team with other students to provide services to elderly members of their communities. Services will include translation, English as a Second Language classes, escorts on public transportation, and health education.

Generations Together/University Challenge for Excellence Program (University of Pittsburgh, Pittsburgh, PA): Teams of students drawn from the incoming freshman class and Pittsburgh College for the over 60 Program will provide a variety of services for the elderly residents of low-income housing.

ADULT EDUCATION

In the past, the education of persons 60 years of age and older may not have been considered an educational priority in the United States. The 1990's may well be considered the decade of growth in educational gerontology. Demographics have tended to make this development inevitable. A recent study entitled, Profiles of the Adult Education Target Population—Information from the 1990 Census, prepared by the Center for Research in Education, Research Triangle Institute, indicates that more than 44 million adults, or nearly 27 percent of the adult population of the United States, have not completed a high school diploma or its equivalent. These individuals make up the adult education target population. Of the 44 million adults in the

target population, more than 18 million or 41 percent are 60 or more years old. Over 53 percent of the adults age 60 and over in the target population have completed fewer than 8 years of schooling. The high rate of under-education indicates a need for emphasizing effective basic skills and coping strategies in programs for older adults.

The U.S. Department of Education is authorized under the Adult Education Act (AEA), Public Law 100–297, as amended by the National Literacy Act of 1991 (P.L. 102–73), to provide funds to the States and outlying areas for educational programs and related support services benefiting all segments of the eligible adult population. The central program established by the AEA is the State-administered Basic Grant Program. The AEA has also provided funds for programs of workplace and English Literacy. In addition, the 1991 amendments established four new programs:

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

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

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

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

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

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

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

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

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

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

(1) Enable adults to acquire the basic educational skills necessary for literate functioning;

(2) Provide sufficient basic education to enable these adults to benefit from job training and retraining and to obtain productive employment; and

(3) Enable adults to continue their education to at least high school completion.

In Program Year 1992–93, 3.9 million adult learners were served through the AEA program nationwide. Of these learners, 597,543 were 45 years of age or older.

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

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

Equally significant is the expanding delivery system, increased public awareness, as well as clearinghouses and satellite centers designed to overcome barriers to participation. Where needed, supportive services such as transportation are provided as

are outreach activities adapting programs to the life situations and experiences of older persons. Individual learning preferences are recognized and assisted through the provision of information, guidance and study materials. To reach more people in the targeted age range, adult education programs often operate in conjunction with senior citizens centers, nutrition programs, nursing homes, and retirement and day care centers.

Increases cooperation and collaboration among organizations, institutions and community groups are encouraged at the national, State and local levels. In addition, sharing of resources and services can help meet the literacy needs for older Americans.

ENFORCEMENT OF THE AGE DISCRIMINATION ACT

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

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

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

Under ED's final regulation, OCR forwards complaints alleging age discrimination to the Federal Mediation and Conciliation Service (FMCS) for resolution through mediation. FMCS has 60 days to mediate the age-only complaints or the age portion of multiple-based complaints. For complaints alleging discrimination on the basis of age and another statutory basis, the applicable OCR case processing time frames are delayed for 60 days or until the complaint is returned from FMCS, whichever is earlier, to allow FMCS to process the age portion of the case. OCR notifies the complainant(s) of the duration of the tolling of the time frames. The other statutes which OCR enforces are Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin; Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex; and Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990, which prohibit discrimination on the basis of physical and mental disability.

If FMCS is successful in mediating an age-only complaint within the 60 days, OCR closes the case. If FMCS does not resolve the case, OCR investigates the allegations according to OCR's case processing time frames. If the case was filed on the basis of age and another statutory basis, FMCS tries to mediate the age portion of the case, as described above. If FMCS is successful in mediating the age portion of the case within the 60 days, OCR then processes the other allegations in the complaint within the applicable OCR case processing time frames. If FMCS is unsuccessful in mediating an agreement between the complainant and the recipient on the age portion of the complaint, it returns the case to OCR. OCR processes the complaints according to applicable OCR case processing time frames.

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

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

OCR received 212 age complaints in FY 1994. As shown in Table 1, below, 165 of the receipts were processed by OCR and 47 were referred to other Federal agencies for processing. The most frequently cited issues in the FY 1994 age complaint receipts were "criteria for selection in hiring," and "academic evaluation and grading" and "student rights."

TABLE 1: FY 1994 AGE-BASED COMPLAINT RECEIPTS

Processed in OCR	165
Referred to FMCS	9
Referred to EEOC	35
Referred to Other Federal Agencies	3
Total Receipts	212

During FY 1994, OCR closed a total of 126 age-based complaints. As shown on Table 2, below, most of the complaints were closed for administrative reasons.

TABLE 2: FY 1994 AGE-BASED COMPLAINT CLOSURES

Administrative Closures	72
Substantive Closures	54
No change as a result of agency investigation	38
Recipient made changes	13
Other	3
Total closures	126

Of the 54 substantive closures, change was achieved in 24 percent of cases. The most frequently cited issues in the cases with change were "student treatment" and "student rights."

OCR confined its age discrimination activities to complaint investigations. OCR did not conduct compliance reviews on age discrimination in FY 1994.

Older Americans in the 1992 National Adult Literacy Survey

While for some the importance of literacy derives from the increasing needs of business for literate workers, for others the importance of literacy derives from the benefits of literacy skills in the everyday life of adults of all ages, including those who have retired from the labor force. Older adults need literacy skills to live independently, to manage their health care and personal finances, and more generally, to function in society. Knowing the nature and extent of the literacy problem in the United States today is an important early step in devising effective policies to ensure adequate literacy skills for every adult and to meet our Nation's literacy goal.

The Adult Education Amendments of 1988 required the U.S. Department of Education to report to Congress on the definition of literacy and to estimate the extent of adult literacy in the Nation. To satisfy these requirements, the National Center of Education States (NCES) and the Office of Vocational and Adult Education (OVAE) cooperated to fund a statistical survey that would assess the literacy of the adult population of the United States. In September 1989, NCES awarded a 5-year contract for the survey to Educational Testing Service, with a subcontract to Westat for sampling and field data collection.

The National Adult Literacy Survey began by consulting advisors and then adopting a definition of literacy—one previously used by the National Assessment of Educational Progress in the 1985 Young Adult Literacy Assessment: Using printed and written information to function in society, to achieve one's goals, and to develop one's knowledge and potential. This definition of literacy differed from previous definitions in that it rejected such arbitrary standards as signing one's name, completing some number of years of school, or scoring above some grade level on a test of reading achievement. Further, this definition went beyond simply decoding words, to include varied uses of many forms of information.

The literacy of adults was assessed using simulations of three kinds of literacy tasks adults would ordinarily encounter in daily life (prose literacy, document literacy, and quantitative literacy). Besides completing literacy tasks, participants answered questions about their demographic characteristics, educational backgrounds, reading practices, labor market experiences, and more.

The 1992 results are based on personal interviews with nearly 27,000 adults aged 16 and older—the oldest was 99 years old—conducted in their homes using an area-based sample of households located in 200 counties throughout the United States. The sample includes 1,100 inmates of Federal and State prisons and 1,000 extra residents in each of 12 States that paid for sample supplements (CA, FL, IL, IN, IA, LA, NJ, NY, OH, PA, TX, and WA). The survey design provides nationally representative results, and for participating States, State-representative results.

Reesults from the survey have so far been published in *Adult Literacy in America* and in *Behind Prison Walls,* available from NCES, and in State-specific reports, available from the 12 State offices of adult literacy. Further reports are planned in several areas: schooling and literacy; literacy in language minority communities; literacy in the labor force; reading habits, library use, voting and literacy; and literacy among older adults.

Results for older adults were briefly covered in the initial survey report, but will be more extensively presented in a forthcoming special report on literacy among older adults. The forthcoming report will include chapters on the distribution of literacy skills among older adults, comparisons of older adults with adults under 60 years old, economic issues, civic participation, and literacy and patterns of mass media usage. The report is expected to be published by April 1995. The results of the survey will not directly benefit older adults, but will instead form the factual basis for policy decisions affecting literacy programs designed for older adults or for adults with limited literacy skills.

The cost of including older adults in the survey and preparing a report on older adults came to about $870,000, or about 8 percent of the Federal share of the total costs of the survey.

LIBRARY SERVICES TO SPECIAL POPULATIONS: THE ELDERLY

There are now on file more than 20 years (1971–1992) of State reports on the Library Services to the Elderly (through the Library Services and Construction Act (LSCA)). (The attached tables show the expenditure breakouts.) The FY 1991 reports show that $1.5 million of LSCA funds supported such efforts. When combined with State and local funds, the total reached $1.8 million. Final figures for FY 1992 indicate that $1.7 was spent in LSCA funds and, when combined with State and local matching funds, amounted to $2.1 million.

In the first few years of LCSA funding, almost all projects were for delivery of books to the homebound and special programs designed for the elderly at the library. The energy crisis caused a revamping of programs dependent on either cars or bookmobiles. During that period, Books-By-Mail took the place of site delivery. Since energy costs are now down and postal rates and personnel costs are up, many of the Books-By-Mail projects rely on delivery by volunteers. Analysis of the projects conducted in FY 1992 (the latest reports available) listed only five projects that included delivery through the mails. Forty projects funded delivery of programs and materials to homes, nursing homes, senior centers, and other congregate sites. All but one of those projects included rotating and/or deposit collections. The Washoe County Library (Nevada) project located a collection of Large Print books and other books of interest to the elderly in the county senior center. This project has proven so successful that the library will continue to support the program after the Federal funds have lapsed, and plans are underway to move it from an extension branch to a full branch with its own separate budget.

Projects that funded the purchases of these rotating collections, as well as collections housed in the library, were usually centered around Large Print books (82 projects). Audio Visual Materials were purchased (69 projects) which included purchases of Talking Books and adapted games. Also noted was the purchase of special materials of interest to the elderly (21 projects for special reference materials, craft and travel books, etc.). The Newton County (Georgia) Library found that the addition of new Large Print books and books on cassette increased the circulation statistics considerably. The circulation of audio books was up 55 percent and Large Print books up 33 percent. When the Mississippi Library Commission (MLC) added new Large Print books to their collection, these materials were 30.5 percent of the total circulation from the MLC collection in 1992.

Additional materials added to the collection at the libraries included multisensory kits to aid in life review and stimulation of the senses (14 projects). Several of these projects were like the one at the White Pine Library Cooperative (Michigan) which checked kits out to local libraries for extended periods before they rotated to another library for use. In this way, the kits were used in over 30 locations in an 11-county area. Visual aids were mentioned in 13 projects, with most citing the Americans with Disabilities Act as an impetus. The Laurens County Library (South Carolina)

provided a low vision center which allowed the visually impaired to try the various aids prior to purchase.

Funded projects in 1992 also included a large number which were for special programming (41). These included book talks, use of BiFokal kits, Read Aloud sessions, travel and other films, etc. Location appears to have a lot to do with the type of programming that is successful, with crafts and travel sessions more popular in more rural areas, crime prevention and social services in urban areas and all areas enjoying book talks and other cultural activities. The words and memories project by the Brooklyn Public Library (New York) presented 178 varied programs at 23 sites. These used multi-media materials, read-a-loud, storytelling, poems, songs, ets., to stimulate reading and sharing memories. Another excellent project is the Nassau Library System's (New York) Lively Minds, a life-long learning program which used library resources for mental stimulation, enjoyment, and empowerment to prove that neither age nor physical infirmity can limit the power of the mind.

The major change in intergenerational projects is one of emphasis. If mentioned in earlier reports, these projects tended to have the youth reading to or delivering books to the homebound or those in nursing homes. The current projects (16) are using the elderly to aid children in need of better reading skills or after school help with homework. Even though the actual help is being given by the senior citizens, projects like Read to Me in New Bedford (Massachusetts) found that the critical element is often the work done by the librarian overseeing the volunteers. The organizational skills and the enthusiasm of the project leader can be critical factors. The project in Fort Scott (Kansas) taught the seniors how many children are reading below grade level or have nonexistent reading skills. An outstanding project in Broward County (Florida) is its Prime Time which matched the elderly and children attending Title XX daycare centers. This project produced a video that captured the joy of this well-planned project. The video is available for the cost of reproduction.

Projects on genealogy and community history (5) are down from previous reports. However, this set of reports included a well-planned project at the Westchester (New York) Library System. Approximately 25–35 persons attended four sessions which studied a variety of memoirs by Americans and a talk by someone who had written his memoirs for his grandchildren. Then there were six sessions on how to write memoirs, and finally a computer instruction course on word processing skills. A second project, at the Harvin Clarendon County Library (South Carolina), used video equipment to record the oral history of the senior citizens of their community as well as produce tapes on the historical sites in the county to show to the immobile elderly.

Six projects noted that Information and Referral was part of the project. The Bethel Park Public Library (Pennsylvania) project included a Senior Information Area in the library. This area was not only for use by the elderly, but was also intended for use by nursing home activity directors, families of those in nursing homes or those dealing with Alzheimers disease.

One general improvement in the projects is the realization that the above projects will not be of value if the clientele do not know about the services. Forty-two projects noted the various ways they promoted their services to the elderly. Interagency cooperation (both for promotion as well as help) was noted in 20 projects. The training of librarians and volunteers was mentioned in 19 projects. The OWLS project by the Mohawk Valley Library Association (New York) received the Bessie Boehm Moore award. This project included three continuing education workshops on improving the service to the elderly in their area. The workshops were for the librarians in four counties. A statewide training institute was presented by the state library of Pennsylvania. This 3-day workshop was the kickoff for a funding push in this area of service and was somewhat patterned after an earlier program in New Jersey. Catalogs and bibliographies were produced in large print in 10 projects. Most of the latter were possible due to computerization and other uses of new technology (noted in 5 projects).

There are still areas in which these projects fall short. The use of an advisory group (usually seniors) was noted only twice. Although manuals were produced in only five projects, the replication potential of ones like the Read Aloud Handbook produced by the Brown County Library (Wisconsin) are obvious. However, many more projects noted their inability to produce written materials. As stated by the evaluator of the Bethel Park project mentioned above, "The production of a resource guide on programming . . . is not feasible at this time. . . . [I]t is the opinion of the Project Coordinator that the service aspect has a higher priority." An exemplary manual is the Library Service to Florida's Elders, which was produced by the Florida Division of Library and Information Services.

TABLE 9.—HIGHEST LEVEL OF EDUCATION ATTAINED BY PERSONS AGE 18 AND OVER, BY AGE, SEX, AND RACE/ETHNICITY: 1993

[In thousands]

Age, sex, and race	Total population[1]	Elementary level		High school			College					
		Less than 7 years	7 or 8 yeas	1 to 3 years	4 years	Graduate	Some college	Associate	Bachelor's	Master's	First-professional	Doctorate
1	2	3	4	5	6	7	8	9	10	11	12	13
Total												
18 and over	187,135	7,199	8,610	18,553	3,063	65,140	35,626	11,471	25,388	8,411	2,247	1,427
18 and 19 years old	6,508	64	95	1,855	654	1,827	1,987	26	—	—	—	—
20 to 24 years old	17,802	271	252	1,744	296	5,724	6,544	1,089	1,769	101	11	2
25 years old and over	162,826	6,864	8,263	14,953	2,113	57,589	27,095	10,356	23,619	8,310	2,236	1,425
25 to 29 years old	19,603	398	327	1,588	290	6,994	3,897	1,471	3,828	580	185	45
30 to 34 years old	22,261	502	378	1,683	331	8,042	4,151	1,843	3,969	942	292	127
35 to 39 years old	21,467	519	342	1,448	191	7,524	4,138	1,856	3,745	1,199	321	185
40 to 49 years old	34,662	900	777	2,194	360	11,592	6,590	2,644	5,748	2,787	656	414
50 to 59 years old	23,434	1,037	1,040	2,362	292	8,847	3,588	1,235	2,837	1,502	380	314
60 to 64 years old	10,529	659	798	1,347	164	4,024	1,284	410	1,095	495	121	132
65 years old and over	30,870	2,849	4,602	4,331	486	10,567	3,446	897	2,396	806	280	209
Men												
18 and over	89,694	3,615	4,062	8,808	1,561	29,523	17,004	5,076	12,922	4,409	1,656	1,060
18 and 19 years old	3,263	38	52	1,071	382	851	857	11	—	—	—	—
20 to 24 years old	8,786	141	144	928	167	2,905	3,227	463	767	40	4	—
25 years old and over	77,644	3,436	3,866	6,809	1,011	25,766	12,920	4,601	12,154	4,368	1,652	1,060
25 to 29 years old	9,767	257	171	786	149	3,565	1,894	657	1,851	294	116	27
30 to 34 years old	11,089	292	197	863	188	4,039	1,945	813	1,971	498	196	88
35 to 39 years old	10,606	249	194	736	111	3,717	1,950	867	1,840	579	243	119
40 to 49 years old	16,987	457	396	1,034	181	5,191	3,235	1,212	3,057	1,448	481	294
50 to 59 years old	11,280	542	590	1,034	135	3,773	1,738	522	1,566	853	283	244
60 to 64 years old	5,084	315	430	631	65	1,663	644	210	636	273	108	109
65 years old and over	12,832	1,324	1,887	1,725	182	3,817	1,515	320	1,234	424	226	177
Women												
18 and over	97,442	3,584	4,548	9,745	1,503	35,618	18,622	6,396	12,466	4,002	591	368
18 and 19 years old	3,244	25	43	784	271	976	1,130	15	—	—	—	—
20 to 24 years old	9,016	130	108	816	129	2,819	3,317	626	1,001	60	7	2
25 years old and over	85,181	3,428	4,398	8,144	1,102	31,823	14,175	5,755	11,465	3,942	584	366
25 to 29 years old	9,836	140	155	802	141	3,429	2,003	814	1,977	287	69	18

30 to 34 years old	11,171	210	181	820	143	4,003	2,207	1,029	1,998	444	96	39
35 to 39 years old	10,861	270	148	712	80	3,807	2,188	989	1,905	620	78	65
40 to 49 years old	17,675	443	381	1,160	179	6,401	3,355	1,432	2,691	1,339	175	120
50 to 59 years old	12,154	495	451	1,328	156	5,073	1,851	713	1,271	649	98	70
60 to 64 years old	5,445	344	368	716	99	2,361	640	199	460	222	14	22
65 years old and over	18,038	1,526	2,714	2,606	303	6,750	1,931	577	1,163	382	54	32
White, non-Hispanic												
18 and over	144,675	2,485	6,279	12,464	1,872	51,826	28,371	9,400	21,512	7,267	1,978	1,222
18 and 19 years old	4,479	7	42	1,157	366	1,350	1,544	14	—	—	—	—
20 to 24 years old	12,595	26	132	949	145	3,967	4,888	866	1,526	85	8	2
25 years old and over	127,601	2,452	6,105	10,358	1,362	46,509	21,938	8,520	19,986	7,182	1,969	1,220
25 to 29 years old	14,070	57	159	878	138	5,009	2,815	1,193	3,172	461	151	37
30 to 34 years old	16,530	94	170	1,019	191	6,099	3,089	1,476	3,277	775	253	86
35 to 39 years old	16,190	87	172	834	102	5,751	3,248	1,475	3,091	980	291	158
40 to 49 years old	27,200	195	424	1,358	207	9,144	5,433	2,164	4,893	2,450	570	363
50 to 59 years old	18,623	406	722	1,628	195	7,335	2,983	1,018	2,411	1,324	332	270
60 to 64 years old	8,647	247	630	997	115	3,494	1,136	378	951	470	113	115
65 years old and over	26,342	1,366	3,829	3,643	414	9,677	3,235	817	2,191	723	258	190
Black, non-Hispanic												
18 and over	21,009	1,174	1,007	3,324	629	7,634	3,951	1,039	1,647	472	76	56
18 and 19 years old	1,004	3	4	366	155	236	231	9	—	—	—	—
20 to 24 years old	2,473	17	29	312	74	1,036	792	108	100	6	—	—
25 years old and over	17,532	1,154	975	2,646	401	6,362	2,928	922	1,546	466	76	56
25 to 29 years old	2,579	9	26	328	85	1,101	554	134	289	43	10	—
30 to 34 years old	2,756	21	56	303	74	1,109	635	208	293	46	8	6
35 to 39 years old	2,509	36	41	309	34	1,011	515	178	296	78	6	5
40 to 49 years old	3,586	82	114	476	76	1,398	642	242	358	151	31	17
50 to 59 years old	2,432	146	138	473	64	877	361	111	156	87	9	10
60 to 64 years old	1,037	135	106	257	23	324	89	11	72	9	2	9
65 years old and over	2,633	726	494	500	45	542	132	39	82	52	11	11
Hispanic												
18 and over	14,913	3,102	1,122	2,301	440	4,027	2,147	629	833	213	66	35
18 and 19 years old	802	54	48	270	98	195	134	2	—	—	—	—
20 to 24 years old	2,011	225	85	441	66	590	468	79	53	4	1	—
25 years old and over	12,100	2,823	989	1,590	275	3,242	1,545	547	780	209	66	35
25 to 29 years old	2,192	317	129	353	58	683	367	102	154	19	9	—
30 to 34 years old	2,086	352	138	302	45	628	304	112	153	30	12	9
35 to 39 years old	1,898	360	119	250	46	527	262	119	156	45	9	6
40 to 49 years old	2,589	565	210	300	59	721	369	119	160	59	16	12

TABLE 9.—HIGHEST LEVEL OF EDUCATION ATTAINED BY PERSONS AGE 18 AND OVER, BY AGE, SEX, AND RACE/ETHNICITY: 1993—Continued

[In thousands]

Age, sex, and race	Total population [1]	Elementary level		High school			College					
		Less than 7 years	7 or 8 yeas	1 to 3 years	4 years	Graduate	Some college	Associate	Bachelor's	Master's	First-professional	Doctorate
1	2	3	4	5	6	7	8	9	10	11	12	13
50 to 59 years old	1,559	445	147	191	26	390	159	61	91	34	10	3
60 to 64 years old	554	222	50	73	20	122	31	11	20	6	1	—
65 years old and over	1,222	561	195	120	22	171	53	23	46	16	9	5

[1] Civilian noninstitutional population.
—Data not applicable or not available.

NOTE.—Data are based on a sample survey of the noninstitutional population. Although cells with fewer than 75,000 people are subject to relatively wide sampling variation, they are included in the table to permit various types of aggregations. Because of rounding, details may not add to totals.

SOURCE: U.S. Department of Commerce, Bureau of the Census, Current Population Survey, unpublished data. (This table was prepared May 1994.)

TABLE 10.—NUMBER OF PERSONS AGE 18 AND OVER WHO HOLD A BACHELOR'S OR HIGHER DEGREE, BY FIELD OF STUDY, SEX, RACE, AND AGE: SPRING 1990

[Numbers in thousands]

Field of study	Total	Sex		Race		Age					
		Men	Women	White [1]	Black [1]	18 to 24 years old	25 to 34 years old	35 to 44 years old	45 to 54 years old	55 to 64 years old	65 years old and over
1	2	3	4	5	6	7	8	9	10	11	12
Total population, 18 and over	182,591	87,240	95,350	156,385	20,401	25,145	43,245	37,708	25,489	21,228	29,776
Number of persons with bachelor's or higher degree	33,554	18,145	15,408	30,049	1,908	1,797	9,657	10,215	5,355	3,249	3,281
Percent of population	18.4	20.8	16.2	19.2	9.4	7.1	22.3	27.1	21.0	15.3	11.0
Agriculture and forestry	371	339	32	351	6	9	90	63	77	28	103
Biology	857	506	351	767	34	89	233	305	118	67	43
Business and management	6,189	4,313	1,876	5,531	368	384	2,148	1,697	1,005	500	454
Economics	691	467	224	581	40	76	206	114	127	84	83
Education	5,879	1,633	4,246	5,296	478	220	943	2,125	1,123	702	766
Engineering	3,090	2,821	269	2,635	154	159	1,104	702	466	340	321
English and journalism	1,369	360	1,009	1,306	40	58	367	434	181	124	204

Home economics	385	8	377	350	14	3	75	85	60	76	85
Law	1,004	797	207	948	15	14	260	320	191	123	96
Liberal arts and humanities	3,002	1,174	1,828	2,703	160	164	938	1,021	396	202	282
Mathematics and statistics	699	467	232	648	13	72	171	173	160	84	36
Medicine and dentistry	1,046	752	294	893	36	44	328	309	104	104	157
Nursing, pharmacy, and health technologies	1,913	353	1,560	1,717	83	111	661	602	249	156	134
Physical and earth sciences	856	631	225	781	35	33	239	283	147	82	73
Police science and law enforcement	238	183	55	201	25	9	53	94	37	33	12
Psychology	1,103	458	645	1,001	80	45	356	358	172	113	58
Religion and theology	488	413	75	452	24	14	85	165	72	103	47
Social sciences	1,960	1,034	926	1,769	124	121	527	666	300	178	169
Vocational and technical studies	179	157	22	155	19	12	69	27	37	26	9
Other fields	2,233	1,277	956	1,963	162	159	803	667	329	124	149
	Percentage distribution of degree holders, by field										
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Agriculture and forestry	1.1	1.9	0.2	1.2	0.3	0.5	0.9	0.6	1.4	0.9	3.1
Biology	2.6	2.8	2.3	2.6	1.8	5.0	2.4	3.0	2.2	2.1	1.3
Business and management	18.4	23.8	12.2	18.4	19.3	21.4	22.2	16.6	18.8	15.4	13.8
Economics	2.1	2.6	1.5	1.9	2.1	4.2	2.1	1.1	2.4	2.6	2.5
Education	17.5	9.0	27.6	17.6	25.1	12.2	9.8	20.8	21.0	21.6	23.3
*COM001*Engineering	9.2	15.5	1.7	8.8	8.1	8.8	11.4	6.9	8.7	10.5	9.8
English and journalism	4.1	2.0	6.5	4.3	2.1	3.2	3.8	4.2	3.4	3.8	6.2
Home economics	1.1	0.0	2.4	1.2	0.7	0.2	0.8	0.8	1.1	2.3	2.6
Law	3.0	4.4	1.3	3.2	0.8	0.8	2.7	3.1	3.6	3.8	2.9
Liberal arts and humanities	8.9	6.5	11.9	9.0	8.4	9.1	9.7	10.0	7.4	6.2	8.6
Mathematics and statistics	2.1	2.6	1.5	2.2	0.7	4.0	1.8	1.7	3.0	2.6	1.1
Medicine and dentistry	3.1	4.1	1.9	3.0	1.9	2.4	3.4	3.0	1.9	3.2	4.8
Nursing, pharmacy, and health technologies	5.7	1.9	10.1	5.7	4.4	6.2	6.8	5.9	4.6	4.8	4.1
Physical and earth sciences	2.6	3.5	1.5	2.6	1.8	1.8	2.5	2.8	2.7	2.5	2.2
Police science and law enforcement	0.7	1.0	0.4	0.7	1.3	0.5	0.5	0.9	0.7	1.0	0.4
Psychology	3.3	2.5	4.2	3.3	4.2	2.5	3.7	3.5	3.2	3.5	1.8
Religion and theology	1.5	2.3	0.5	1.5	1.3	0.8	0.9	1.6	1.3	3.2	1.4
Social sciences	5.8	5.7	6.0	5.9	6.6	6.7	5.5	6.5	5.6	5.5	5.2
Vocational and technical studies	0.5	0.9	0.1	0.5	1.0	0.7	0.7	0.3	0.7	0.8	0.3
Other fields	6.7	7.0	6.2	6.5	8.5	8.8	8.3	6.5	6.1	3.8	4.5

[1] Includes persons of Hispanic origin.

NOTE.—Data are based on a sample survey of the civilian noninstitutional population. Because of rounding, details may not add to totals.

SOURCE: U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P–70, No. 32, ''What's It Worth? Educational Background and Economic Status: Spring 1990.'' (This table was prepared February 1993.)

TABLE 11.—HIGHEST LEVEL OF EDUCATION ATTAINED BY PERSONS AGE 18 AND OVER, BY SEX, RACE, AND AGE: SPRING 1990

[Numbers in thousands]

Sex, race, and age	Total	Not high school graduate[1]	High school graduate only	Some college, no degree or certificate	Vocational certificate	Associate degree	Bachelor's degree	Master's degree	Professional degree	Doctor's degree
1	2	3	4	5	6	7	8	9	10	11
Total population, 18 and over	182,591	38,012	65,291	33,191	4,973	7,570	22,845	7,599	2,054	1,056
Men	87,240	17,948	29,713	16,099	1,737	3,600	11,769	3,996	1,547	833
Women	95,350	20,065	35,578	17,092	3,236	3,970	11,076	3,603	506	223
White, total[2]	156,385	30,270	56,240	28,608	4,541	6,677	20,381	6,813	1,898	956
Men	75,262	14,425	25,556	14,076	1,588	3,242	10,629	3,552	1,449	744
Women	81,123	15,845	30,684	14,532	2,953	3,435	9,752	3,261	449	212
Black, total[2]	20,401	6,510	7,495	3,534	284	670	1,367	462	46	34
Men	9,158	3,045	3,483	1,441	87	257	581	199	38	28
Women	11,242	3,465	4,012	2,094	197	413	786	262	8	6
Hispanic, total[3]	13,548	5,934	4,091	1,933	208	316	734	245	55	32
Men	6,708	2,950	1,961	976	89	153	388	121	44	27
Women	6,841	2,984	2,130	958	119	163	346	124	11	5
Age										
18 to 24 years old	25,145	4,892	8,877	8,357	451	770	1,725	50	22	—
25 to 34 years old	43,245	5,392	16,034	8,277	1,215	2,670	7,522	1,508	509	118
35 to 44 years old	37,708	4,332	12,655	6,910	1,213	2,383	6,415	2,859	648	292
45 to 54 years old	25,489	4,796	9,937	3,718	753	931	3,132	1,599	295	329
55 to 64 years old	21,228	6,063	8,315	2,573	530	497	1,896	888	310	156
65 years old and over	29,776	12,537	9,473	3,356	811	319	2,156	694	270	160
	Percentage distribution, by highest degree earned									
Total population, 18 and over	100.0	20.8	35.8	18.2	2.7	4.1	12.5	4.2	1.1	0.6
Men	100.0	20.6	34.1	18.5	2.0	4.1	13.5	4.6	1.8	1.0
Women	100.0	21.0	37.3	17.9	3.4	4.2	11.6	3.8	0.5	0.2
White, total[2]	100.0	19.4	36.0	18.3	2.9	4.3	13.0	4.4	1.2	0.6
Men	100.0	19.2	34.0	18.7	2.1	4.3	14.1	4.7	1.9	1.0

Women	100.0	19.5	37.8	17.9	3.6	4.2	12.0	4.0	0.6	0.3
Black, total[2]	100.0	31.9	36.7	17.3	1.4	3.3	6.7	2.3	0.2	0.2
Men	100.0	33.2	38.0	15.7	0.9	2.8	6.3	2.2	0.4	0.3
Women	100.0	30.8	35.7	18.6	1.7	3.7	7.0	2.3	0.1	0.1
Hispanic, total[3]	100.0	43.8	30.2	14.3	1.5	2.3	5.4	1.8	0.4	0.2
Men	100.0	44.0	29.2	14.5	1.3	2.3	5.8	1.8	0.7	0.4
Women	100.0	43.6	31.1	14.0	1.7	2.4	5.1	1.8	0.2	0.1
Age										
18 to 24 years old	100.0	19.5	35.3	33.2	1.8	3.1	6.9	0.2	0.1	([4])
25 to 34 years old	100.0	12.5	37.1	19.1	2.8	6.2	17.4	3.5	1.2	0.3
35 to 44 years old	100.0	11.5	33.6	18.3	3.2	6.3	17.0	7.6	1.7	0.8
45 to 54 years old	100.0	18.8	39.0	14.6	3.0	3.7	12.3	6.3	1.2	1.3
55 to 64 years old	100.0	28.6	39.2	12.1	2.5	2.3	8.9	4.2	1.5	0.7
65 years old and over	100.0	4.21	31.8	11.3	2.7	1.1	7.2	2.3	0.9	0.5

[1] Some people are still enrolled in high school.
[2] Includes persons of Hispanic origin.
[3] Persons of Hispanic origin may be of any race.
[4] Less than .05 percent.
—Data not available.

NOTE.—Data are based on sample surveys of the civilian noninstitutional population. Because of rounding, details may not add to totals.

SOURCE: U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P–70, No. 32, "What's It Worth? Educational Background and Economic Status: Spring 1990." (This table was prepared February 1993.)

TABLE 20.—HOUSEHOLD INCOME AND POVERTY RATES, BY STATE: 1990[1] AND 1992[2]

State	Median household income, 1990	Distribution of persons by household income, 1990				Percent of persons below the poverty level									
						1990								1992	
		Less than $25,000	$25,000 to $49,999	$50,000 to $74,999	$75,000 or more	Total	Under 5 years	5 years	6 to 11 years	12 to 17 years	18 to 64 years	65 to 74 years	75 years and over	Total	Standard error
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
United States	$30,056	41.8	33.7	15.0	9.5	13.1	20.1	19.7	18.3	16.3	11.0	10.4	16.5	14.5	0.11
Alabama	23,597	52.3	31.3	11.2	5.2	18.3	26.1	25.8	24.3	22.3	14.6	19.2	31.1	17.1	1.93
Alaska	41,408	28.0	32.2	21.3	18.6	9.0	13.6	10.6	10.9	9.8	7.9	6.4	10.6	10.0	1.45
Arizona	27,540	45.1	34.1	13.3	7.5	15.7	24.9	24.2	21.8	19.1	14.0	9.3	13.2	15.1	1.87
Arkansas	21,147	57.8	30.1	8.4	3.7	19.1	28.5	26.6	25.2	22.7	15.3	18.0	29.9	17.4	1.92
California	35,798	34.1	32.9	18.4	14.7	12.5	19.0	19.3	18.3	17.1	10.9	6.5	9.5	15.8	0.71

TABLE 20.—HOUSEHOLD INCOME AND POVERTY RATES, BY STATE: 1990 [1] AND 1992 [2]—Continued

State	Median household income, 1990	Distribution of persons by household income, 1990				Percent of persons below the poverty level									
						1990								1992	
		Less than $25,000	$25,000 to $49,999	$50,000 to $74,999	$75,000 or more	Total	Under 5 years	5 years	6 to 11 years	12 to 17 years	18 to 64 years	65 to 74 years	75 years and over	Total	Standard error
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Colorado	30,140	41.3	35.1	15.1	8.6	11.7	17.9	16.5	15.3	12.5	10.3	8.5	15.1	10.6	1.70
Connecticut	41,721	27.5	32.4	21.7	18.4	6.8	11.7	11.9	11.2	8.9	5.3	5.6	9.7	9.4	1.73
Delaware	34,875	33.9	36.7	18.4	11.0	8.7	13.3	12.7	11.8	10.8	7.2	8.2	13.5	7.6	1.46
District of Columbia	30,727	41.0	30.4	14.4	14.2	16.9	27.0	25.5	25.0	24.4	14.3	15.5	19.7	20.3	2.58
Florida	27,483	45.1	34.1	12.9	7.9	12.7	20.3	20.1	18.8	16.8	11.0	9.0	13.5	15.3	0.90
Georgia	29,021	43.1	34.0	14.4	8.4	14.7	22.1	21.3	20.1	18.1	11.4	16.5	26.7	17.8	1.95
Hawaii	38,829	29.8	33.7	20.6	15.8	8.3	12.6	12.6	11.2	10.8	6.9	6.7	10.4	11.0	1.67
Idaho	25,257	49.5	35.2	10.7	4.7	13.3	19.6	18.9	15.9	13.3	12.0	8.7	15.6	15.0	1.72
Illinois	32,252	38.3	34.5	16.7	10.5	11.9	18.9	18.7	17.0	15.0	10.0	8.9	13.4	15.3	0.98
Indiana	28,787	43.1	36.6	14.1	6.2	10.7	16.8	15.8	14.1	11.8	9.1	8.7	14.0	11.7	1.72
Iowa	26,229	47.5	36.3	11.4	4.8	11.5	17.5	15.4	14.1	11.7	10.3	8.1	15.3	11.3	1.58
Kansas	27,291	45.5	35.2	12.9	6.4	11.5	16.8	16.5	14.1	11.6	10.1	8.5	16.8	11.0	1.56
Kentucky	22,534	54.2	31.1	10.2	4.6	19.0	27.9	26.5	24.6	22.4	16.2	17.5	25.3	19.7	2.08
Louisiana	21,949	55.1	29.4	10.3	5.2	23.6	33.4	33.0	31.1	29.7	19.6	20.5	30.1	24.2	2.31
Maine	27,854	44.6	37.1	12.8	5.5	10.8	15.7	15.9	14.0	11.5	8.9	11.0	18.3	13.4	1.80
Maryland	39,386	29.0	34.6	20.8	15.6	8.3	11.9	11.9	11.5	10.2	6.8	8.8	13.6	11.6	1.74
Massachusetts	36,952	33.3	32.4	19.7	14.6	8.9	14.5	14.8	13.8	11.0	7.3	7.3	12.6	10.0	0.85
Michigan	31,020	40.6	34.0	16.3	9.2	13.1	22.1	20.4	18.1	15.7	11.2	8.7	14.3	13.5	0.94
Minnesota	30,909	39.9	36.3	15.6	8.1	10.2	14.8	14.6	12.5	10.6	8.8	8.4	17.2	12.8	1.79
Mississippi	20,136	58.9	28.5	8.7	3.8	25.2	35.8	35.1	33.5	31.9	20.0	24.0	37.1	24.5	2.08
Missouri	26,362	47.4	33.6	12.6	6.4	13.3	20.4	19.2	17.8	15.1	11.1	11.3	19.7	15.6	1.96
Montana	22,988	53.9	33.0	9.2	3.9	16.1	24.3	23.0	20.3	17.1	14.7	9.9	16.6	13.7	1.73
Nebraska	26,016	47.9	35.8	11.4	5.0	11.1	17.3	15.4	13.4	10.8	9.7	8.6	16.8	10.3	1.49
Nevada	31,011	39.1	37.3	15.2	8.3	10.2	15.1	14.4	12.6	11.9	9.1	8.4	12.3	14.4	1.80
New Hampshire	36,329	31.8	37.8	19.8	10.7	6.4	8.5	8.7	7.3	6.2	5.4	7.7	13.9	8.6	1.63
New Jersey	40,927	28.8	32.0	20.9	18.3	7.6	11.7	12.6	11.7	10.4	6.0	6.8	11.3	10.0	0.82
New Mexico	24,087	51.6	31.7	11.0	5.6	20.6	30.3	30.6	27.6	25.2	17.8	13.7	21.2	21.0	2.04
New York	32,965	38.1	31.6	16.7	13.6	13.0	20.6	21.2	19.6	17.0	11.0	10.0	14.7	15.3	0.75
North Carolina	26,647	46.8	34.8	12.4	6.0	13.0	19.2	18.5	17.2	15.3	10.1	15.7	25.9	15.7	0.96

North Dakota	23,213	53.4	33.6	9.4	3.5	14.4	19.6	18.4	17.2	14.7	13.0	10.8	19.5	11.9	1.61
Ohio	28,706	43.5	35.5	14.1	6.9	12.5	21.1	19.9	17.8	14.6	10.7	8.7	13.8	12.4	0.88
Oklahoma	23,577	52.5	31.8	10.6	5.0	16.7	25.3	23.4	21.7	18.5	14.2	13.5	24.1	18.4	1.96
Oregon	27,250	45.6	35.7	12.5	6.2	12.4	19.7	16.1	14.8	13.3	11.5	8.1	13.1	11.3	1.73
Pennsylvania	29,069	43.0	35.0	14.1	7.9	11.1	17.5	17.0	15.7	13.8	9.5	8.7	13.5	11.7	0.85
Rhode Island	32,181	38.5	35.1	16.7	9.7	9.6	16.3	16.1	13.8	11.0	7.6	8.9	15.6	12.0	1.91
South Carolina	26,256	47.6	34.5	12.4	5.6	15.4	22.8	21.8	21.2	19.1	12.0	17.3	26.5	18.9	1.80
South Dakota	22,503	55.0	33.4	8.2	3.5	15.9	23.6	22.2	20.2	17.3	13.6	11.1	21.3	14.8	1.64
Tennessee	24,807	50.3	32.6	11.4	5.6	15.7	23.9	22.5	20.8	18.5	12.5	17.2	26.7	17.0	1.85
Texas	27,016	46.3	32.3	13.3	8.0	18.1	25.6	25.5	24.2	23.0	15.2	14.9	23.8	17.8	1.01
Utah	29,470	41.4	38.8	13.8	6.0	11.4	15.8	14.4	12.0	10.0	11.0	6.4	12.5	9.3	1.45
Vermont	29,792	41.2	37.7	14.3	6.8	9.9	13.5	13.7	12.5	9.8	8.5	9.7	16.3	10.4	1.71
Virginia	33,328	36.4	34.7	17.7	11.8	10.2	14.5	14.5	13.5	11.9	8.4	11.6	18.5	9.4	1.35
Washington	31,183	39.3	36.4	15.8	8.5	10.9	17.0	16.4	14.3	12.2	9.8	7.0	12.4	11.0	1.58
West Virginia	20,795	57.8	29.7	9.0	3.5	19.7	31.7	30.3	25.9	22.4	17.7	14.1	20.8	22.3	2.20
Wisconsin	29,442	42.1	37.6	14.1	6.2	10.7	17.7	16.4	15.0	11.9	9.2	6.6	12.6	10.8	1.49
Wyoming	27,096	46.0	36.5	12.8	4.8	11.9	18.3	16.2	14.1	11.2	10.8	8.4	14.3	10.3	1.83

[1] Based on 1989 incomes collected in the 1990 Census. May differ from data derived from the Current Population Survey presented in other tables.
[2] Based on 1991 incomes.

SOURCE: U.S. Department of Commerce, Bureau of the "Census, Decennial Census, Minority Economics Profiles," unpublished data: and "Current Population Reports," Series P–60, no. 185, "Poverty in the United States, 1992." (This table was prepared May 1994.)

TABLE 172.—TOTAL FALL ENROLLMENT IN INSTITUTIONS OF HIGHER EDUCATION, BY LEVEL, SEX, AGE, AND ATTENDANCE STATUS OF STUDENT: 1991

Attendance status and age of student	All levels			Undergraduate			First-professional			Graduate		
	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women
1	2	3	4	5	6	7	8	9	10	11	12	13
All students	14,358,953	6,501,844	7,857,109	12,439,287	5,571,003	6,868,284	280,531	169,875	110,656	1,639,135	760,966	878,169
Under 18	213,684	87,145	126,539	213,097	86,888	126,209	51	37	14	536	220	316
18 and 19	2,593,623	1,175,496	1,418,127	2,592,594	1,175,068	1,417,526	338	142	196	691	286	405
20 and 21	2,752,642	1,298,156	1,454,486	2,729,707	1,287,028	1,442,679	8,092	4,080	4,012	14,843	7,048	7,795
22 to 24	2,150,871	1,095,190	1,055,681	1,820,695	930,872	889,823	97,499	57,277	40,222	232,677	107,041	125,636
25 to 29	1,897,644	910,849	986,795	1,355,909	615,336	740,573	91,607	58,668	32,939	450,128	236,845	213,283
30 to 34	1,270,208	538,698	731,510	960,503	371,317	589,186	30,409	19,311	11,098	279,296	148,070	131,226
35 to 39	965,541	356,601	608,940	736,886	252,476	484,410	15,899	9,238	6,661	212,756	94,887	117,869
40 to 49	1,053,932	337,673	716,259	773,473	236,796	536,677	12,165	6,373	5,792	268,294	94,504	173,790
50 to 64	281,986	91,315	190,671	215,507	68,904	146,603	2,335	1,202	1,133	64,144	21,209	42,935

TABLE 172.—TOTAL FALL ENROLLMENT IN INSTITUTIONS OF HIGHER EDUCATION, BY LEVEL, SEX, AGE, AND ATTENDANCE STATUS OF STUDENT: 1991—Continued

Attendance status and age of student	All levels			Undergraduate			First-professional			Graduate		
	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women
1	2	3	4	5	6	7	8	9	10	11	12	13
65 and over	63,566	24,543	39,023	58,343	22,148	36,195	172	102	70	5,051	2,293	2,768
Age unknown	1,115,256	586,178	529,078	982,573	524,170	458,403	21,964	13,445	8,519	110,719	48,563	62,156
Full-time	8,115,329	3,929,375	4,185,954	7,221,412	3,435,526	3,785,886	252,012	152,356	99,656	641,905	341,493	300,412
Under 18	114,591	47,016	67,575	114,435	46,921	67,514	43	32	11	113	63	50
18 and 19	2,256,045	1,032,557	1,223,488	2,255,405	1,032,264	1,223,141	328	140	188	312	153	159
20 and 21	2,215,877	1,064,488	1,151,389	2,196,395	1,054,778	1,141,617	7,996	4,038	3,958	11,486	5,672	5,814
22 to 24	1,376,269	753,084	623,185	1,129,520	623,063	506,457	94,910	55,708	39,202	151,839	74,313	77,526
25 to 29	799,421	433,186	366,235	510,589	259,596	250,993	83,395	53,505	29,890	205,437	120,085	85,352
30 to 34	395,588	182,117	213,471	273,210	108,334	164,876	24,589	15,465	9,124	97,789	58,318	39,471
35 to 39	254,555	100,816	153,739	183,140	63,429	119,711	11,847	6,818	5,029	59,568	30,569	28,999
40 to 49	227,918	83,407	144,511	160,276	54,915	105,361	8,355	4,335	4,020	59,287	24,157	35,130
50 to 64	43,821	15,987	27,834	30,219	10,625	19,594	1,494	772	722	12,108	4,590	7,518
65 and over	5,500	2,685	2,815	4,702	2,266	2,436	92	55	37	706	364	342
Age unknown	425,744	214,032	211,712	363,521	179,335	184,186	18,963	11,488	7,475	43,260	23,209	20,051
Part-time	6,243,624	2,572,469	3,671,155	5,217,875	2,135,477	3,082,398	28,519	17,519	11,000	997,230	419,473	577,757
Under 18	99,093	40,129	58,964	98,662	39,967	58,695	8	5	3	423	157	266
18 and 19	337,578	142,939	194,639	337,189	142,804	194,385	10	2	8	379	133	246
20 and 21	536,765	233,668	303,097	533,312	232,250	301,062	96	42	54	3,357	1,376	1,981
22 to 24	774,602	342,106	432,496	691,175	307,809	383,366	2,589	1,569	1,020	80,838	32,728	48,110
25 to 29	1,098,223	477,663	620,560	845,320	355,740	489,580	8,212	5,163	3,049	244,691	116,760	127,931
30 to 34	874,620	356,581	518,039	687,293	262,983	424,310	5,820	3,846	1,974	181,507	89,752	91,755
35 to 39	710,986	255,785	455,201	553,746	189,047	364,699	4,052	2,420	1,632	153,188	64,318	88,870
40 to 49	826,014	254,266	571,748	613,197	181,881	431,316	3,810	2,038	1,772	209,007	70,347	138,660
50 to 64	238,165	75,328	162,837	185,288	58,279	127,009	841	430	411	52,036	16,619	35,417
65 and over	58,066	21,858	36,208	53,641	19,882	33,759	80	47	33	4,345	1,929	2,416
Age unknown	689,512	372,146	317,366	619,052	344,835	274,217	3,001	1,957	1,044	67,459	25,354	42,105
	Percentage distribution											
All students	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under 18	1.5	1.3	1.6	1.7	1.6	1.8	(1)	(1)	(1)	(1)	(1)	(1)
18 and 19	18.1	18.1	18.0	20.8	21.1	20.6	0.1	0.1	0.2	(1)	(1)	(1)
20 and 21	19.2	20.0	18.5	21.9	23.1	21.0	2.9	2.4	3.6	0.9	0.9	0.9

22 to 24	15.0	16.8	13.4	14.6	16.7	13.0	34.8	33.7	36.3	14.2	14.1	14.3
25 to 29	13.2	14.0	12.6	10.9	11.0	10.8	32.7	34.5	29.8	27.5	31.1	24.3
30 to 34	8.8	8.3	9.3	7.7	6.7	8.6	10.8	11.4	10.0	17.0	19.5	14.9
35 to 39	6.7	5.5	7.8	5.9	4.5	7.1	5.7	5.4	6.0	13.0	12.5	13.4
40 to 49	7.3	5.2	9.1	6.2	4.3	7.8	4.3	3.8	5.2	16.4	12.4	19.8
50 to 64	2.0	1.4	2.4	1.7	1.2	2.1	0.8	0.7	1.0	3.9	2.8	4.9
65 and over	0.4	0.4	0.5	0.5	0.4	0.5	0.1	0.1	0.1	0.3	0.3	0.3
Age unknown	7.8	9.0	6.7	7.9	9.4	6.7	7.8	7.9	7.7	6.8	6.4	7.1
Full-time	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under 18	1.4	1.2	1.6	1.6	1.4	1.8	(1)	(1)	(1)	(1)	(1)	(1)
18 and 19	27.8	26.3	29.2	31.2	30.0	32.3	0.1	0.1	0.2	(1)	(1)	0.1
20 and 21	27.3	27.1	27.5	30.4	30.7	30.2	3.2	2.7	4.0	1.8	1.7	1.9
22 to 24	17.0	19.2	14.9	15.6	18.1	13.4	37.7	36.6	39.3	23.7	21.8	25.8
25 to 29	9.9	11.0	8.7	7.1	7.6	6.6	33.1	35.1	30.0	32.0	35.2	28.4
30 to 34	4.9	4.6	5.1	3.8	3.2	4.4	9.8	10.2	9.2	15.2	17.1	13.1
35 to 39	3.1	2.6	3.7	2.5	1.8	3.2	4.7	4.5	5.0	9.3	9.0	9.7
40 to 49	2.8	2.1	3.5	2.2	1.6	2.8	3.3	2.8	4.0	9.2	7.1	11.7
50 to 64	0.5	0.4	0.7	0.4	0.3	0.5	0.6	0.5	0.7	1.9	1.3	2.5
65 and over	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.1	0.1	0.1
Age unknown	5.2	5.4	5.1	5.0	5.2	4.9	7.5	7.5	7.5	6.7	6.8	6.7
All students	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.1	100.0	100.0	100.0	100.0
Under 18	1.6	1.6	1.6	1.9	1.9	1.9	(1)	(1)	(1)	(1)	(1)	(1)
18 and 19	5.4	5.6	5.3	6.5	6.7	6.3	0.0	(1)	0.1	(1)	(1)	(1)
20 and 21	8.6	9.1	8.3	10.2	10.9	9.8	0.3	0.2	0.5	0.3	0.3	0.3
22 to 24	12.4	13.3	11.8	13.2	14.4	12.4	9.1	9.0	9.3	8.1	7.8	8.3
25 to 29	17.6	18.6	16.9	16.2	16.7	15.9	28.8	29.5	27.7	24.5	27.8	22.1
30 to 34	14.0	13.9	14.1	13.2	12.3	13.8	20.4	22.0	17.9	18.2	21.4	15.9
35 to 39	11.4	9.9	12.4	10.6	8.9	11.8	14.2	13.8	14.8	15.4	15.3	15.4
40 to 49	13.2	9.9	15.6	11.8	8.5	14.0	13.4	11.6	16.1	21.0	16.8	24.0
50 to 64	3.8	2.9	4.4	3.6	2.7	4.1	2.9	2.5	3.7	5.2	4.0	6.1
65 and over	0.9	0.8	1.0	1.0	0.9	1.1	0.3	0.3	0.3	0.4	0.5	0.4
Age unknown	11.0	14.5	8.6	11.9	16.1	8.9	10.5	11.2	9.5	6.8	6.0	7.3

[1] Less than .05 percent.

NOTE.—Because of rounding, details may not add to 100.0 percent.

SOURCE: U.S. Department of Education, National Center for Education Statistics, Integrated Postsecondary Education Data System, "Fall Enrollment, 1991" survey. (This table was prepared February 1993.)

TABLE 173.—TOTAL FALL ENROLLMENT IN INSTITUTIONS OF HIGHER EDUCATION, BY TYPE AND CONTROL OF INSTITUTION, AND AGE AND ATTENDANCE STATUS OF STUDENT: 1991

Attendance status and age of student	All institutions			Public institutions			Private institutions		
	Total	4-year	2-year	Total	4-year	2-year	Total	4-year	2-year
1	2	3	4	5	6	7	8	9	10
All students	14,358,953	8,707,053	5,651,900	11,309,563	5,904,748	5,404,815	3,049,390	2,802,305	247,085
Under 18	213,684	113,777	99,907	162,678	66,966	95,712	51,006	46,811	4,195
18 and 19	2,593,623	1,676,660	916,963	1,996,126	1,136,632	859,494	597,497	540,028	57,469
20 and 21	2,752,642	1,942,306	810,336	2,132,991	1,361,340	771,651	619,651	580,966	38,685
22 to 24	2,150,871	1,515,478	635,393	1,733,554	1,129,085	604,469	417,317	386,393	30,924
25 to 29	1,897,644	1,165,950	731,694	1,484,825	784,563	700,262	412,819	381,387	31,432
30 to 34	1,270,208	678,344	591,864	1,018,605	447,336	571,269	251,603	231,008	20,595
35 to 39	965,541	504,151	461,390	784,425	336,295	448,130	181,116	167,856	13,260
40 to 49	1,053,932	549,964	503,968	853,930	361,332	492,598	200,002	188,632	11,370
50 to 64	281,986	125,802	156,184	235,622	82,214	153,408	46,364	43,588	2,776
65 and over	63,566	19,394	44,172	57,733	14,211	43,522	5,833	5,183	650
Age unknown	1,115,256	415,227	700,029	849,074	184,774	664,300	266,182	230,453	35,729
Full-time	8,115,329	6,040,799	2,074,530	5,974,577	4,088,970	1,885,607	2,140,752	1,951,829	188,923
Under 18	114,591	81,779	32,812	76,190	46,921	29,269	38,401	34,858	3,543
18 and 19	2,256,045	1,597,791	658,254	1,675,153	1,071,167	603,986	580,892	526,624	54,268
20 and 21	2,215,877	1,778,684	437,193	1,633,403	1,228,607	404,796	582,474	550,077	32,397
22 to 24	1,376,269	1,147,292	228,977	1,054,517	848,962	205,555	321,752	298,330	23,422
25 to 29	799,421	606,382	193,039	578,563	406,688	171,875	220,858	199,694	21,164
30 to 34	395,588	263,746	131,842	294,925	175,975	118,950	100,663	87,771	12,892
35 to 39	254,555	164,433	90,122	190,126	107,806	82,320	64,429	56,627	7,802
40 to 49	227,918	145,874	82,044	167,759	91,977	75,782	60,159	53,897	6,262
50 to 64	43,821	26,029	17,792	31,711	15,378	16,333	12,110	10,651	1,459
65 and over	5,500	3,026	2,474	3,875	1,779	2,096	1,625	1,247	378
Age unknown	425,744	225,763	199,981	268,355	93,710	174,645	157,389	132,053	25,336
Part-time	6,243,624	2,666,254	3,577,370	5,334,986	1,815,778	3,519,208	908,638	850,476	58,162
Under 18	99,093	31,998	67,095	86,488	20,045	66,443	12,605	11,953	652
18 and 19	337,578	78,869	258,709	320,973	65,465	255,508	16,605	13,404	3,201
20 and 21	536,765	163,622	373,143	499,588	132,733	366,855	37,177	30,889	6,288
22 to 24	774,602	368,186	406,416	679,037	280,123	398,914	95,565	88,063	7,502
25 to 29	1,098,223	559,568	538,655	906,262	377,875	528,387	191,961	181,693	10,268
30 to 34	874,620	414,598	460,022	723,680	271,361	452,319	150,940	143,237	7,703
35 to 39	710,986	339,718	371,268	594,299	228,489	365,810	116,687	111,229	5,458
40 to 49	826,014	404,090	421,924	686,171	269,355	416,816	139,843	134,735	5,108

50 to 64	238,165	99,773	138,392	203,911	66,836	137,075	34,254	32,937	1,317
65 and over	58,066	16,368	41,698	53,858	12,432	41,426	4,208	3,936	272
Age unknown	689,512	189,464	500,048	580,719	91,064	489,655	108,793	98,400	10,393
	Percentage distribution								
All students	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under 18	1.5	1.3	1.8	1.4	1.1	1.8	1.7	1.7	1.7
18 and 19	18.1	19.3	16.2	17.6	19.2	15.9	19.6	19.3	23.3
20 and 21	19.2	22.3	14.3	18.9	23.1	14.3	20.3	20.7	15.7
22 to 24	15.0	17.4	11.2	15.3	19.1	11.2	13.7	13.8	12.5
25 to 29	13.2	13.4	12.9	13.1	13.3	13.0	13.5	13.6	12.7
30 to 34	8.8	7.8	10.5	9.0	7.6	10.6	8.3	8.2	8.3
35 to 39	6.7	5.8	8.2	6.9	5.7	8.3	5.9	6.0	5.4
40 to 49	7.3	6.3	8.9	7.6	6.1	9.1	6.6	6.7	4.6
50 to 64	2.0	1.4	2.8	2.1	1.4	2.8	1.5	1.6	1.1
65 and over	0.4	0.2	0.8	0.5	0.2	0.8	0.2	0.2	0.3
Age unknown	7.8	4.8	12.4	7.5	3.1	12.3	8.7	8.2	14.5
Full-time	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under 18	1.4	1.4	1.6	1.3	1.1	1.6	1.8	1.8	1.9
18 and 19	27.8	26.4	31.7	28.0	26.2	32.0	27.1	27.0	28.7
20 and 21	27.3	29.4	21.1	27.3	30.0	21.5	27.2	28.2	17.1
22 to 24	17.0	19.0	11.0	17.7	20.8	10.9	15.0	15.3	12.4
25 to 29	9.9	10.0	9.3	9.7	9.9	9.1	10.3	10.2	11.2
30 to 34	4.9	4.4	6.4	4.9	4.3	6.3	4.7	4.5	6.8
35 to 39	3.1	2.7	4.3	3.2	2.6	4.4	3.0	2.9	4.1
40 to 49	2.8	2.4	4.0	2.8	2.2	4.0	2.8	2.8	3.3
50 to 64	0.5	0.4	0.9	0.5	0.4	0.9	0.6	0.5	0.8
65 and over	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.2
Age unknown	5.2	3.7	9.6	4.5	2.3	9.3	7.4	6.8	13.4
Part-time	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under 18	1.6	1.2	1.9	1.6	1.1	1.9	1.4	1.4	1.1
18 and 19	5.4	3.0	7.2	6.0	3.6	7.3	1.8	1.6	5.5
20 and 21	8.6	6.1	10.4	9.4	7.3	10.4	4.1	3.6	10.8
22 to 24	12.4	13.8	11.4	12.7	15.4	11.3	10.5	10.4	12.9
25 to 29	17.6	21.0	15.1	17.0	20.8	15.0	21.1	21.4	17.7
30 to 34	14.0	15.5	12.9	13.6	14.9	12.9	16.6	16.8	13.2
35 to 39	11.4	12.7	10.4	11.1	12.6	10.4	12.8	13.1	9.4
40 to 49	13.2	15.2	11.8	12.9	14.8	11.8	15.4	15.8	8.8

TABLE 173.—TOTAL FALL ENROLLMENT IN INSTITUTIONS OF HIGHER EDUCATION, BY TYPE AND CONTROL OF INSTITUTION, AND AGE AND ATTENDANCE STATUS OF STUDENT: 1991—Continued

Attendance status and age of student	All institutions			Public institutions			Private institutions		
	Total	4-year	2-year	Total	4-year	2-year	Total	4-year	2-year
1	2	3	4	5	6	7	8	9	10
50 to 64	3.8	3.7	3.9	3.8	3.7	3.9	3.8	3.9	2.3
65 and over	0.9	0.6	1.2	1.0	0.7	1.2	0.5	0.5	0.5
Age unknown	11.0	7.1	14.0	10.9	5.0	13.9	12.0	11.6	17.9

NOTE.—Because of rounding, details may not add to 100.0 percent.

SOURCE: U.S. Department of Education, National Center for Education Statistics, Integrated Postsecondary Education Data System, "Fall Enrollment, 1991" survey. (This table was prepared February 1993).

TABLE 343.—PARTICIPANTS IN ADULT EDUCATION 17 YEARS OLD AND OLDER, BY SELECTED CHARACTERISTICS OF PARTICIPANTS: 1991

[Numbers in thousands]

Characteristics of participants	Number of adults in population [1]	Ever a participant in adult education [2]		Participated in adult education [2] in past 3 years		Participated in adult education [2] in past year	
		Number	Percent of population	Number	Percent of population	Number	Percent of population
1	2	3	4	5	6	7	8
Total	181,800	97,397	54	69,361	38	57,391	32
Age:							
17 to 24 years	21,688	9,240	43	8,756	40	7,125	33
25 to 34 years	47,244	27,325	58	22,773	48	17,580	37
35 to 44 years	38,565	25,043	65	19,581	51	17,083	44
45 to 54 years	25,375	14,755	58	9,351	37	8,107	32
55 to 64 years	19,967	10,101	51	5,150	26	4,516	23
65 years and over	28,960	10,934	38	3,750	13	3,031	10
Sex:							
Men	82,154	42,163	51	29,945	36	25,963	32
Women	99,646	55,234	55	39,415	40	31,469	32
Racial/ethnic group:							
White, non-Hispanic	143,144	80,099	56	56,715	40	47,401	33
Black, non-Hispanic	20,141	8,213	41	5,552	28	4,586	23

Hispanic	13,804	6,905	50	5,396	39	4,032	29
Other races, non-Hispanic	4,711	2,180	46	1,698	36	1,371	29
Highest level of education completed:							
Less than high school diploma	28,306	7,337	26	4,127	15	3,437	12
High school diploma	110,384	58,135	53	39,403	36	31,602	29
Associate degree	5,034	3,949	78	3,191	63	2,461	49
Bachelor's degree or higher	38,076	27,976	73	22,640	59	19,891	52
Labor force status:							
In labor force	125,440	73,513	59	58,078	46	49,242	39
Employed	115,620	69,421	60	55,093	48	47,143	41
Unemployed	9,820	4,092	42	2,985	30	3,099	21
Not in labor force	56,361	23,884	42	11,283	20	8,149	14
Annual family income:							
$10,000 or less	27,504	10,706	39	5,766	21	3,843	14
$10,001 to $15,000	15,465	7,014	45	4,426	29	3,178	21
$15,001 to $20,000	16,117	6,335	39	4,183	26	3,308	21
$20,001 to $25,000	16,092	7,666	48	5,343	33	4,063	25
$25,001 to $30,000	17,973	9,309	52	6,570	37	5,445	30
$30,001 to $40,000	26,110	14,922	57	10,313	39	9,043	35
$40,001 to $50,000	21,303	13,270	62	10,526	49	9,313	44
$50,001 to $75,000	24,540	16,629	68	12,971	53	11,235	46
More than $75,000	16,695	11,546	69	9,263	55	7,963	48

[1] Persons 17 years of age and over on the date of the survey.
[2] Adult education is defined as all non-full-time education activities such as part-time college attendance, classes or seminars given by employers, and classes taken for adult literacy purposes, or for recreation and enjoyment.

NOTE.—Data are based upon a sample survey of the civilian noninstitutional population. Because of rounding and survey item nonresponse, details may not add to totals.

SOURCE: U.S. Department of Education, National Center for Education Statistics, "Participation in Adult Education," unpublished data. (This table was prepared July 1991.)

Table 344.—TYPE OF EMPLOYER INVOLVEMENT AND NUMBER OF COURSES TAKEN BY ADULT EDUCATION PARTICIPANTS[1] 17 YEARS OLD AND OLDER, BY SELECTED CHARACTERISTICS OF PARTICIPANTS: 1991

Characteristics of participants	Adult education participants in the past year, in thousands	Type of employer involvement (percent of adult education participants)						Percentage distribution of the number of adult education courses taken in the past year		
		Any type	Given at place of work	Employer paid some portion	Employer provided course	Employer required course	Employer provided time off	One	Two or three	Four or more
1	2	3	4	5	6	7	8	9	10	11
Total	57,391	64	32	51	38	30	48	43	34	21
Age:										
17 to 24 years	7,125	54	28	39	36	26	39	46	30	22
25 to 34 years	17,530	68	31	55	40	36	50	43	34	20
35 to 44 years	17,083	70	35	56	40	30	53	38	36	23
45 to 54 years	8,107	71	39	59	44	32	55	41	36	22
55 to 64 years	4,516	64	30	48	36	27	45	50	32	16
65 years and over	3,031	18	8	12	9	9	12	60	27	9
Sex:										
Men	25,923	73	35	58	42	34	56	42	37	19
Women	31,469	57	29	46	35	27	41	44	31	22
Racial/ethnic group:										
White, non-Hispanic	47,401	65	32	53	39	30	49	42	35	21
Black, non-Hispanic	4,586	59	36	48	41	38	44	41	31	24
Hispanic	4,032	58	30	39	33	31	43	56	27	14
Other races, non-Hispanic	1,371	56	28	36	30	20	40	39	27	28
Highest level of education completed:										
Less than high school diploma	3,437	35	17	21	19	21	19	72	17	8
High school diploma	31,602	52	31	50	36	31	45	47	32	18
Associate degree	2,461	76	47	66	51	39	63	32	40	25
Bachelor's degree or higher	19,891	71	34	57	44	30	56	33	39	26
Labor force status:										
In labor force	49,242	72	36	58	43	34	54	41	35	22
Employed	47,143	74	37	60	44	35	56	40	36	22
Unemployed	2,099	35	12	13	12	19	18	56	23	16
Not in labor force	8,149	16	7	11	9	8	10	60	26	12

Annual family income:										
$10,000 or less	3,843	39	18	25	24	23	29	59	20	15
$10,001 to $15,000	3,178	52	27	37	24	27	37	53	32	13
$15,001 to $20,000	3,308	57	28	42	35	29	39	46	37	15
$20,001 to $25,000	4,063	67	34	46	37	34	48	48	32	17
$25,001 to $30,000	5,445	58	30	48	38	29	39	44	34	19
$30,001 to $40,000	9,043	68	35	57	43	35	50	42	32	24
$40,001 to $50,000	9,313	67	34	55	42	33	50	45	32	20
$50,001 to $75,000	11,235	72	35	61	43	32	58	39	37	22
More than $75,000	7,963	68	30	54	37	24	53	32	41	26

[1] Adult education is defined as all non-full-time education, activities such as part-time college attendance, classes or seminars given by employers, and classes taken for adult literacy purposes, or for recreation and employment.

NOTE.—Data are based upon a sample survey of the civilian noninstitutional population. Because of rounding and survey item nonresponse, details may not add to totals.

SOURCE: U.S. Department of Education, National Center for Education Statistics, Participation in Adult Education,'' unpublished data. (This table was prepared July 1991.)

TABLE 345.—PARTICIPANTS IN ADULT BASIC AND SECONDARY EDUCATION PROGRAMS, BY LEVEL OF ENROLLMNET AND STATE: FISCAL YEARS 1980, 1990, and 1991

State or other area	1980				1990			1991		
	Total	Level of enrollment			Total	Level of enrollment		Total	Level of enrollment	
		Adult basic education	Adult secondary education	Ungraded		Adult basic education[1]	Adult secondary education		Adult basic education[1]	Adult secondary education
1	2	3	4	5	6	7	8	9	10	11
United States	2,018,906	915,936	531,663	571,307	3,535,970	2,435,649	1,100,321	3,694,217	2,513,371	1,180,846
Alabama	51,599	36,726	12,372	2,501	40,177	32,984	7,193	45,700	36,319	9,381
Alaska	5,667	2,200	2,188	1,279	5,067	4,267	800	5,399	4,488	911
Arizona	9,996	9,968	22	6	33,805	24,915	8,890	36,717	26,709	10,008
Arkansas	8,583	7,308	1,275	.....	29,065	17,103	11,962	30,845	17,437	13,408
California	267,625	60,385	.....	207,240	1,021,227	753,282	267,945	1,022,583	761,637	260,946
Colorado	9,381	4,295	2,644	2,442	12,183	9,877	2,306	13,742	10,764	2,978
Connecticut	21,889	8,882	4,805	8,202	46,434	25,560	20,874	57,188	32,117	25,071
Delaware	1,797	1,110	503	184	2,662	2,348	314	2,567	2,167	400
District of Columbia	25,214	4,928	6,502	13,784	19,586	12,631	6,955	20,309	13,207	7,102
Florida	467,162	100,958	184,568	181,636	419,429	249,339	170,090	436,766	260,761	176,005
Georgia	50,820	26,734	17,008	7,078	69,580	49,622	19,958	80,119	59,107	21,012
Hawaii	16,457	16,457	.....	.....	52,012	31,766	20,246	53,051	29,816	23,235
Idaho	12,851	8,915	3,010	926	11,171	9,180	1,991	10,215	8,407	1,808
Illinois	76,456	59,314	17,142	.....	87,121	69,770	17,351	91,383	72,997	18,386

TABLE 345.—PARTICIPANTS IN ADULT BASIC AND SECONDARY EDUCATION PROGRAMS, BY LEVEL OF ENROLLMNET AND STATE: FISCAL YEARS 1980, 1990, and 1991—Continued

State or other area	1980				1990			1991		
	Total	Level of enrollment			Total	Level of enrollment		Total	Level of enrollment	
		Adult basic education	Adult secondary education	Ungraded		Adult basic education[1]	Adult secondary education		Adult basic education[1]	Adult secondary education
1	2	3	4	5	6	7	8	9	10	11
Indiana	20,882	18,127	2,660	95	44,166	27,138	17,028	50,483	31,101	19,382
Iowa	25,851	16,928	5,153	3,770	41,507	30,470	11,037	38,998	28,009	10,989
Kansas	14,405	3,687	7,436	3,282	10,274	9,191	1,083	11,179	8,877	2,302
Kentucky	27,800	6,147	4,735	16,918	28,090	20,406	7,684	23,248	16,683	6,565
Louisiana	16,046	12,608	2,485	953	40,039	20,941	19,098	43,349	22,254	21,095
Maine	5,327	3,029	942	1,356	14,964	6,620	8,344	16,573	7,505	9,068
Maryland	34,572	23,421	6,043	5,108	41,230	36,244	4,986	53,505	49,804	3,701
Massachusetts	20,420	10,241	5,044	5,135	34,220	28,140	6,080	23,218	18,289	4,929
Michigan	40,973	29,945	.....	11,028	194,178	80,206	113,972	205,545	75,897	129,648
Minnesota	10,826	8,627	877	1,322	45,648	33,190	12,458	48,853	31,964	16,889
Mississippi	14,317	10,340	2,918	1,059	18,957	15,834	3,123	20,015	17,269	2,746
Missouri	33,292	27,206	3,732	2,354	31,815	27,274	4,541	33,060	28,211	4,849
Montana	3,525	1,795	978	752	6,071	3,962	2,109	5,942	3,665	2,277
Nebraska	7,514	5,152	2,362	.....	6,158	5,349	809	6,597	5,786	811
Nevada	3,063	845	82	2,136	17,262	7,270	9,992	19,682	6,329	13,353
New Hampshire	4,844	2,657	1,625	562	7,198	5,073	2,125	7,137	4,282	2,855
New Jersey	35,770	17,152	6,790	11,828	64,080	46,526	17,554	65,379	43,162	22,217
New Mexico	13,102	3,590	5,147	4,365	30,236	18,069	12,167	30,287	17,154	13,133
New York	94,574	57,217	20,002	17,355	156,611	125,893	30,718	182,879	146,265	36,614
North Carolina	84,252	33,854	46,679	3,719	109,740	71,698	38,042	120,347	79,641	40,706
North Dakota	2,810	1,963	538	309	3,587	2,500	1,087	3,853	2,725	1,128
Ohio	50,056	42,421	7,635	.....	95,476	79,527	15,949	108,753	88,302	20,451
Oklahoma	14,701	6,983	5,697	2,021	24,307	19,131	5,176	26,707	20,473	6,234
Oregon	27,645	10,690	12,594	4,361	37,075	24,915	12,160	40,285	24,791	15,494
Pennsylvania	29,477	19,246	6,436	3,795	52,444	40,108	12,336	48,590	38,054	10,536
Rhode Island	5,844	2,266	1,357	2,221	7,347	5,874	1,473	7,264	5,431	1,833
South Carolina	69,659	27,959	35,165	6,535	81,200	37,117	44,083	86,776	35,911	50,865
South Dakota	4,067	2,080	1,109	878	3,184	2,458	726	3,079	2,349	730
Tennessee	26,268	17,079	3,244	5,945	41,721	39,604	2,117	49,556	40,702	8,854
Texas	157,349	94,245	51,126	11,978	218,747	145,067	73,680	220,027	150,322	69,705

Utah	18,541	3,756	14,785	.....	24,841	6,003	18,838	24,028	6,788	17,240
Vermont	4,583	3,990	.....	593	4,808	4,452	356	5,330	4,862	468
Virginia	21,525	10,480	3,804	7,241	31,649	30,005	1,644	25,456	14,450	11,006
Washington	16,286	7,245	3,894	5,147	31,776	25,336	6,440	34,401	27,752	6,649
West Virginia	14,628	9,743	3,672	1,213	21,186	14,227	[2] 6,959	23,077	16,903	6,174
Wisconsin	16,158	14,185	1,973	.....	61,081	45,116	15,965	70,838	53,524	17,314
Wyoming	2,457	857	905	695	3,578	2,071	[2] 1,507	3,337	1,952	1,385
Outlying areas										
American Samoa	313	252	61	.....	.....	.....	.....	.....	.....	.....
Northern Marianas	.....	.....	.....	.....	.....	.....	.....	290	270	20
Guam	1,346	612	471	263	1,311	414	[2] 897	1,466	478	988
Puerto Rico	30,164	17,844	9,010	3,310	28,436	28,436	.....	26,845	26,845	.....
Trust Territory of the Pacific	3,753	2,138	699	916	.....	.....	.....	.....	.....	.....
Virgin Islands	3,500	1,002	859	1,639	1,653	1,215	438	.....	.....	.....

[1] Includes English as a second language.
[2] Estimated.
—Data not available or not applicable.

SOURCE: U.S. Department of Education, National Center for Education Statistics, "Women and Minority Groups Make Up Largest Segment of Adult Basic and Secondary Education Programs;" and Office of Vocational and Adult Education, "Adult Education Program Facts, Program Year 1990–1991." (This table was prepared June 1993).

LSCA TITLE I—EXPENDITURES FOR THE ELDERLY, FY 1991

STATE	FEDERAL	STATE	LOCAL	TOTAL	POPULATION SERVED
ALABAMA	$29,900	$0	$13,981	$43,881	15,115
ALASKA	0	0	0	0	0
ARIZONA	10,025	0	0	10,025	109,722
ARKANSAS	9,000	0	0	9,000	23,452
CALIFORNIA	401,600	0	0	401,600	141,500
COLORADO	30,825	0	0	30,825	515
CONNECTICUT	0	0	0	0	0
DELAWARE	5,569	4,040	0	9,609	5,500
DIST OF COLUMBIA	72,000	73,530	0	145,530	76,000
FLORIDA	74,280	0	43,966	118,246	188,334
GEORGIA	10,000	2,000	2,120	14,120	138,590
HAWAII	0	0	0	0	0
IDAHO	0	0	0	0	0
ILLINOIS	0	0	0	0	0
INDIANA	20,399	0	0	20,399	21,000
IOWA	3,876	0	0	3,876	10,482
KANSAS	39,625	0	0	39,625	54,576
KENTUCKY	73,728	0	0	73,728	290,269
LOUISIANA	11,747	6,684	0	18,431	468,991
MAINE	0	42,158	0	42,158	500
MARYLAND	11,297	0	0	11,297	6,173
MASSACHUSETTS	0	0	0	0	0
MICHIGAN	9,510	0	0	9,510	2,549
MINNESOTA	5,146	0	0	5,146	21,716
MISSISSIPPI	0	0	0	0	0
MISSOURI	48,681	0	0	48,681	200
MONTANA	0	0	0	0	0
NEBRASKA	1,501	0	0	1,501	205,684
NEVADA	5,800	0	0	5,800	12,500
NEW HAMPSHIRE	3,177	1,000	0	4,177	165,000
NEW JERSEY	0	0	0	0	0
NEW MEXICO	0	0	0	0	0
NEW YORK	153,970	0	0	153,970	58,874
NORTH CAROLINA	0	0	0	0	0
NORTH DAKOTA	0	0	0	0	0
OHIO	20,527	8,605	0	29,132	20,672
OKLAHOMA	48,430	0	0	48,430	0
OREGON	906	0	0	906	20,000
PENNSYLVANIA	34,470	0	0	34,470	21,000
RHODE ISLAND	0	0	0	0	0
SOUTH CAROLINA	23,950	0	19,450	43,400	10,000
SOUTH DAKOTA	12,942	14,434	0	27,376	123,063
TENNESSEE	51,167	0	0	51,167	841,907
TEXAS	152,506	0	0	152,506	130,285
UTAH	0	0	0	0	0
VERMONT	0	0	0	0	0
VIRGINIA	20,128	0	0	20,128	3,030
WASHINGTON	20,993	0	0	20,993	665
WEST VIRGINIA	0	0	0	0	0
WISCONSIN	107,847	0	0	107,847	104,655
WYOMING	0	0	0	0	0
GUAM	2,000	2,000	0	4,000	0
PUERTO RICO	0	11,525	0	11,525	4,135
VIRGIN ISLANDS	0	0	0	0	0
TOTAL	1,527,522	165,976	79,517	1,773,015	3,296,654

LSCA TITLE I—EXPENDITURES FOR THE ELDERLY, FY 1992

STATE	FEDERAL	STATE	LOCAL	TOTAL	POPULATION SERVED
ALABAMA	0	0	0	0	0

LSCA TITLE I—EXPENDITURES FOR THE ELDERLY, FY 1992—Continued

STATE	FEDERAL	STATE	LOCAL	TOTAL	POPULATION SERVED
ALASKA	0	0	0	0	0
ARIZONA	3,500	0	0	3,500	550
ARKANSAS	0	0	0	0	0
CALIFORNIA	0	0	0	0	0
COLORADO	28,175	0	0	28,175	833
CONNECTICUT	0	0	0	0	0
DELAWARE	10,690	0	12,774	23,464	5,628
DIST OF COLUMBIA	3,005	103,921	0	106,926	76,000
FLORIDA	151,814	0	111,343	263,157	60,083
GEORGIA	16,000	2,000	2,290	20,290	97,991
HAWAII	0	0	0	0	0
IDAHO	697	0	0	697	447
ILLINOIS	31,234	0	0	31,234	60,000
INDIANA	5,826	0	0	5,826	100
IOWA	9,313	0	0	9,313	500
KANSAS	30,000	0	0	30,000	7,776
KENTUCKY	62,830	0	0	62,830	347,002
LOUISIANA	15,240	3,891	0	19,131	468,991
MAINE	124	41,624	0	41,748	500
MARYLAND	32,050	0	0	32,050	3,675
MASSACHUSETTS	20,800	0	0	20,800	3,030
MICHIGAN	76,284	0	0	76,284	1,505,154
MINNESOTA	5,185	0	0	5,185	22,000
MISSISSIPPI	2	94	0	96	15,132
MISSOURI	47,360	0	0	47,360	200,000
MONTANA	0	0	0	0	0
NEBRASKA	1,845	0	0	1,845	205,684
NEVADA	25,000	0	0	25,000	266,800
NEW HAMPSHIRE	1,423	1,500	0	2,923	168,522
NEW JERSEY	20,000	0	0	20,000	250
NEW MEXICO	0	0	0	0	0
NEW YORK	103,970	0	0	103,970	10,752
NORTH CAROLINA	21,602	0	0	21,602	(1)
NORTH DAKOTA	0	0	0	0	0
OHIO	16,969	1,120	21,000	39,089	21,859
OKLAHOMA	49,365	0	0	49,365	1,641
OREGON	12,116	0	0	12,116	1,600
PENNSYLVANIA	409,209	0	0	409,209	71,710
RHODE ISLAND	11,098	24,449	0	35,547	239,750
SOUTH CAROLINA	29,824	37,839	24,483	92,146	19,409
SOUTH DAKOTA	7,445	6,223	13,668	27,336	(1)
TENNESSEE	58,650	0	0	58,650	131,548
TEXAS	264,840	0	0	264,840	187,295
UTAH	0	0	0	0	0
VERMONT	0	0	0	0	0
VIRGINIA	0	0	0	0	0
WASHINGTON	0	0	0	0	0
WEST VIRGINIA	0	0	0	0	0
WISCONSIN	111,452	0	0	111,452	122,983
WYOMING	0	0	0	0	0
GUAM	2,000	2,000	0	4,000	(1)
PUERTO RICO	0	11,525	0	11,525	1,307
VIRGIN ISLANDS	0	0	0	0	0
TOTAL	1,696,937	236,186	185,558	2,118,681	4,326,502

[1] Not available.

NATIONAL INSTITUTE ON DISABILITY AND REHABILITATION RESEARCH AGING PROGRAMS—FY 1995

The National Institute on Disability and Rehabilitation Research (NIDRR), authorized by Title II of the Rehabilitation Act, has specific responsibilities for conducting and coordinating research that relates directly to the rehabilitation of per-

sons with disabilities. Disability is very closely associated with increasing age. Grants and contracts are made to public and private agencies and organizations, including institutions of higher education, Indian Tribes and tribal organizations, for the purpose of planning and conducting research, demonstrations, and related activities which bear directly on the development of methods, procedures and devices which assist in the provision of rehabilitation services.

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

The Institute accomplishes its mission through the following programs:

Rehabilitation Research and Training Centers
Rehabilitation Engineering and Research Centers
Research and Demonstration Projects
Field-Initiated Projects
Dissemination and Utilization Projects
Career Development Projects, which include:
  Fellowships
  Research Training

AGING-RELATED ACTIVITIES

RESEARCH AND TRAINING CENTERS

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

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

Research addressed by the Center includes:

The applicant is developing an RRTC which focuses on the problems experienced by people who are aging with a disability acquired before late life and includes some of the problems of people with onset of disability late in life. Four kinds of conditions (cerebral palsy, post-polio, rheumatoid arthritis and stroke) are chosen for in-depth study and serve as a basis for developing models from which to understand other impairments.

Study One (Variations in Late Onset Complications).

Study Two (Preventing and Treating Late Life Complications Through Improved, Quantified Identification of Weakness).

Study Three (Evaluation of Residential Care Facilities as an Alternative Community Service Model for Disabled Older Adults).

Study Four (Role of Training to Enhance Utilization of Inhome Support: A Comparison Between Older Disabled Hispanics and Anglos).

Study Five (Use of Technology Services to Maintain Employment Among People Aging with a Disability).

Study Six (A Study of Policy Barriers that Impede Utilization of Technology).

2. Rehabilitation Research and Training Center on Aging With Mental Retardation, The University of Illinois at Chicago, University of Illinois UAP, 1640 West Roosevelt Road, Chicago, IL

The Illinois University Affiliated Program in Developmental Disabilities (UAP), University of Illinois at Chicago (UIC), has established the Rehabilitation Research and Training Center on Aging with Mental Retardation. This center will build on the strength and continuity of the current RRTC on Aging and Developmental Disabilities and bring to it the resources of a major university with considerable commitment, applied research and clinical expertise in the fields of mental retardation and aging. The RRTC will build on the continuity of its collaboration over the last 5 years. The RRTC has developed a greater understanding of aging and developmental disabilities by capitalizing on large data bases, longitudinal investigations, and multi state sites.

Investigators from other universities in Minnesota, Ohio, Indiana, Wisconsin, Kentucky, and Hawaii contribute strengths to the RRTC in epidemiological and clinical research on age-related changes, family future planning, self-determination, cultural diversity, and public policy analysis. In addition, the RRTC has assembled a network of national, state, and local organizations to ensure that the RRTC programs are widely disseminated, have practical applications, and will stimulate public policy change.

The research is applied and examines individuals' lives in their natural settings. It is focused on outcomes in the lives of older persons with mental retardation. The main goal of the research is to translate the knowledge gained into practice through broad-based training; technical assistance; and dissemination to persons with mental retardation, their families, service providers, administrators and policy makers, advocacy groups, and the general community.

3. Rehabilitation Research and Training Center on Stroke Rehabilitation, Rehabilitation Institute Research Corporation, 345 East Superior, Chicago, IL

Enhancing the quality of life of individuals with stroke and their families requires reducing the impact of medical comorbidity, maximizing functional independence, and promoting optimal psychosocial adaptation. The objectives of the Rehabilitation Research and Training Center are to develop, evaluate, and demonstrate the usefulness and effectiveness of a variety of medical, rehabilitative, psychological, and social strategies designed to improve outcomes in survivors of stroke. Major areas of focus for this project will include the assessment of functional performance, of psychological well being, of the contributions of medical and psychological factors to functional capabilities, and the dissemination of information and innovations to patients, their families, and rehabilitation professionals.

4. Rehabilitation Research and Training Center on Aging with Spinal Cord Injury, Craig Hospital and the University of Colorado, Health Science Center, Research Department, 3425 South Clarkson, Englewood, CO

This rehabilitation and research training center in aging with spinal cord injury describes a 4-year collaborative effort. The project targets "aging" spinal cord injury survivors—those injured 20 or more years ago, and/or those over the age of 55 years when initially injured—as well as their families and personal caregivers, and the physicians and health care professionals who treat them.

The RRTC proposes six specific research investigations addressing the broad research goal, "to conduct longitudinal research to document the natural course of aging with spinal cord injury and identify risk factors associated with increasing medical complications, functional limitations, psychosocial concerns, and escalating costs."

Study One (The completion of longitudinal medical, health, functional, and psychosocial follow-up of 282 British spinal cord injury survivors who have been injured 20 or more years).

Study Two (The follow-up and assessment of Craig Hospital's clients who have been injured two or more decades).

Study Three (The initiation of a population-based study comparing the outcomes of individuals who are over 55 years old when initially spinal cord injured with those who are under age 35 at the time of injury).

Study Four (Analysis of the National Database of the Model Spinal Cord Injury Systems with respect to aging issues).

Study Five (A study of the lifetime costs of spinal cord injury and its care).

Study Six (Implementation of longitudinal study of psychological adjustment to spinal cord injury 20 or more years post-injury).

5. Rehabilitation Research and Training Center on Spinal Cord Injury and Aging, Rancho Los Amigos Medical Center, Downey, CA

The center will conduct programmatic research on the medical, functional, psychological, social, and service delivery issues important to rehabilitation of older persons with either an early onset or late life onset of disability; and provide state-of-the-art training to health professionals, students, researchers, families and consumers about test practices of geriatric rehabilitation service; and research and disseminate information on geriatric rehabilitation. Research on the late effects of life disability is comparing older persons with early-life onset of spinal cord injury and polio and assessing their medical, psychological, social, and rehabilitation service needs and how these needs should be addressed. Research on attitudes of and toward older disabled persons is examining the impact of these attitudes on effective service delivery and rehabilitation success. Research on technology solutions for older persons is developing and evaluating the benefits of a sub-center on technology within a rehabilitation program. Research on policy and funding alternatives to promote community and supportive services of older persons with disabilities is examining various policies and their impact on the rehabilitation of the older person. The Center's training activities are designed to improve knowledge and skills regarding the rehabilitation of older persons and are targeted to students and practitioners in rehabilitation and other health disciplines.

6. Disability Statistics Rehabilitation Research and Training Center, University of California, San Francisco, Institute for Health and Aging, Box 0646, Laurel Heights, San Francisco, CA

The center conducts research in areas of high priority in the field of disability and disability policy, including costs, employment statistics, health and long-term care statistics, statistical indicators, and congregate living statistics. Statistical information is disseminated through published statistical reports and abstracts, a CD–ROM subscription, journals, professional presentations, and a publications mailing list. Training activities and resources (such as a predoctoral program) disseminate scientific methods, procedures, and results to both new and established researchers, policy makers, and other consumers, and assists them in interpreting statistical information. A National Disability Statistics and Policy Forum is being conducted periodically to establish a national dialogue between people with disabilities and representative organizations, researchers, and policy makers.

REHABILITATION ENGINEERING AND RESEARCH CENTERS

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

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

The assistive potential of low and high technology devices

Exploring the environment in which older persons with disabilities apply technology, and

Improving the public and private sector systems delivering assistive technology services.

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

device utilization,

professional education, and

technical assistance.

FIELD INITIATED RESEARCH PROGRAM

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

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

2. Rehabilitation of Visually Impaired Older Persons, The Lighthouse, New York Association for the Blind, New York, NY

The primary long-range goal of the proposed project is to enhance the availability, accessibility and effectiveness of rehabilitation services and technological resources for visually impaired and blind older persons in order to maximize functional independence and well-being in later life.

This research and demonstration project will provide an accumulated fund of knowledge about programs and services for visually impaired older adults. This knowledge is critical to consumers, families, service providers and planners as they prepare for the continued increase of this population.

A national survey of programs and services will document the current status of service delivery to visually impaired older persons and describe model programs and their development. A low vision curriculum targeted to generic health and human service providers, to be developed and tested, will offer a systemic assessment of the impact of low vision training on non-eye care professionals, the gatekeepers to service for a majority of older adults. The expertise of State program directors and agency executives in the development of programs funded under the Older Blind Independent Living Program will be tapped along with that of program consumers in

a series of focus groups intended to pinpoint effective strategies for program delivery under this appropriation.

3. Assistive Technology Training for Individuals With a Visual Disability Preparing to Enter the Job Market, The Carroll Center for the Blind, Inc., 770 Centre Street, Newton, MA

The project will develop, implement, evaluate and disseminate assistive technology training curricula dedicated to helping people with visual disabilities to develop skills for successful employment in actual work settings. These curricula contain practical knowledge and enable the acquisition of functional skills related to the uses and benefits of assistive technology in the workplace. Content is intended to go beyond the technical aspects of assistive devices and systems, and is sufficiently comprehensive to permit individualized and personalized usage. Substantive content is being drawn from a body of knowledge accumulating in such fields as post-secondary education, corporate training, access technology, career development and transition, and adjustment to disability. The focus, relevance, scope sequence and understandability of the training activities are being guided by a curriculum steering committee consisting of consumers, their families, special educators, rehabilitation professionals, employers, technical support personnel and human resource specialists.

The overall project goal is to produce three stand-alone curricula which will prepare blind job seekers to use individually-tailored assistive technology in three distinct career alternatives. The first curriculum to be developed is on the preparation of medical transcriptionists.

4. Measuring Functional Communication: A Research Project to Establish the Reliability and Validity of a Functional Communication Measure for Adults, American Speech-Language-Hearing Association, 10801 Rockville Pike, Rockville, MD

The project will revise the American Speech-Language-Hearing Association Functional Communication Scales for Adults (ASHS FCS–A); complete the first of a series of field testing and evaluation projects to establish the reliability and validity of the scales with various communication disordered individuals at various intervention sites; and develop administration and scoring materials for dissemination to users of the instrument.

Objectives of the project include the identification of the functional communication abilities and needs of adults with communication disorders in order to maximize their ability to communicate in natural environments.

5. Aging and Vision Loss: The Development of Guidelines for Innovative Personnel Preparation Curriculum in Gerontology, American Foundation for the Blind, 15 W. 16th Street, New York, NY

The project will research, develop, and disseminate guidelines for a model competency-based curriculum on aging and vision loss for accredited institutions of higher education offering coursework in gerontology. The guidelines for the curriculum model will be designed for use by faculty of these institutions to establish a course in aging and vision loss, or to infuse content on aging and vision loss into existing course curricula. The project objectives will be accomplished by conducting a national survey of university gerontology programs and vision loss; convening a curriculum development workshop to determine curriculum competencies, content, and teaching methods; and disseminating findings and guidelines for a model curriculum on aging and vision loss through the publication of articles in relevant aging and vision journals and presentations at national conferences.

6. Aging and Adjustment after Spinal Cord Injury: A 20-Year Longitudinal Study, Shepherd Center for Spinal Injuries, Inc., 2020 Peachtree Road, NW, Atlanta, GA

This fourth study phase will be the most extensive follow-up yet performed and will use an expanded version of the same questionnaire that was used in each of the three previous followups (1973, 1984, 1988). Three types of research designs will be used for data analysis, including: (1) traditional longitudinal analysis of 1973 to 1992 data from the original participant sample; (2) cross-sequential analysis of the repeated measures data from 1984 to 1992 for samples one and two; and (3) time-sequential analysis of time-lagged data comparing the 1984 data for sample two with that of the new third sample.

7. Rehabilitation of Visually Impaired Older Persons, The Lighthouse, Inc., 111 East 59th Street, New York, NY 10022

This research and demonstration project will provide an accumulated fund of knowledge about programs and services for older adults with visual impairments.

This knowledge is critical to consumers, families, service providers, and planners as they prepare for the continued increase of this population. A national survey of programs and services will document the current status of service delivery to older people with visual impairments and describe model programs and their development. A low-vision curriculum targeted to generic health and human service providers, to be developed and tested, will offer a systemic assessment of the impact of low-vision training on noneye care professionals, the gatekeepers to service for a majority of older adults. The expertise of State program directors and agency executives in the development of programs funded under the Older Blind Independent Living Program will be tapped along with that of program consumers in a series of focus groups intended to pinpoint effective strategies for program delivery under this appropriation.

8. Rehabilitation Research Fellowship on Aging and Cerebral Palsy, Gary B. Seltzer, PhD, 3501 Blackhawk Drive, Madison, WI 53705

The fellowship will research the following: to follow up a cohort of persons with cerebral palsy, all of whom had bone scans about 4 years ago; to compare the results to normative data on persons of the same age without cerebral palsy; to conduct a survey of persons identified through the United Cerebral Palsy Association that examines relationships among coping strategies, functional abilities, social support systems, and access to health care on this group's psychological well being; to conduct a series of focus groups with older persons who have cerebral palsy; and to continue involvement with small groups of persons who are disseminating material on the topic of aging and cerebral palsy and identifying funding sources for future research.

9. Perceived Direction and Speech Intelligibility in Sensorineural, Hearing Loss and Blindness, Smith-Kettlewell Eye Research Institute, 2232 Webster Street, San Francisco, CA

Experiencing great difficulty processing speech in noise is one of the most characteristic and devastating aspects of the sensory deficit of hearing loss in aging (presbycusis). Conventional binaural hearing aids do not satisfactorily solve this problem. The digital four-channel hearing aid is innovative because of its use of temporal as well as intensity parameters, unlike any other binaural hearing aid on the market. Since sensorineural hearing loss (SNHL) and blindness may interfere with localization of potentially hazardous situations, a second goal of this project is to explore and develop the parameters for improved localization as well as improved speech intelligibility (comprehension) utilizing a new rationale. According to the project's model, a binaural balance of interaural intensity difference (IID) and interaural time delay (ITD) across frequencies is required to restore optimum speech intelligibility and localization ability by eliminating or lessening exaggerated dominance consequent of asymmetric hearing loss. Variations of either or both IID and ITD at different frequencies would impair directional localization and, therefore, intelligibility of one speaker in a group. This new hearing aid may permit people with SNHL and blindness, using acoustic cues, to locate and avoid a hazard. To accomplish this, the project will adjust the physical inputs of intensity and interaural delay time across frequencies to compensate for perceptual imbalances (i.e., deviations from IID and ITD) and to test for the consequent restoration of optimal localization and speech intelligibility inherent in normally balanced auditory systems.

REHABILITATION SERVICES ADMINISTRATION

INDEPENDENT LIVING SERVICES FOR OLDER INDIVIDUALS WHO ARE BLIND PROGRAM

The Rehabilitation Act of 1973, as amended (the Act), authorizes a program to provide independent living services to individuals who are blind (OIB). This specialized program supports projects that provide independent living services to individuals who are age 55 or older and whose severe visual impairment makes competitive living goals are feasible. This program also supports projects that conduct activities that will improve or expand services for these individuals and conduct activities to help improve public understanding of the problems of these individuals.

Any designated State agency is eligible for an award under this program if the designated State agency is authorized to provide rehabilitation services to individuals who are blind. A designated State agency may operate or administer the program or projects under this program either directly or through grants to public or private nonprofit agencies or organizations; or through contracts with individuals, entities, or organizations; or through contracts with individuals, entities, or organizations that are not public or private nonprofit agencies or organizations. A des-

ignated State agency also may enter into assistance contracts, but not procurement contracts, with public or private nonprofit agencies or organizations.

The program currently supports programs in 48 States and expects to fund additional States and outlying areas in fiscal year 1995. The fiscal year 1995 appropriation for this program is $8,952,000. An estimated 12,000 older persons are receiving core services under this program, with over half of these persons being older than age 75 and having a disability in addition to blindness.

The program is designed to be flexible to meet the wide variety of independent living needs of older individuals who are blind that remain after considering the service gaps of State supported and other related programs. Independent living services supported under this program include:

(1) services to help correct blindness, such as—

(A) outreach services;

(B) visual screening;

(C) surgical or therapeutic treatment to prevent, correct, or modify disabling eye conditions; and

(D) hospitalization related to such services;

(2) the provisions of eyeglasses and other visual aids;

(3) the provision of services and equipment to assist an older individual who is blind to become more mobile and more self-sufficient;

(4) mobility training, Braille instruction, and other services and equipment to help an older individual who is blind adjust to blindness;

(5) guide services, reader services, and transportation;

(6) any other appropriate service designed to assist an older individual who is blind in coping with daily living activities, including supportive services or rehabilitation teaching services;

(7) independent living skills training, information and referral services, peer counseling, and individual advocacy training; and

(8) other independent living services including—

(A) (i) information and referral services;

(ii) independent living skills training;

(iii) peer counseling, including cross-disability peer counseling;

(iv) individual and systems advocacy; and

(B) (i) counseling services, including psychological, psychotherapeutic, and related services;

(ii) services related to securing housing or shelter, including services related to community group living, and supportive of the purposes of this Act and of the titles of this Act, and adaptive housing services (including appropriate accommodations to and modifications of any space used to serve, or occupied by, individuals with disabilities);

(iii) rehabilitation technology;

(iv) mobility training;

(v) services and training for individuals with cognitive and sensory disabilities, including life skills training, and interpreter and reader services;

(vi) personal assistance services, including attendant care and the training of personnel providing such services;

(vii) surveys, directories, and other activities to identify appropriate housing, recreation opportunities, and accessible transportation, and other support services;

(viii) consumer information programs on rehabilitation and independent living services available under this Act, especially for minorities and other individuals with disabilities who have traditionally been unserved or underserved by programs under this Act;

(ix) education and training necessary for living in the community and participating in community activities;

(x) supported living;

(xi) transportation, including referral and assistance for such transportation;

(xii) physical rehabilitation;

(xiii) therapeutic treatment;

(xiv) provision of needed prostheses and other appliances and devices;

(xv) individual and group social and recreational services;

(xvi) training to develop skills specifically designed for youths who are individuals with disabilities to promote self-awareness and esteem, develop advocacy and self-empowerment skills, and explore career options;

(xvii) services for children;

(xviii) services under other Federal, State, or local programs designed to provide resources, training, counseling, or other assistance of substantial

benefit in enhancing the independence, productivity, and quality of life of individuals with disabilities;

(xix) appropriate preventive services to decrease the need of individuals assisted under this Act for similar services in the future;

(xx) community awareness programs to enhance the understanding and integration of individuals with disabilities; and

(xxi) any other services that may be necessary to improve the ability of an individual with a significant disability to function, continue functioning, or move toward functioning independently in the family or community or to continue in employment and that are not inconsistent with any other provisions of the Act.

The programs are currently funded by competitive discretionary grants. If the appropriation for this program is equal to or greater than $13 million, funds are awarded to States on a formula basis. An application for a grant under this program may be funded only if it is consistent with the State Plan for Independent Living in each State that is jointly developed by the State Vocational Rehabilitation agency and the Statewide Independent Living Council.

ITEM 5. DEPARTMENT OF ENERGY

INTRODUCTION

During 1994, the Department of Energy (DOE) made significant progress in adapting its culture and operations to reflect its new missions and priorities since the end of the Cold War.

In February, Secretary Hazel R. O'Leary announced sweeping revisions in DOE's contracting system to carry out the Administration's effort to "reinvent government, make government work better and cost less." The reforms are designed to increase competition, reduce waste, eliminate duplication and make contractors more accountable. Contracts previously issued on a cost-reimbursable basis now include incentives for better performance and job creation through technology transfer. And major contracts routinely extended in the past are now being recompeted. In 1994 alone, some $28 billion was competed, and over 5 years that sum will rise to $40 billion.

In April, the department released its first comprehensive Strategic Plan which identified key lines of business, strategies to reach the department's goals, and ways to measure progress. "The end of the Cold War, the globalization of world markets, increasing public demands for environmental quality, and the election of President Clinton have given us a new national agenda," said Secretary O'Leary. "Through a comprehensive strategic planning process, the department must now focus on new goals: fueling a competitive economy, improving the environment through waste management and pollution prevention, reducing the nuclear danger, and sustainable energy development."

The Strategic Plan identifies five business lines that most effectively utilize and integrate the department's unique scientific and technological assets, engineering expertise and facilities: economic productivity; energy resources; science and technology; national security; and environmental quality.

Critical to the success of these business lines is a commitment to improving communication and trust; realigning human resources and changing missions; making improved environment, safety and health a part of every employee's job; and instituting better management practices to enable DOE and its laboratories to operate in more business-like ways. The department also pledged to replace a cultural of secrecy with a culture of openness.

In December, Deputy Secretary Bill White announced the DOE contribution to the Administration's plan to reduce Federal spending: a reduction in outlays of $10.6 billion over a 5-year period. The Deputy Secretary noted that, "These are *real cuts* from existing levels of funding, not simply cuts from projected levels of future funding." He explained that, "The budget cuts we have identified result from eliminating unnecessary middle management and internal regulations; getting more for the dollars of services we buy; and getting out of some businesses that the Federal Government just does not need to be in."

Also in December, Secretary O'Leary announced the next phase in realigning the department to meet the needs of the post-Cold War era: human and capital resources will be matched with the business lines and goals identified in the Strategic Plan. A Structure Team of approximately 40 employees began a comprehensive review of all departmental functions for the purpose of developing recommendations to improve efficiency, eliminate redundancy, and streamline overlapping programs and management. Where DOE's support service contractors are an integral part of

the agency's operations, they are included in this review. The Structure Team is scheduled to report its recommendations for consolidation and cost reduction to the Steering Committee in April 1995.

ENERGY EFFICIENCY PROGRAMS

Weatherization Assistance Program.—The elderly and persons with disabilities receive priority under this program, which provides grants to States for the installation of energy saving building and heating and cooling system improvements in low-income homes. In 1994, the Weatherization Assistance Program awarded $202.9 million of appropriated funds through grants to the 50 States, the District of Columbia, and six Native American tribal organizations. Awards for 1995 are projected at $225.5 million.

The program operates through a network of State grantees and approximately 1,200 local subgrantee agencies. Local service providers are predominantly Community Action Agencies. In addition to DOE appropriations, State and local programs receive funding from the Department of Health and Human Services Low Income Home Energy Assistance Program, from utilities and from States.

As of September 30, 1994 about 4.4 million homes had been weatherized with Federal, State, and utility funds; of these an estimated 1.73 million—or 40 percent—were occupied by elderly persons.

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

Senior citizens are eligible for services provided through the SECP. In addition, many States have developed and implemented projects specifically for the elderly. Examples include senior citizen weatherization projects and related training, hands-on energy conservation workshops, low-interest loan programs, senior energy savings months, and numerous seminars addressing the needs of senior citizens. These projects are often cosponsored with agencies whose primary focus is on senior citizens. In FY 1995, $23.99 million was appropriated for the SECP.

INFORMATION COLLECTION AND DISTRIBUTION

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

The results of these surveys are analyzed and published by the Energy Information Administration. The most recent survey for which all reports have been published is the 1990 RECS. Results of the 1990 RECS are published in three reports: *Housing Characteristics 1990* (published in May 1992); *Household Energy Consumption and Expenditures 1990;* and *Household Energy Consumption and Expenditures 1990 Supplement: Regional Data* (both published in February 1993). The data file for the 1990 RECS is available on diskettes for use with personal computers. The data file contains demographic characteristics of the elderly such as age, employment status, marital status, and family income.

Preliminary data from the 1993 RECS are available. Tables from *Housing Characteristics 1993* are available through an electronic bulletin board (202–586–2557) or in paper copy from the National Energy Information Center (202–586–8800). The report is scheduled for publication in May 1995. Energy consumption and expenditures data will be available in preliminary form in May 1995 and the two-part report will be published in the fall 1995.

Household Energy Consumption and Expenditures 1990 provides estimates of consumption and expenditures for electricity, natural gas, fuel oil, kerosene, and liquefied petroleum gas for elderly households. These data are presented by the age of the householder.

Analysis of the 1990 RECS data shows that consumption patterns differed between the elderly and the nonelderly for some uses of energy. The elderly used

slightly more energy to heat their homes, for example, but used less energy for air conditioning, water heating, and appliances. Expenditures followed the same pattern. Differences in use of energy for refrigerators were very small. Approximately 61 percent of the elderly's total energy consumption and about 38 percent of their total energy expenditures were for space heating.

Household Energy Consumption and Expenditures 1990 Supplement: Regional Data provides energy consumption and expenditure data by four Census regions and nine Census divisions. These data are also presented by the age of the householder. Consumption and expenditure patterns in each of the Census regions mirrored those seen at the national level.

The most recent triennial RTECS was conducted for the calendar year 1991 and the results reported in *Household Vehicles Energy Consumption 1991* (published December 1993). Data presented in this publication are categorized by age of householder for vehicle miles traveled, gallons of motor fuel consumed, and expenditures for motor fuel. These data show that for calendar year 1991, the elderly drove fewer miles and used less motor fuel on a per household basis than the average for all households. For example, households with an elderly householder (and no other adults in the household) drove 7,300 miles and consumed 417 gallons of fuel. Those households with an elderly householder and one or more other adults in the household drove 15,000 miles and consumed 822 gallons of fuel. These averages are below the average for all households which is 18,900 miles and 979 gallons of fuel.

Research Related to Aging

In 1994, the Office of Environment, Safety and Health sponsored research to further an understanding of the human health effects of radiation. As part of this research program, DOE sponsored epidemiological studies concerned with understanding biological changes over time, including those of aging. Lifetime studies of humans constitute a significant part of the research related to aging. The Department also supports research to characterize late-appearing effects induced by chronic exposure to low levels of physical agents and some basic research concerning a few diseases of aging. Summarized below and specific research projects addressing aging in humans that the Department sponsored in 1994.

Because health effects resulting from chronic low-level exposure to energy-related toxic agents may develop over a lifetime they must be distinguished from normal aging processes. To distinguish between induced and spontaneous changes, information is collected from both exposed and nonexposed groups on changes that occur throughout the life span. These data help characterize normal aging processes as well as the toxicity of energy related agents.

As in the past, lifetime studies of humans constitute a significant part of the research related to biological aging sponsored by the Office of Environment, Safety and Health. Research concerned with the aging process has been conducted at several of the Department's contractor facilities. Summarized below are specific research projects addressing aging that the Department sponsored in 1994.

LONG-TERM STUDIES OF HUMAN POPULATIONS

Through the Office of Environment, Safety and Health, DOE supports epidemiological studies of health effects in humans who may have been exposed to chemicals and radiation associated with energy. Information on life span and aging in human populations is obtained as part of these studies. Because long-term studies of human populations are difficult and expensive, they are initiated on a highly selective basis.

The Radiation Effects Research Foundation (RERF), sponsored jointly by the United States and Japan, continued work on a lifetime follow-up of survivors of atomic bombings that occurred in Hiroshima and Nagasaki in 1945. Over 100,000 persons are under observation in this study.

One important feature of this study is the acquisition of valuable quantitative data on dose-response relationships. Studies specifically concerned with age-related changes are also conducted. No evidence of radiation-induced premature aging has been obtained.

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

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

Other epidemiologic or human studies currently involving the department include:

An epidemiologic study of plutonium workers at three Department of Energy facilities. An estimated 14,000 to 20,000 workers will be followed in this retrospective mortality study which is being managed by the Department of Health and Human Services (DHHS).

Another epidemiologic study of some 600,000 contractor employees at Department of Energy facilities is being managed by DHHS to asses health effects produced by long-term exposure to low levels of ionizing radiation.

The U.S. Uranium/Transuranium Registry, which is operated by Washington State University, is collecting occupational data (work, medical, and radiation exposure histories) and information on mortality in worker populations exposed to plutonium or other transuranic elements.

ITEM 6. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADMINISTRATION ON AGING

INTRODUCTION

This report describes the major activities of the Administration on Aging (AoA) in Fiscal Year 1994. Title II of the Older Americans Act of 1965 (the Act; OAA) established the Administration on Aging as the principal Federal agency for carrying out the provisions of the Act. The 1992 Amendments to the Act reaffirmed the responsibilities of AoA, the State Agencies on Aging, and Area Agencies on Aging to assure that provisions for serving older people are established, strengthened, and extended throughout the Nation. Through the Amendments, Congress underscored the concern it had for the most vulnerable elderly and emphasized that particular attention should be given to strengthening community level services for these individuals. The Technical Amendments of 1993 formally elevated the Commissioner on Aging to Assistant Secretary for Aging and served as a catalyst for the creation of the Office of the Assistant Secretary for Aging in the Department of Health and Human Services. The Presidential appointment of Fernando M. Torres-Gil to this post has elevated aging issues both within the Department and at the national level, and reaffirmed the commitment of the Federal Government to address the issues of an aging society.

The Older Americans Act seeks to remove barriers to economic and personal independence for older persons and to assure the availability of appropriate services for those older individuals age 60 and over with particular attention to those in greatest social or economic need. The provisions of the Act are implemented primarily through a national "aging network" consisting of the Administration on Aging at the Federal level, State and Area Agencies on Aging, and community level agencies and organizations. In Fiscal Year 1994, Congress appropriated $871,687,000 to support AoA-administered programs and activities to implement the provisions of the Act. This excludes $177,000 available for the Federal Council on the Aging and $16,563,000 for Federal Program Administration.

This report is divided into 11 sections. Section I discusses the OAA Technical Amendments of 1993. Section II describes the Office of Assistant Secretary for Aging. Section III examines the office of Field Operations. Section IV discusses operations and management of AoA and Section V highlights interagency agreements and priority Initiatives of the Assistant Secretary for Aging. Section VI provides an overview of the provisions of Title III of the Older Americans Act and a summary of the principal activities of the network of State and Area Agencies on Aging in Fiscal Year 1994, particularly as they relate to the provision of supportive in-home and community services, and congregate and home-delivered meals. Section VII describes the vulnerable elder rights protection activities under Title VII of the Act. Section VIII describes the Title VI program of grants to Indian tribal organizations, Native Hawaiians, and Alaskan Natives as well as AoA's efforts in assessing the effectiveness of outreach to older Native Americans. Section IX presents a summary of AoA's Fiscal Year 1994 discretionary activities under Title IV (Research, Demonstrations, and Training). Section X discusses the 1995 White House Conference on Aging (WHCOA), the first such conference since 1981. Section XI describes the Federal Council on the Aging (FCoA) and its activities.

SECTION I—THE OFFICE OF ASSISTANT SECRETARY FOR AGING

Soon after being named Secretary of Health and Human Services, Donna E. Shalala elevated aging issues within the Department by creating an entirely new operating division—the Office of the Assistant Secretary for Aging. One of the major responsibilities of this office is to educate citizens, government departments and

agencies, businesses and community organizations about ways to plan for an aging America. This is critically important because by the year 2030, one out of every five Americans will be 60 or older.

After being nominated by President Clinton and confirmed by the U.S. Senate, Fernando M. Torres-Gil was sworn in as the first Assistant Secretary for Aging in the Department of Health and Human Services (HHS) on May 6, 1993. The Assistant Secretary for Aging serves as the principal advisor to the Secretary of Health and Human Services on matters related to an aging society and functions as the Federal Government's leading advocate for older Americans. In this capacity, he is also responsible for directing the Administration on Aging, which carries out a wide range of responsibilities under the Older Americans Act.

As the first Assistant Secretary for Aging, his primary goals are to serve today's older population while creating a blueprint to meet the needs of future retirees. Torres-Gil stresses that in planning for an aging society, all segments of government and our communities must recognize and plan for the needs of the growing number of older Americans. In this context, the Office of the Assistant Secretary for Aging will have major responsibility for developing aging policy not only within HHS, but also in cooperation with Departments across the Federal Government, including Housing and Urban Development, Labor, Transportation, Justice and Treasury. In so doing, Federal laws, policies, and programs can be better coordinated and improved. A focal point for aging policy will enable the Federal Government to better assist the elderly as well as to help younger Americans to plan, far in advance, for a secure and creative old age.

The Immediate Office of the Assistant Secretary for Aging has responsibility for legislative oversight and Congressional liaison to assist in meeting the mandates of this elevated status. This responsibility includes handling and/or disseminating all Congressional inquiries and requests for information to the proper offices or individuals within the Administration on Aging. In addition, this office produces in final form all Congressional testimony, statements and speeches given by the Assistant Secretary for Aging in Congressional settings, as well as being the liaison between Congressional offices and the Administration on Aging. The Congressional Liaison also works with the Department's Office of Legislation and attends regular weekly meetings.

The Office of the Assistant Secretary for Aging also includes a general publications request hotline for printed materials of information on various subject matters pertaining to the elderly. Requests through the mail are also handled in the Office of the Assistant Secretary. When materials are not available through AoA, information and referral to other appropriate agencies/organizations is provided to assure that individuals have access to requested information in a timely fashion.

Public affairs and press relations are maintained in the Office of the Assistant Secretary for Aging. There is active coordination with the Office of the Assistant Secretary for Public Affairs to enhance this effort. A number of press releases were disseminated in fiscal year 1994 relating to a variety of issues affecting older Americans (see end of this Report for a listing of these releases).

SECTION II—THE OLDER AMERICANS ACT TECHNICAL AMENDMENTS OF 1993

P.L. 103–171, the Older Americans Act Technical Amendments of 1993, was signed by the President on December 2, 1993. These technical amendments, which were introduced in March, 1993, accomplished several things:

(1) extended the deadlines on many Congressionally mandated requirements that appear throughout the Act;

(2) formally changed the name of Commissioner on Aging to Assistant Secretary for Aging; and

(3) changed the date of the mandated White House Conference on Aging from no later than December 31, 1994, to no later than May 31, 1995.

SECTION III—OFFICE OF FIELD OPERATIONS

The AoA Office of Field Operations (OFO) was created in 1991. A Director was selected in April 1993. The primary responsibility of OFO is to provide leadership and technical guidance to the 10 AoA Regional Offices (ROs) as they implement the national programs of the Older Americans Act.

During fiscal year 1994, OFO developed the agency's National Plan for AoA Regional Office visits to State Agencies to assess compliance requirements of Title III of the OAA in the following areas:

Financial Management
Ombudsman

Nutrition
Targeting
Stewardship

Regional Office staff visited 25 States and 1 Territory to assess implementation requirements of Title III of the OAA in the areas of Financial Management, Ombudsman, Targeting and Stewardship. Twenty-five additional States were visited by Regional Office staff to assess implementation of the Nutrition requirements. OFO also provided oversight to Regional Office staff in the monitoring of 75 Title VI Tribal Organizations, and 40 Title IV grantees.

In fiscal year 1994 OFO also developed AoA's first Action Plan to strengthen the Disaster response capacity of AoA and the Aging Network to serve older people. OFO provided oversight and technical guidance to Regional Offices and State staff in the application for and award of disaster funds totaling $14.4 million. The funds were combined Title IV dollars ($377,000) and Supplemental Appropriations ($14,023,000).

In addition, the Assistant Secretary for Aging appointed within AoA a National Disaster Coordinator and 10 Regional Disaster Officers to elevate the importance of Emergency Preparedness during times of disaster to serve older persons. A National Emergency Preparedness on Aging Conference was planned for November 8–9, 1994 to strengthen disaster response capacity of the Aging Network.

SECTION IV—OPERATIONS AND MANAGEMENT

REORGANIZATION

AoA's reorganization was implemented early in September 1994. The reorganization identified AoA as an Operating Division (OPDIV), established two Offices headed by Deputy Assistant Secretaries, under which all programmatic units were grouped, implemented recent revisions to the Older Amerians Act, and made other minor organizational revisions for more logical functional alignment and flow of authority.

The reorganization improved the manager-to-staff ratio and provided a more efficient base for streamlining. This streamlining has begun with the elimination of two deputy managerial positions in headquarters and the proposed elimination of five Deputy Regional Administrator positions in AoA's Regional Offices.

CONTINUOUS IMPROVEMENT PROCESS (CIP)

AoA's reorganization represents one step toward its commitment to reinventing government and continuous improvement efforts. The Continuous Improvement Process (CIP) provided AoA with an opportunity to reinvigorate an agency that had experienced a steady decline in funding levels and staffing resources in recent years. By creating an atmosphere that supports employee empowerment to benefit AoA's customers (i.e. seniors), the staff has developed a vision statement and a strategic plan.

The plan presents such goals as "Providing Leadership for an Aging Society," and "Making the Administration on Aging a Premier Model Government Agency." The vision statement and strategic plan are the foundation through which AoA is pursuing several of the Assistant Secretary for Aging's priority areas including a Blueprint for an Aging Society, home and community-based long-term care, older women, nutrition and malnutrition among older Americans, and crime/violence prevention.

AoA has also worked closely with HHS's CIP efforts, making great strides in reducing internal controls in areas including correspondence and assignment control, information resources management, the Federal Managers' Financial Integrity Act, and grants management.

In addition, AoA has developed customer service standards to document its commitment to a higher level of support to the Aging Network entities in delivering services to older Americans and their families.

AOA'S DIVISION OF MANAGEMENT SERVICES

During FY 1994, AoA continued to integrate the principles of the Federal Managers' Financial Integrity Act (FMFIA) into daily agency operations such as discussions in management meetings and Continuous Improvement Program processes. The Division of Management Services worked to carefully monitor activities, and adapt planned actions in order to proactively address vulnerabilities in management control areas rated as "High Risk."

In the past year, AoA has witnessed the benefits of its proactive approach to addressing weaknesses in management controls. One example of this is success in the

area of Grants Management, a management control area formerly rated "High Risk" and the subject of a material weakness. During this past Fiscal Year, this Division has:

Developed an internal Grants Operations Manual;

Eliminated the awarding of unsolicited proposals and supplements to existing grants in excess of 25 percent outside the competitive process;

Resolved 66 audit reports for FY 1992, 1993, and 1994, and have no unresolved audit reports over 6 months old;

Intensified monitoring of reports in Titles III, VI, and VII, with follow-up by grants specialists, and more readily assigned "high risk" rating to grants as a result of a grantee's failure to report in a timely manner; and

Funded all new FY 94 discretionary grants prior to September 30.

The FMFIA principles are also fundamental elements of AoA's "Rightsizing Initiative," a multi-year effort to institute dramatic changes in the efficiency of operations and in the effectiveness of information management. This new initiative, and the resulting information systems will provide managers and staff at every level in AoA with access to information and linkages to other systems not currently available. Management controls such as security, availability of data, and the like, will be centralized and will help to ensure the most effective use of limited resources.

These activities illustrate significant progress toward improving management controls throughout AoA's programs so that limited resources are maximized. This outcome reflects the guiding principle of the FMFIA program.

In early FY 1994, AoA senior managers reviewed administrative and personnel delegations of authority previously delegated to OPDIVs or STAFFDIVs as mandated by ASMB and ASPER. As a result of that review and subsequent discussions and evaluations of agency operations, AoA has clarified and formalized delegations for 46 authorities. These delegations are consistent with the National Performance' Review's recommendation to maximize the decentralization of the decision making process.

AOA'S INFORMATION RESOURCES MANAGEMENT PROGRAM

AoA's Information Resources Management (IRM) Program supports the Department and AoA's programs, administrative components, and Regional Offices in meeting their responsibilities. The Program also ensures that AoA's IRM goals, policies, plans, strategies, and requirements support the mission of HHS and AoA.

The purpose of the IRM Program is to strengthen the use and management of information resources in AoA. The IRM Program addresses two major enterprises in AoA: the IRM Infrastructure and the Corporate Data Enterprise. The IRM Infrastructure provides a foundation for managing the information resources in AoA. The Corporate Data Enterprise represents all the actions necessary to turn raw data associated with AoA programs (corporate data) into a usable information resource.

The Assistant Secretary for Aging appointed the Director of the Office of Administration and Management to serve as the AoA Principal IRM Official. Certain other responsibilities for IRM in FY 1994 were fulfilled by the AoA Information Resources Management Board (IRMB) representatives. The Board, appointed by the Assistant Secretary for Aging, was comprised of the Deputy Assistant Secretaries, Associate Commissioners and Directors of AoA offices. The Board advised the Principal IRM Official and the Assistant Secretary for Aging on the efficient management and utilization of information resources in AoA. The Principal IRM Official disbanded the IRM Board at the end of FY 1994. However, the development of a newly-configured IRM advisory body, however, will be begun during the first 6 months of FY 1995.

The AoA IRM Program supports the program goals and strategies of the agency in the most cost efficient manner possible. IRM works to provide an expanding range of automation tools designed to improve AoA's staff's capacity to more effectively, efficiently, and economically use AoA's information resources to carry out the agency's program goals.

AoA's Information Resources Management Goals for 1993–99 include:

(1) Designing, establishing and maintaining an IRM Infrastructure that provides the most effective support tools and structure to help agency staff meet their programmatic responsibilities; and

(2) Designing, establishing and maintaining an IRM Corporate Data Enterprise to structure, organize, and standardize the Agency's data and information resources.

An IRM annually revised developed by the IRM staff with input from all offices within the Agency, directs the efforts of the IRM staff in achieving the various strategies under each of the above-stated goals. Each successfully completed project creates or enhances instruments for AOA staff and managers to more effectively

achieve AoA's mission and address the priority areas of the Assistant Secretary for Aging.

As its major strategy to address the two IRM goals, AoA has undertaken its Rightsizing Initiative similar to the systems currently maintaining the Administration for Children and Families (ACF) mainframe computer. The IRM Division has undertaken this approach to take advantage of the more economical and efficient hardware and software currently available and to re-engineer the way we perform our business functions. The initial emphasis for this effort was support for the administrative responsibilities of AoA. Our FY 1994 IRM discretionary funds were entirely devoted to the re-design and implementation of our grants management and financial management systems.

The movement to a new computing platform has offered AoA the opportunity to thoroughly reassess how the basic support functions are performed, organized and automated. Fiscal Year 1994 could be considered the "cusp" for the Rightsizing Initiative. Efforts that were initiated in FY 1992 and implemented in 1993 culminated in the deployment of the first products under the Rightsizing Initiative. In September 1994, the first re-engineered components of the Grants Management System (GMS) were implemented for the Title IV Discretionary Grants Program. The work completed under the Rightsizing Initiative serves as an excellent foundation upon which to build future applications.

TRAINING

In Fiscal Year 1994, more training dollars were spent on managerial/supervisor training than in the past years. As a result of the National Program Review (NPR), managers have been asked to deal more directly with employees on a variety of issues. Two managers within AoA have completed the Federal Executive Institute (FEI) training, two attended Management Development Seminars, six attended the Supervisor in Context Program offered through the Mary Switzer Training Center (two are now certified instructors for this program), and the Assistant Secretary for Aging convened a senior management caucus late in September 1994.

During this past year, AoA also opened its own Training Center equipped with capabilities for independent learning and career assessment. All staff have completed mandatory HIV/AIDS Training, and those who were required to completed the annual (mandatory) Ethics Training have done so. All staff also received Windows Training.

In addition, AoA was one of the first organizations to go on line with Time and Attendance Information Management (TAIMS).

SECTION V—INTERAGENCY AGREEMENTS, SPECIAL PROJECTS AND PRIORITY INITIATIVES

COORDINATION WITH OTHER FEDERAL AGENCIES

In accordance with Title II of the Older Americans Act, the Assistant Secretary for Aging and the Administration on Aging (AoA) functions as the focal point within the Federal Government for aging-related concerns. In that capacity, the Assistant Secretary advises the Secretary of Health and Human Services on matters affecting older Americans and provides consultation and information to entities across the Federal Government on the characteristics, circumstances, and needs of older persons. AoA has a strong commitment to working with other Federal agencies on policy and program development in areas of importance to older Americans. To carry out its national level program and advocacy responsibilities, AoA places major emphasis on developing collaborative relationships with other Federal agencies aimed at coordinating diverse and wide-ranging Federal program resources and linking those resources to the diverse needs of older persons.

Dating back two decades, AoA has worked hard to develop and implement a network of Federal Interagency Agreements to better serve older Americans, combining its resources with those of the Departments of Transportation, Housing and Urban Development, Labor, and Education, the Farmers Home Administration, and the Corporation for National and Community Service (formerly ACTION). Agreements were also made with other agencies within the Department of Health and Human Services, such as the Social Security Administration (SSA), the Health Care Financing Administration (HCFA), the Administration for Children and Families (ACF), and the Public Health Service (PHS) (including the National Institute on Aging).

Interagency collaborations represent a strategic coupling of AoA's resources to serve the Nation's elderly, especially those at risk of losing their independence. Current AoA Federal Interagency Agreements cover a spectrum of program efforts including: in-home and community-based long-term care; board and care homes; and

living (ASPE); aging and disability (NIDRR); housing (HUD); employment (DOL); elder abuse (ACF); and aging research (NIA).

During FY 1994, interagency agreements designed to effectively coordinate research, demonstration, training, and dissemination initiatives were implemented with the following agencies:

National Institute on Aging (NIA).—AoA has an agreement with NIA to support workshops in stimulating research on the aging process and ensuring the use of research information to improve health and social service delivery to the elderly. A workshop focusing on improving the quality of life of minority elderly was held at San Diego State University. This workshop is producing papers on issues in research on minority aging including areas such as long-term care, in-home and community-based care, and attitudes of this population toward health care. A seminar will be conducted for science writers on the demographics of the Nation's aging population and the growing importance of population studies for aging and national health policy. A multidisciplinary work group will be convened to address a number of questions on socioeconomic status, aging and health. Two workshops are planned to outline research data needs on the health status of the Asian elderly and to explore the feasibility of conducting a national survey on aging and health among Asian Americans.

Office of the Assistant Secretary for Planning and Evaluation (ASPE).—Two interagency agreements covering FY 1994 and FY 1995 have been signed with ASPE. The FY 1994 agreement will support a study to determine the capacity and potential of States and localities to manage and deliver home- and community-based long-term care, as well as research and evaluation activities related to board and care homes. A clearinghouse will be established to disseminate information about board and care facilities. ASPE will also support AoA's efforts to develop a blueprint for how the Nation can and should prepare for the retirement of future generations.

The FY 1995 agreement will support a national study of how assisted living facilities are developed and of how they operate. Under the FY 1995 agreement, AoA and ASPE will analyze data from the State Performance Reports on Titles III and VII to determine the effectiveness of new uniform data collection procedures.

National Institute on Disability and Rehabilitation Research (NIDRR).—AoA's agreement with NIDRR supports research which can be applied directly to the development of effective community and in-home long-term care and rehabilitative services. Both AoA and NIDRR are supporting a project at the University of Buffalo on "The Effectiveness of Environmental Interventions and Assistive Technology Devices in Maintaining Independence in Home-Based Elderly Persons."

Employment and Training Administration of the Department of Labor.—This interagency agreement has a number of objectives that include: Encouraging employers to hire, instruct, and retain older workers; promoting research and demonstrations, training; and disseminating information that fosters improved employment opportunities for older persons.

Substance Abuse and Mental Health Services Administration (SAMHSA.—This agreement supports activities to increase the detection of mental illness among the rural elderly and to provide referral for treatment. AoA and SAMHSA have jointly funded project grants that are testing the feasibility of training non-mental health care providers in meeting the needs of older persons suffering from mental health impairments who reside in areas which are underserved by mental health professionals. In addition, funding is being provided by the Community Mental Health Service for the dissemination of technical assistance materials to State mental health and aging agencies to plan future programs to better serve the rural elderly.

Agency for Health Care Policy and Research (AHCPR).—AoA collaborated with AHCPR to support a conference conducted by the Boston Hebrew Rehabilitation Center for the Aged on "Overcoming Barriers to Mental Health Care of Nursing Home Residents."

Administration for Children and Families (ACF).—The agreement with the ACF supports the investigation of the national incidence of elder abuse, neglect and financial exploitation in domestic settings. Advocates for the elderly agree that incidents are substantially under reported and undetected and that reports by states of all types of elder maltreatment represent only the "tip of the iceberg."

AoA is also actively participating on a number of interagency committees and task forces. One example is the Historically Black Colleges and Universities (HBCU) Initiative Steering Committee which is implementing the Executive Order on HBCUs by looking at the special academic and research interests of historically Black institutions of higher education. AoA is a member of the HBCU Steering Committee of the Subcommittee on Capacity Building which is specifically looking at strategies to offer training and employment opportunities to HBCU students and graduates. Another example is AoA's membership of the HHS Cross Cutting Healthy People

2000 Task Force, which is developing and coordinating health promotion objectives of the Department. AoA also actively participates on the Geriatrics and Gerontology Committee of the Department of Veterans Affairs, as well as the National Institute on Aging's Interagency Committee on Research in Aging.

SHARING EXPERIENCES WITH THE INTERNATIONAL COMMUNITY

During 1994, the Assistant Secretary for Aging and the AoA continued to participate in international aging activities which included:

Hosting a number of individual and group delegations visiting from other countries (i.e. Japan, Canada, Russia, Latvia, Israel, Belgium, and Taiwan) interested in aging policies and programs.

Responding to numerous written requests for information from other countries.

Continuing to participate in the United States-Japan Joint Commission on Aging established by the United States and the Japanese Governments. This Commission will address a wide range of long-term care issues of interest to both countries. The first Commission meeting was held in Washington, DC in October 1993. The second meeting is scheduled to be held in Tokyo, Japan in September 1995.

Presenting a 1 day briefing session on U.S. aging programs and policies to an official delegation interested in starting senior centers.

Participating in a briefing session for members of the Moscow Duma.

Assisting HHS in developing its response to the State Department's request for input to the U.S. National Report to the International Conference on Population and Development.

Serving on HHS's follow-up committee to the Cairo International Conference on Population and Development. This committee is considering the Department's involvement and responsibilities with respect to the Programme of Action of the Conference.

Providing comment on the proposed U.N. documentation for the 1995 World Summit for Social Development, "Reshaping the World Summit for Social Development."

Hosting an official from the Japanese Ministry of Health and Welfare through a fellowship of the National Personnel Authority of Japan. This official will spend 5 months with the Administration on Aging, learning about U.S. aging policy and programs.

Providing funding to the First International Expert Group Meeting on Indigenous Elderly People held at the University of New Mexico Center on Aging.

Co-sponsoring the inaugural Conference of the World Organization for Care in the Home and Hospice.

Participating through video remarks by the Assistant Secretary for Aging, in the PanAmerican Day Care Conference held in Miami, Florida.

INTERAGENCY AGREEMENTS WITH THE BUREAU OF THE CENSUS

During Fiscal Year 1992, AoA entered into four multi-year interagency agreements with the Bureau of the Census under which the Bureau will prepare a variety of statistical materials. In Fiscal Year 1993, one of these projects were completed and work continued on the remainder. The projects are briefly described below.

(1) AoA had an interagency agreement with the Bureau of the Census whereby the Bureau produced a special tabulation of 1990 census data, known as the Special Tabulation on Aging. The specifications for this tabulation were designed by a working group on its principal users, the State and area agencies on aging. The entire tabulation consisting of 711 tables of population and housing data for each of approximately 100,000 geographic units of the United States has been completed. One version is stored on computer tape and has been archived with the National Archive of Computerized Data at the University of Michigan. In addition, selected summary data were printed for States and their individual planning and service areas. A technical documentation report has been produced of this summary data.

During the period from July to October 1994, the Bureau delivered to AoA the final major products from this project—a set of 22 CD–ROM disks containing the entire tabulation. Each disk contains 711 tables of data for each geographic unit in one or more States, as well as an electronic version of the printed technical documentation and easy-to-use, but powerful access software. The geographic units include States, counties, minor civil divisions (towns and cities), metropolitan statistical areas, urbanized areas, places with 2,500 or more inhabitants, census tracts, American Indian reservations, planning and service areas, and their components.

The aging network has never before had a statistical resource like the Special Tabulation on Aging and the reaction to this instrument has been quite enthusiastic. Each State agency on aging has received the printed summary tables for its State, the printed technical documentation, and the CD–ROM disk for its State. AoA also disseminated copies of the CD–ROM disks and printed tables to various national aging organizations. The Bureau of the Census has made all of the products from the tabulation available for purchase by the public.

(2) AoA will enhance the use of the Microdata Sample of Older Persons. This computer file contains actual 1990 census questionnaire responses for a 3 percent sample of households containing one or more members 60 years of age or older. The file enables users to tabulate raw census data for individuals (without identifying information) in any way the user desires.

The geographic codes attached to each record of this file will only identify relatively large geographic areas (e.g., region, State, metropolitan area). This project was completed during Fiscal Year 1993.

(3) The Census Bureau will explore alternative techniques for estimating the 60+ population by age group, sex, race, and ethnicity for States and sub-State areas. The project includes an evaluation of estimation techniques, an evaluation of data sets e.g., the various Medicare files) and the development of a pilot program of estimates for selected areas. The Bureau will prepare an outline, with cost estimates, for a full-scale program to develop annual estimates of the elderly population for States and sub-State areas. This project has been completed by early fiscal year 1994.

TRANSPORTATION

AoA has worked with the National Eldercare Institute on Transportation and the Joint DOT/DHHS Coordinating Council on Human Services Transportation to highlight transportation as an important factor in permitting on older persons to continue to live independently and remain involved in their communities.

National Eldercare Institute on Transportation.—The National Eldercare Institute on Transportation is conducted by the Community Transportation Association of America (CTAA) in partnership with the National Association of Area Agencies on Aging, the National Caucus and Center on Black Aged, Inc., the National Council on the Aging, Inc. and the National Association of State Units on Aging. The Institute has provided technical assistance to many State and Area Agencies to enable them to meet the mobility and transportation access needs to older persons. The Institute sponsored a mini-White House Conference on Aging where older persons presented their issues, views, and concerns about transportation and a report was prepared for dissemination. A poster was developed to promote the availability of transportation services in a local community and was received well by the State Agencies on Aging and the Area Agencies on Aging. A series of articles on the five AoA-sponsored transportation demonstrations was prepared and disseminated through the *CTR* magazine. Two national teleconferences were convened with the State Units on Aging to discuss the Americans with Disabilities Act of 1990 (ADA) and the opportunities for public participation in transportation planning. Currently, in development is a transportation primer explaining the demographics of the aging population, the transportation services that exist now, and recommendations to address the anticipated future mobility and transportation needs of an aging population.

Joint DOT/DHHS Coordinating Council on Human Services Transportation.—The Administration on Aging has worked with the Coordinating Council over the past year to improve the availability and quality of transportation options for clients of HHS-funded programs through more effective use of existing resources. Activities included the development of several reports. Ecosometrics, Inc. prepared a report on the Transportation Needs and Problems Among the Elderly. The National Eldercare Institute prepared a report on successful examples of transportation where State Units on Aging and State Departments of Transportation have coordinated their efforts. The Coordinating Council and the National Highway Traffic Safety Administration have signed an Interagency Agreement to look at older driver safety issues. AoA will participate as an advisor to the joint effort. AoA brought tribal sovereignty concerns and Native American transportation issues (on and off the reservation) to the attention of the Coordinating Council. AoA activity participated in the Department of Transportation's Roundtable where States were asked to come in to discuss their transportation issues and concerns.

AOA ACTIVITIES IN HOUSING

AoA has worked with the Institute for Housing and Supportive Services to enhance opportunities for older persons to continue to live independently and be involved in their communities. The Institute has provided technical assistance to

many State and area agencies to meet the needs of older persons seeking alternatives to long-term care.

AoA/HUD Workgroup.—The mission of the AoA/HUD Coordination and Access to Services Housing Work Group is to strengthen access to services in multifamily federal-assisted housing. The Assistant Secretary for Aging, public and private agencies, foundations and housing and community organizations are working together to demonstrate the value of public/private partnerships in helping to address issues of concern to both the aging and disability communities.

In light of diminishing public resources, the Assistant Secretary for Aging has intensified AoA efforts to foster continued relationships with the private sector, and promote partnerships and new approaches to service delivery in housing for the elderly and disabled. AoA activity in this area has generated a favorable response from public and private agencies involved in the management and operation of housing facilities for the elderly.

HOUSING COALITION PARTICIPATION

AoA has become an active participant in meetings of the Elderly Housing Coalition. This activity improves AoA's ability to disseminate information and encourages the enhanced exchange of information related to housing and long-term care issues.

EVALUATION OF THE NUTRITION PROGRAM FOR THE ELDERLY

A contract to perform a Congressionally mandated program evaluation was awarded to Mathematica Policy Research, Inc. (MPR) of Princeton, NJ on September 27, 1993. The 2 year study addresses the following research questions:

1. What are the characteristics of program participants and to what extent does the program reach special populations of the elderly, such as low-income and minority elderly?
2. What is the impact of the program on the dietary intake, health status, and socio-psychological well-being of the elderly?
3. Are the organizational, administrative and service delivery components of the program efficient and cost effective?
4. How much program funding is available, what are its sources, how is it used, and is it adequate?

Design, sampling tasks, and pre-testing of study instruments have been completed. Telephone and in-person surveys to State and Area Agencies on Aging, Indian Tribal Organizations, providers, and participants of congregate and home-delivered nutrition services began in September 1994 and should be completed in December 1994. Preliminary findings will be available in March 1995 and the final report should be released in July 1995.

The data from this study will provide descriptive tabular, cross tabulations, multivariate and descriptive policy analyses used to address the research questions. The results of this study will assist the Administration on Aging in determining how effective the Elderly Nutrition Program has been, where changes need to be made to make the services more efficient, and what policy directions should be considered to better meet the evolving needs of the elderly.

INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES STUDY TO EVALUATE THE STATE LONG-TERM CARE OMBUDSMAN PROGRAMS OF THE OLDER AMERICANS ACT

On September 30, 1993, The Institute of Medicine was awarded a contract to conduct a Congressionally-mandated national effectiveness study of the following aspects of State ombudsman programs:

1. The availability, access, and effectiveness of the ombudsman program for residents of long-term care facilities (including board and care and other similar adult care facilities);
2. The adequacy of Federal and other resources available to operate the programs throughout the United States;
3. State compliance and the barriers to compliance in implementing the program;
4. The presence of any actual and potential conflicts of interest in the administration and operation of the program; and
5. The need for and feasibility of providing ombudsman services to older individuals who are not residing in long-term care facilities, but are users of health and long-term care services.

The increasing responsibilities assigned to the ombudsman program, often without regard to the resources available, has been of particular concern to many people familiar with the program. This study will examine whether those aspects of the

program that possibly contribute to its success in long-term care facilities are transferable to settings, such as private homes, community health clinics, and the like. Most of the field work has been completed and the draft final report should be available in January or February of 1995.

PUBLIC-PRIVATE PARTNERSHIPS

The Administration on Aging held several meetings with the Business and Aging Leadership Roundtable to strengthen the business and government partnership in support of aging issues. The Assistant Secretary for Aging has taken a strong role in coordinating efforts of corporations and business organizations to demonstrate the value of public/private partnerships in helping to address aging-related issues in the workplace, market place, and the community-at-large. As a result of these meetings in FY 1994, the Roundtable was instrumental in identifying and developing a visible role for business in the 1995 White House Conference on Aging. HHS Secretary Donna E. Shalala signed the charger for the establishment of the Business Advisory Council to the White House Conference on Aging. Planning meetings are underway to discuss events and activities for the business community. The Business Advisory Committee to the White House Conference on Aging will advise and recommend to the Secretary ways to plan, conduct and review business issues as they relate to the problems of an aging society. The Roundtable will assist in reviewing a broad range of aging issues and identify and prioritize business aspects of those issues. The Roundtable will also play a role in implementing policy recommendations following the 1995 White House Conference on Aging.

NATIONAL ELDERCARE INSTITUTE ON BUSINESS AND AGING

The National Eldercare Institute on Business and Aging is administered by the Washington Business Group on Health (WBGH) in partnership with the American Society on Aging (ASA). The efforts of the Institute emphasized the initiatives established by the Assistant Secretary for Aging with a particular focus on health care reform, long-term care and preparation for the elderly of tomorrow. The Institute provided ongoing training, technical assistance, and dissemination activities to enhance collaboration between the aging network and the business company. The Institute conducted a Workshop on Managed Care and Medicare Options, a survey of corporate retirement planning programs for baby boomers, a Design for Maturity Technology Conference, a Think Tank of Products, Designs and Technologies for the Mature Market, and a Roundtable on Telecommunications and Aging.

VOLUNTEERISM AND AGING

AoA continued its efforts in the area of volunteerism and aging by providing funding for the third year to the National Eldercare Institute on Employment and Volunteerism. The Institute has worked to increase public awareness of volunteerism issues and opportunities in the care of the elderly and to enhance the potential for the development of new or expanded approaches in volunteerism in both the public and private sectors.

AoA, in conjunction with the National Eldercare Institute on Employment and Volunteerism, the Corporation for National and Community Service, and AARP, sponsored on interactive leadership development program entitled the National Training Institute for Leadership in Senior Volunterrism. The 4 day Training was developed in order to respond to the evolution of senior volunteerism in a variety of organizations and agencies at the federal, state, and local levels, creating an environment required strong leadership and management capabilities. The training was offered at four sites nationwide—Washington, DC, Atlanta, GA, Denver, CO, and Minneapolis, MN.

COLLABORATIVE EFFORTS IN VOLUNTEERISM

AoA has been meeting on a regular basis with representatives from AARP, the Corporation for National and Community Service, the Points of Light Foundation and the National Eldercare Institute on Employment and Volunteerism. The purpose of these meetings has been to explore ways in which these organizations can more closely and collaboratively work at the national, State, and local levels. In their first joint effort, these agencies engaged in a dialogue with local organizations in Richmond, Virginia to discuss strategies for now national organizations can best promote State and local collaboration in senior volunteerism.

COLLABORATIVE EFFORTS WITH THE OFFICE OF PERSONNEL MANAGEMENT (OPM)

AoA continues to work with the OPM in an effort to promote and encourage the development of eldercare programs throughout the U.S. Government. AoA assisted OPM in the planning of a caregivers conference which provided Federal personnel directors and employees information on issues surrounding aging and caregiving. AoA and OPM co-sponsored a lunchtime seminar on caregiving during National Caregivers Week.

PRIORITY AREAS OF THE ASSISTANT SECRETARY FOR AGING

In the spring of 1993, the Assistant Secretary for Aging identified several; priority Initiatives for the Administration to focus its attention upon that would comprehensively address the needs of our older constituents and their families. These include: A Blueprint for An Aging Society, Long-Term Care Agenda, Older Women's Intitiative, Nutrition/Malnutrition Initiative, and Crime Violence Prevention Initiative. During FY 1994 AoA continued in its efforts to implement several goals in these priority areas in order to prepare older persons for a long lifespan. These priority areas served to focus AoA's discretionary and research and funding under Title IV of the OAA as discussed in Section IX of this Report.

AoA's Blueprint for an Aging Society is the overarching theme for each of the Assistant Secretary's priority areas. It is designed to provide a framework for responding to the issues of preparing older persons for a long lifespan which include long-term care, older women, nutrition/malnutrition, and crime/violence prevention. In the spring of 1994, AoA commissioned the National Academy on Aging to examine a comprehensive array of issues that affect the baby boom population and to offer suggestions as to how to address such concerns. The National Academy's report, entitled "Old Age in the 21st Century" underscores the need to comprehensively address the myriad issues that will impact our aging society. AoA has started working on formulating a public education agenda which will focus on personal responsibility in the aging process.

AoA's Home and Community-Based Long-Term Care Agenda is a comprehensive series of plans and activities for the continued development of consumer-driven home and community-based systems of care for persons who need services. It is a multi-year effort and includes plan to work with other agencies and organizations that are interested in promoting home and community-based care. During FY 1994, a number of actions were taken to implement the Agenda:

AoA conducted a Health Care University in January 1994 for several hundred staff of State Units and Area Agencies on Aging. This event provided important information to the aging network about the health care reform proposals of the Administration, as well as the AoA Agenda for home- and community-based long-term care.

AoA strengthened its relationships with other Federal agencies and offices in HHS, including Planning and Evaluation (ASPE) and the Health Care Finance Administration (HCFA). AoA participated in the HHS-Department of Transportation Coordinating Council on elderly transportation issues. In addition, a new relationship with Housing and Urban Development was implemented to enhance the provision of supportive services in federally assisted housing. AoA also participated in a HCFA task force seeking to develop recommendations to improve the long-term care components of Medicare and Medicaid.

AoA signed an interagency agreement with the Office of the Assistant Secretary for Planning and Evaluation to do a national study on assisted living. This study will investigate the role of community-based living arrangements in the long-term care continuum.

AoA funded a new National Long-Term Care Center on Housing and Supportive Services to assist the aging network to develop housing options and supportive services for the frail elderly. The center will provide important support for the development of systems of care for home and community-based services.

AoA funded several projects for the development of models to coordinate home and community-based services for the disabled and the frail elderly.

AoA established a national data base on home and community-based services. Data were collected from all State Units on Aging to create a profile of the major publicly funded Federal and state programs providing home and community-based services. Briefings on the highlights of the data analysis were provided to a variety of interested groups, including the staff of several Congressional committees, Federal agencies and public interest groups. AoA developed a State Source Book which provides data on a State by State basis.

AoA's Older Women's Initiative was formally launched on September 27, 1994, at a "Celebration of Older Women" reception which honored older Americans who rep-

resent the countless contributions that women make to society in areas of public/community service, intergenerational caregiving, and successful aging. A concept paper for the Initiative was fully developed and released to the public.

To heighten sensitivity to older women's issues, AoA also organized a brown bag luncheon in conjunction with the Employee Assistance Program and Office of Personnel Management to highlight National Family Caregivers Week (Week of Thanksgiving). The luncheon highlighted the services offered by the AoA-funded Eldercare Locator which assists caregivers and older persons to access the services necessary to maximize their independence.

AoA's Nutrition/Malnutrition Initiative was launched by the Assistant Secretary for Aging at the American Dietetic Association's annual meeting in October 1994. By July 1995, the Congressionally-mandated Elderly Nutrition Program Evaluation will be completed and the findings publicized.

AoA also began a series of 10 Regional forums to increase awareness of the issues and inter-relationships of adequate nutrition, malnutrition, hunger and food insecurity on health, independence, and quality of life for older individuals. The Assistant Secretary for Aging has met with officials at the Department of Agriculture to explore the development of a joint task force to address common concerns dealing with nutrition, food access, and the elderly.

The Crime/Violence Prevention Initiative was newly-conceptualized in FY 1994. It will focus on prevention efforts. As part of this Initiative, AoA has signed an Interagency agreement with the Administration for Children, Youth and Families to study the incidence of elder abuse. AoA will also continue public awareness activities under Title VII, Vulnerable Elder Rights Protection Activities, of the OAA. During FY 1994, the Assistant Secretary for Aging, along with Attorney General Janet Reno, participated in a House of Representatives Older Americans Caucus symposium on violence against the elderly.

SECTION VI—TITLE III SUPPORTIVE AND NUTRITION SERVICES

For FY 1994, 57 States and territories received a total of $799.992 million of Title III funds to carry out the objectives of the Older Americans Act (OAA) to ensure that older Americans (present and future) have an independent, productive, healthy and secure life. A network of State units on aging, 670 Area Agencies on Aging, 25,000 service providers, and 227 tribal organizations which have been in place for almost three decades, have been faced with the twin challenges of escalating numbers of older persons and decreasing resources to serve them. In response to these challenges, the network continued to build upon the foundation provided by the OAA resources to enhance comprehensive and coordinated systems which are responsive to the needs of the elderly. As advocates, State and Area Agencies on Aging use OAA funds to leverage State and local resources to expand and improve services. These services make a vital difference in the lives of older persons who are attempting to remain self-sufficient and to live in their homes and communities for as long as possible.

The debate over health care reform during this year provided an opportunity for the aging network to join in the national dialogue on home and community based long-term care which is essential to achieving the goals of the OAA. While national health care reform was not achieved home and community-based care, once thought expendable, is now closely identified with health care reform. State and Area Agencies on Aging and service providers will continue to engage in coordinated and comprehensive long term care systems building and strengthening their role in providing home and community-based services.

As a result of the 1992 amendments to the Older Americans Act, the Administration on Aging has been involved in two major efforts which impact on the network: the promulgation of regulations regarding the development and approval of intrastate funding formulas (IFFs), and the development of a new data collection and reporting system.

INTRASTATE FUNDING FORMULA (IFF)

The 1992 amendments to the Older Americans Act (P.L. 102–375) now require States to submit their intrastate funding formulas (IFFs) to the Assistant Secretary for Aging for approval, rather than only for review and comment, as was the case prior to the 1992 amendments. The amendments also require the Assistant Secretary to provide guidance to States in the development of their intrastate funding formulas. AoA has interpreted the amendments to require that this guidance be in addition to the language contained in section 305(a)(2)(C) of the statute which requires State Units on Aging to take into account the geographic distribution, greatest economic and social need of older individuals in the development of their IFFs.

If the Assistant Secretary does not approve the IFF, a new requirement under section 304(c) mandates the Assistant Secretary to withhold the State's allotment of funds.

On March 17, 1994, the Notice of Proposed Rulemaking (NPRM) on the Intrastate Funding Formula was published in the Federal Register. During the 60-day comment period following publication of the NPRM, AoA received over 2,300 comments: Members of Congress (11), national aging organizations (8), State Units on Aging (33), State human services agencies (3), Area Agencies on aging (117), community service provider agencies (66), and individuals (2,114). The greatest number of comments pertained to the proposed definition of "rural" and the IFF regulations. In general, the comments supported the goal of the proposed changes and additions to provide a standard definition for the term "rural area," and to develop standards for the review and approval of intrastate funding formulas. Numerous comments confirmed the need to recognize the diversity of conditions between and within States. Others expressed a variety of interests seeking either greater or less prescriptiveness. Diverse and competing interests were presented by the comments. Representatives of State and local organizations were seeking optimum flexibility to develop a formula based on a consensus of parties within each State. Minority and rural advocates wanted a more prescriptive stance by AoA and inclusion and exclusion of specific factors and weights of AoA's guidance requirements.

The current rules are revised by the final rule in order to comply with the new statutory requirements, as well as to address the intent of Congress that the targeting of services and resources to those older individuals identified as having the greatest economic need, the greatest social need, or is a low-income minority, be accomplished through the intrastate funding formula. In the rule, the Assistant Secretary has developed standards for review and provided directions to State Agencies on Aging on how to evaluate whether their formulas meet those standards. The regulations were designed to provide States with flexibility to either maintain their current formula or, if necessary, to allow for the development of a modified or new formula that addresses the requirements set out by Congress in section 305(a)(2)(C) of the OAA.

NATIONAL AGING PROGRAM INFORMATION SYSTEM (NAPIS)

The Older Americans Act requires annual reports from State Units on Aging on the performance of the services programs for the elderly provided through the aging network. The information is used by AoA to administer the program and to report to the Congress and the public about the program. Over the last 30 years, the aging network has developed and evolved into a diverse network of programs and services which support the goal of the OAA to help older individuals remain independent in their own homes and communities for as long as possible. The "Government Performance and Results Act of 1993" (GPRA) (P.L. 103–62) focuses on the need to improve Federal program effectiveness, particularly using information about program results and service quality to set program goals and measure performance against those goals. Therefore, the need to accurately portray who is served and what types of services are provided is more critical today than it has ever been. The introduction of these new reporting requirements is a significant and important step in bringing about improved data and enhancing the capacities of the aging network at all levels to utilize the data in support of policy development and advocacy including the requirements for the development of the IFF.

The 1992 Reauthorization of the Older Americans Act directed AoA to develop reporting procedures for use by States to correct deficiencies in current reporting practices. In response to this mandate, AoA has developed a revised reporting system known as the National Aging Program Information System (NAPIS). NAPIS will provide for improved reporting guidelines for Title III (Grants for State and Community Programs on Aging) Title VII (Allotments for Vulnerable Elder Rights Protection Activities). It will also include a separate reporting component for the Ombudsman Program to be effective in Fiscal Year 1996.

The improved components of NAPIS will allow AoA to meet a number of new legislative requirements. Some of the new reporting requirements are uniform definitions and nomenclature, standardized data collection procedures, and a participant identification and description system. In addition, the new system will improve reporting accuracy, focus data collection on clients and their characteristics, and make performance data part of a broader information acquisition and analysis strategy within AoA.

AoA sought considerable input from the aging network, including policy and technical review committee meetings in 1992, workgroup sessions, selected State visits, phone conversations and opportunities for the network to provide written comments

to draft copies of the two major components of NAPIS: the Title III State Program Performance Report (SPR) and the State Annual Ombudsman Report. Three major areas of concern were identified in the public comments from State and Area Agencies on Aging, service providers and other aging advocates: (1) timing of the implementation; (2) cost of implementation; and (3) level of reporting detail. In response to these comments, AoA scaled down our initial reporting design and submitted revised requirements to the Office of Management and Budget (OMB) for clearance. This data collection effort is now intended to be phased in over a 3-year period with levels of detail increasing annually.

Several State Agencies on Aging indicated that they already collect many of the data elements which are required, or that they could do so with little effort. AoA is strongly encouraging those States to voluntarily report on all of the data elements, even if the required implementation date is delayed. In addition, many State and Area Agencies on Aging collect data which are not required to be reported. Though the States are not expected to report this information to AoA, some information may be useful to plan and develop responsive service systems for Older Americans.

REAUTHORIZATION OF THE OLDER AMERICANS ACT

It must be recognized that the political context for addressing the present challenges of an aging society is far different from that of the mid 1960's when the Older Americans Act was first enacted. The reauthorization process of the OAA will help to identify needed changes to enable the aging network to face the challenges of an aging society. The possibility of a 1-year delay in the reauthorization would enable AoA to incorporate recommendations and policy proposals from the May 1995 White House Conference on Aging and to receive input from events and studies which are also critical in shaping the direction of the aging network.

Three are many questions which arise to the impending reauthorization. To explore answers to those questions, the Assistant Secretary convened a meeting of representatives from all levels of the aging network to discuss a broad range of issues, particularly the role of the Aging Network in long term care. This dialogue raised as many questions as it answered, but there was a general consensus that the reauthorization of the OAA needed to support and enhance the development of an infrastructure for home and community-based care built by the aging network. Additionally, AoA staff held special workshops at the annual meeting of State Agency on Aging Directors and the annual meeting of the National Association of Area Agencies on Aging to provide an opportunity for broad-based discussion and input into the reauthorization process.

TITLE III SERVICES

All individuals age 60 and over are eligible for services, although the OAA directs that priority be given to serving those with greatest economic and social need, with particular attention to low-income minority older individuals. There are no mandatory fees in this program. Older persons, however, are encouraged to make voluntary contributions to help defray the costs of services. Under current law, these contributions are used to expand services. In addition, volunteer support is an integral component of the service system.

TITLE III–B SUPPORTIVE SERVICES

In FY 1994, the $306.711 million provided through Title III served to support the infrastructure needed to provide home and community based care as well as leveraged resources from other Federal, State, and local entities. Most supportive services fall under three broad categories: access services such as transportation, outreach, information and assistance, and case management; in-home services such as homemaker and home health aides, chore maintenance, and supportive services for families of older individuals who are victims of Alzheimer's disease; and community services such as adult day care, legal assistance, and recreation.

Supportive services are designed to maximize informal support provided by caregivers and to enhance the capacity of the older individual to remain self-sufficient. Program data FY 1993 indicate that information and assistance services were provided to over 3 million older persons and their caregivers. Over 3 million outreach contacts were made to identify older persons who needed to gain access to services. Transportation continued to be one of the most heavily used services. Over 800,000 older persons received over 40 million units of transportation services to their doctor, clinic or senior center. Nineteen percent of all Title III-B participants

were minorities and 39 percent were low-income. (See Table 1 in the *Tables and Charts* Section at the end of this Report.)

TITLE III–C CONGREGATE AND HOME DELIVERED MEALS

Nutrition services are provided under Title III–C of the Older Americans Act (OAA). The title contains two Parts, Congregate Nutrition Services (C–1) and Home-Delivered Nutrition Services (C–2). The services provided under these parts are similar but are targeted to different populations of older people. A State may elect to transfer up to 20 percent of the funds appropriated among Supportive Services and Senior Centers, and the Nutrition Services according to service need.

Although meals are the primary service provided, other nutrition services are rendered including nutrition screening, education, counseling, and outreach. Congregate meals provided under the OAA must comply with the *Dietary Guidelines for Americans* and provide a minimum of 33 percent of the Recommended Dietary Allowances (RDA) if one meal is served; a minimum of 66 percent of the RDA if two meals are served; and 100 percent of the RDA if three meals are served. Service providers are encouraged to expand meal service to more than one meal per day, more than 5 days a week, to persons with increased needs. Where feasible and appropriate, meals are provided to meet the special health, religious, and ethnic requirements of participants.

There is substantial private sector, state, and local community financial and volunteer support for the program. Although there are no fees in this program, older persons are encouraged to contribute through volunteerism and financial support to help defray the cost of services. In FY 1993, program income, including contributions from Congregate Nutrition Program participants, was over $170 million. Under current law, these contributions are used by local programs to expand services. Also, volunteers, many of them older Congregate Nutrition Program participants, perform essential program tasks such as managing nutrition sites, delivery of meals and record keeping.

Many of the participants in this program have one or more disabling condition. The nature of this program has evolved over the years so that the importance of nutrition intervention and nutrition services is more critical then ever as an essential service component integral to ensuring that older people are maintained in their homes and communities. Most recent data for FY 1993 indicates that 126.3 million congregate meals were served to 2.36 million older persons of whom 28 percent were frail and disabled; 47 percent were low-income; 42 percent were rural residents; 18 percent were minority; and 13 percent were low-income minority. Also in FY 1993 102.5 million home-delivered meals were served to 794.5 thousand persons of whom 77 percent were frail and disabled; 58 percent were low-income; 45 percent were rural residents; 19 percent were minority; and 15 percent were low-income minority. (See Chart 1 in the *Tables and Charts* Section at the end of this Report.)

Adequate nutritional status is essential to well-being, health, self-sufficiency, and quality of life for all older persons—from those who are well, healthy, more able older persons to those who are frail, ill, and functionally impaired. The nutrition services program strives to provide a continuum of services to meet these individual needs.

TITLE III–D IN-HOME SERVICES FOR FRAIL ELDERLY

In FY 1994 $7.075 million was provided via Title III to provide in-home services to frail older individuals, including services to older individuals who are victims of alzheimer disease. Services provided under this part include homemaker and home health aides, visiting and telephone reassurance, chore and maintenance services, in-home respite care and adult day care as respite service, minor modification of homes to facilitate continued occupancy by older individuals, and personal care services and other in-home services as defined by the State and area agencies on aging.

The main objective of in-home services to the frail aged is to direct resources specifically at the group of older Americans most at risk of losing their self-sufficiency. In FY 1993 in-home services were provided to over 70,000 persons of whom 19 percent were minority and 87 percent were low income. (See Chart 2 in the *Tables and Charts* Section at the end of this Report for FY 1993 percentage of expenditures in the various general service categories.)

TITLE III–F DISEASE PREVENTION AND HEALTH PROMOTION SERVICES

The 1992 amendments to the Older Americans Act added Part F to Title III entitled "Disease Prevention and Health Promotion Services." In FY 1994 $17,032,000 was allocated to the State Unit on Aging for activities in this area. Title III–F funds are used to leverage other resources to increase public understanding of how

healthy lifestyle choices throughout life reduces the risk of chronic health conditions in later years. (See Chart 3, p. for FY 1993 percentage of expenditures by service category.)

To gather more detailed data on the implementation of Title III-F, a survey of SUAs was undertaken in 1994 by the American Association of Retired Persons' (AARP) National Eldercare Institute of Health Promotion in collaboration with AoA and the National Association of State Units on Aging (NASUA). The highlights of the findings of this study are as follows:

1. Approximately half of the SUAs allocated Title III–F funds according to formula they used for allocation of Title III–B and C funds and the others developed special formula for allocating Title III–F funds but often based on or adapted from their Title III–B and C formulas.
2. Some common issues regarding the allocation of III–F funds were:
   - Permitted uses of funds;
   - Definition and documentation of medically underserved populations;
   - Funding level;
   - Insufficient information and guidance from AoA; and
   - Insufficient time to properly plan for implementation of new program.

SUAs allocated funds to over 20 general types of organizations with public health, education, community-based agencies, hospitals/medical institutions, and senior centers being the most common. Most SUAs indicated that there were formal or informal mechanisms at the local level for coordination or collaboration among agencies receiving III–F funds. Ten types of such local-level mechanisms were identified.

The percentage of SUAs funding each of the OAA prescribed III–F categories of programs and services are as follows: (93%)—routine health screening; (89%)—physical fitness programs; (85%)—health promotion programs on chronic disabling conditions; (76%)—nutritional screening and educational services/educational programs on preventive health services; (75%)—health risk assessments/information on age-related diseases and chronic disabling conditions); (69%)—mental health screening, education and referral; (65%)—home injury control services; (51%)—counseling regarding social services and follow-up health services; (35%)—gerontological counseling. Most SUAs are not funding any other health promotion or disease prevention programs or services.

The percentage of SUAs identifying and maintaining continuing barriers to the availability and accessibility of disease prevention and health promotion for older adults identified were as follows: (33%)—rural/geographic isolation; (29%)—lack of funds; (27%)—lack of transportation; (27%)—insufficient supply of trained staff and/or volunteers; (20%)—program accessibility/lack of programs; (18%)—elders need to take more responsibility; (15%)—lack of providers, especially in rural areas; (13%)—many older adults lack basic [related] knowledge; (13%)—insufficient collaboration and coordination among agencies.

SECTION VII—VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES

BACKGROUND ON TITLE VII

The 1992 Amendments to the Older Americans Act (the Act) brought about a significant development in the Act—Title VII, the Vulnerable Elder Rights Protection Title. In creating Title VII, Congress recognized the critical importance of strong and effective advocacy to protect and enhance essential rights and benefits of vulnerable older people. Congress refocused the Older Americans Act on its original advocacy mission and empowered State Agencies on Aging to "provide firm leadership . . . to assure that the rights of older individuals . . . [are] protected." (S. Rep. No. 102–151, 102nd Cong, 1st Sess, 103 (1991)). Congress also recognized that while the profile of the older population has improved markedly since 1965, there remain many very vulnerable older persons who suffer serious deprivation, are denied basic rights and benefits, and need strong and vigorous advocacy on their behalf. Title VII therefore encourages State Agencies to concentrate advocacy efforts on issues affecting those who are the most socially and economically vulnerable.

Title VII has a dual focus. It brings together and strengthens (in Chapters 2, 3, 4 and 5) four existing advocacy programs—Long-Term Care Ombudsman Program; Programs for the Prevention of Abuse, Neglect and Exploitation; State Elder Rights and Legal Assistance Development Programs; and Insurance/Benefits Outreach, Counseling and Assistance Programs—and calls for their coordination and linkage within each State. In addition, Title VII (in Chapter 1) calls on State Agencies to look beyond individual programs and take a holistic approach to elder rights advocacy, not only by coordinating the four programs, but by fostering collaboration

among programs and with other advocates across each State to address—at a systems level—issues of the highest priority for the most vulnerable elders.

The FY 1994 appropriation for programs under Title VII included funding for the Long-Term Care Ombudsman Program, Programs for Prevention of Elder Abuse, Neglect and Exploitation, and for pension counseling activities under the new Title VII. The appropriation did not include funding for the State Elder Rights and Legal Assistance Development Program or for elder rights activities to assist Native American Organizations under Subtitle B. The amounts allocated to the States were $4,648,000 for elder abuse prevention; $4,370,000 for ombudsman activities; and $2,000,000 for pension counseling.

Combining the State advocacy programs under a single title has fostered increased collaboration among advocates within a State—and between States—to assist individual older people, their families and representatives, while preserving and strengthening the distinct mission and function of each program.

FY 1994 OMBUDSMAN PROGRAM HIGHLIGHTS

The Long-Term Care Ombudsman Program:

Assists residents of long-term care facilities and their family and friends to express themselves regarding the conditions of their life and care; and

Promotes policies and practices needed to improve the quality of life in nursing and board and care homes and similar adult care facilities.

Working through hundreds of grassroots programs, ombudsmen and ombudsman volunteers monitor both private and publicly-subsidized care. They educate consumers and providers about residents' rights and good care practices, such as alternatives to chemical and physical restraints, that limit individual freedom, leading to physical and spiritual deterioration. The date in some States demonstrate that ombudsman presence in a facility can help reduce the level of deficiencies in the facility. The ombudsman's role in preventing neglect and even abuse of residents is one of their most important roles.

A 1994 American Association of Retired Persons survey of ombudsman programs found that, nationwide, 839 paid staff and 6,591 volunteers in the program.

State Ombudsman reports for FY 1994 are not yet available, but reports for FY 1993 provided the following data on the nationwide program:

there are 549 local or regional ombudsman programs;

there were 154,400 thousand people who filed complaints;

there were 197,800 thousand complaints were filed;

seventy-four percent of complaints were resolved; and

the program was funded at a level of $37.4 million (21% of which was State funds).

During FY 1994, AoA provided active leadership and support to State long-term care ombudsman programs. AoA also promoted increased collaboration between the ombudsman and State adult protective services programs. AoA activities included:

Completion and clearance of proposed regulations for implementation of Title VII statutory requirements. (Although the NPRM will not be published in the Federal Register until FY 1995 on November 15, 1994.)

Continued financial support for an independent, comprehensive study of the effectiveness of the Ombudsman Program being conducted by the Institute of Medicine (IOM). (The report on this study will be released in January 1994.)

Completion of a 2-year effort to revise the State ombudsman reporting system that will enable the States and AoA to comply with the reporting requirements in Sections 207(b) and 712(c) and (h) of the Act. The result, the National Ombudsman Reporting System (NORS), was submitted to the Office of Management and Budget for approval for required use by the States beginning in FY 1996. (Thirty-five States had voluntarily converted to the NORS by or before October 1, 1994.)

Award of a 2-year grant to the University of Louisville to develop software for optional use by States to collect and analyze data on complaints made to the ombudsman and other ombudsman activities. Kentucky, New Hampshire, South Carolina, Utah, Florida and North Dakota are participating in the pilot work on the software.

Steps to ensure that States meet the Title VII and ombudsman requirements of the Act, including:

Completion of an instrument for use by the AoA regional offices in their review of States' ombudsman programs carried out under the Act;

Completion of the first AoA Regional Office review of State ombudsman programs using the new instrument (see the Office of Field Operations section of this report);

Issuance of a series of guidance memoranda to the AoA Regional Offices and the States regarding Title VII and ombudsman fiscal requirements and development of standard procedures to ensure State and Area Agency adherence to the minimum ombudsman funding requirements in Section 306(a)(11) and 307(a)21 of the Act; and

Enforcement in several States of the ombudsman conflict-of-interest requirements in the Act.

Establishing dialogue and a basis for coordination between the ombudsman and State Adult Protective Services programs (APS) through:

Holding, in October 1993, a 2-day symposium of ombudsman, APS, and legal experts to discuss the similarities and differences in the functions and roles of ombudsman and APS workers and related legal issues, and to recommend to AoA policies and activities to clarify roles and increase collaboration between these programs;

Issuing a report on the October 1993 symposium to the Directors of State and Area Agencies on Aging, State ombudsman, State legal assistance developers, and directors of State adult protective services programs; and

Arranging for a presentation at the national meeting of State Adult Protective Services Directors on successful collaboration between ombudsman and adult protective services workers at the county level.

Intensive support, technical assistance and training for State ombudsmen through the AoA-funded National Long-Term Care Ombudsman Resource Center. The Center, which is operated by the National Citizens Coalition for Nursing Home Reform (NCCNHR), in collaboration with the National Association of State Units on Aging (NASUA), carried out the following activities in its first full year of operation;

Responded to approximately 480 calls for information and assistance from State and regional ombudsman (These calls were received in addition to the nearly 2,500 telephoned requests to NCCNHR for information on a broad range of institutional care issues in FY 1994; approximately two-thirds of those callers were referred to State and/or regional ombudsman programs for assistance);

Conducted a National Training Conference for State Ombudsman in San Antonio, Texas. The over 100 participants representing 40 States gave the conference excellent evaluations. Program materials were distributed to the ombudsman who were unable to attend, as well as to conference participants;

Provided special training to new State ombudsman prior to the National Training Conference;

Developed a comprehensive orientation curriculum for new ombudsman;

Provided on-going review of newsletters from State and regional ombudsman programs to assess regulatory and legislative activity, as well as best practices in such key areas as fund raising, problem solving, and community involvement projects; incorporated highlights in speeches, training and technical assistance to the States, and in the Center's bi-monthly newsletter to State ombudsmen, InfoBulletin;

Expanded information for ombudsmen on the computer bulletin board used by State units on aging;

Distributed on operations manual to all State ombudsmen;

Researched and produced a paper on methods of providing legal backup for the Ombudsman Program for use by the Institute of Medicine committee studying the effectiveness of the program (A paper based on this research entitled "Legal Counsel for LTCO's: Seven Years Later," was published in the Clearinghouse Review in October 1994.);

Distributed five technical assistance mailings, with contents ranging from program management materials to substantive issues to reference lists;

Expanded the Ombudsman Desk Reference by approximately 150 pages (to include such substantive issues as the Americans With Disabilities Act, spousal impoverishment, the Patient Self-Determination Act, and a history of the Ombudsman Program) and distributed to all State ombudsmen;

Updated the *Ombudsman's Guide to OBRA* and distributed it to all State ombudsmen;

Developed a resource guide for attorneys and distributed it for comment;

Conducted special ombudsman training and or provided on-site consultation in New England, South Carolina, Alabama, Kentucky, Georgia, Indiana, Louisiana, and Missouri;

Delivered presentations, which included information on the Ombudsman Program and its services to residents at least twice a month during the

year, to such organizations as the Association of Medical Directors, the American Society on Aging, the Gerontology Society of America, and many others;

Revised a video tape of the Ombudsman Program and distributed to all States, with the new opening by Dr. Arthur Flemming;

Provided exhibits featuring ombudsman services to residents at six national conferences;

Facilitated exchange of State program promotion and community education materials;

Assisted the American Association of Retired Persons' Legal Counsel for the Elderly with meetings for 10 State and local ombudsmen on recruiting and managing volunteers and developing a manual for ombudsman programs;

Facilitated the teleconferences on both the housing ombudsman program and ombudsman services in home-care situations and distributed reports to all States;

Held a 1-day symposium on neglect and abuse in nursing homes which was attended by over 40 people representing national organizations;

Provided State and local ombudsman contacts through national minority associations to assist in the recruitment of mentor facilities across the country;

Participated in meetings and training events with the Health Care Financing Administration on an average of twice a month, focusing primarily on survey protocols and resident assessment issues;

Surveyed the States, collected and categorized State law and regulation in the areas of ombudsman enabling legislation, residents rights, contracts, memoranda of understanding, volunteer training manuals, promotional materials, and any existing regulations governing other institutional care; matrixed this information and distributed it to all programs, enabling them to examine which States had materials already developed. A matrix specific to each State was also produced and distributed, for use as a checklist of what materials needed to be developed in each State; and

Surveyed the satisfaction level of State ombudsmen with the Center.

FY 1994 PROGRAMS FOR PREVENTION OF ELDER ABUSE, NEGLECT, AND EXPLOITATION HIGHLIGHTS

The goals of the Prevention of Elder Abuse, Neglect, and Exploitation Programs are to:

develop and strengthen activities for the prevention and treatment of elder abuse, neglect, and exploitation;

use a comprehensive approach to identify and assist older individuals who are subject to abuse, neglect, and exploitation; and

coordinate with other State and local programs and services for the protection of vulnerable adults, particularly older individuals.

Since Fiscal Year 1991, the State Elder Abuse Prevention Program has used its funds to strengthen prevention and treatment programs through statewide and local professional and public education initiatives. Following the pasage of the 1992 Older Americans Act Amendments, States increased use of Title III funds to support activities promoting coordination among programs (e.g., multidisplinary teams, interagency working groups, and coalitions).

During FY 1994, AoA has provided leadership for State elder abuse prevention programs. AoA activities have emphasized: (1) increasing professional awareness of the need for coordination among service systems to prevent elder abuse and combat crimes against the elderly; (2) increasing professional awareness outside the aging network of the potential of Older American Act programs to prevent abuse and combat crime against the elderly; and (3) increasing public awareness of the seriousness of the problem of crimes against the elderly. The Assistant Secretary for Aging promoted these ideas by: delivering major addresses at the National Training Conference for Law Enforcement Agencies participating in the TRIAD programs and the Joint Conference on Law and Aging; and giving a statement at the U.S. House of Representatives Older Americans Caucus Symposium on "Crime and Violence Against the Elderly." Two Deputy Assistant Secretaries delivered major addresses at State elder abuse training conferences on the implementation of the new Title VII and coordination of service systems to prevent and treat elder abuse. AoA staff participated in the Family Violence Subgroup of the Department's Violence Working Group which developed a report for submission to the Interagency Working Group. AoA assisted the American Medical Association in the development of its "Diag-

nostic and Treatment Guidelines on Elder Abuse and Neglect." AMA distributed the "Guidelines" nationwide to physicians. AoA continued follow-up work generated by the distribution of the "Guidelines" and AMA's National Conference on Violence, held in March, 1994. AoA has been working with the American Bar Association Commission on Legal Problems to develop recommendations for state courts on the handling of elder abuse cases. AoA worked with the Police Executive Research Forum, the Justice Department, and the American Association of Retired Persons to improve the response of the law enforcement community to the problems of crimes against the elderly and elder abuse.

Programs for prevention of elder abuse, neglect, and exploitation were also supported by awarding Title IV funds to establish the National Center on Elder Abuse (Center). The Center supported State elder abuse prevention programs through providing a national information clearinghouse at the University of Delaware, conducting short term studies, and providing training and technical assistance activities. The Center participated in the National Elder Rights Dissemination Conference, sponsored by AoA and the AoA supported National Dissemination Center. The Center shared information about its activities and products that the Aging network can use in Title VII Elder Rights advocacy and in implementing State and local elder abuse prevention programs. The Center has started the first phase of an elder abuse incidence study, supported jointly by the Administration for Children and Families and AoA. Increased information from this study will enable program administrators to design programs appropriate to meet prevention and treatment needs as part of an elder abuse specific program and an elder rights advocacy strategy. (See Section IX for more information on this grant.)

FY 1994 OUTREACH, COUNSELING, AND ASSISTANCE PROGRAM HIGHLIGHTS

The State Outreach, Counseling, and Assistance Program for Insurance and Public Benefits was funded for the first time during this fiscal year. The States implemented the program in a variety of ways in consonance with the needs found within their States. The States coordinated their activities with related counseling and outreach programs. Different States emphasized areas such as pensions, outreach to those eligible for SSI and Food Stamps, and expansion of health insurance counseling and assistance efforts.

THE ADMINISTRATION ON AGING BI-REGIONAL MEETINGS ON TITLE VII: A CALL TO ELDER RIGHTS ADVOCACY

AoA planned to convene five 2½-day bi-regional meetings between November, 1994 and January, 1995, in order to facilitate the development of an effective elder rights system in each State. Meetings are to be held in Boston, Atlanta, Chicago, Denver, and San Francisco. The goals of the bi-regional meetings are:

To provide to States an overview of the mission and mandates of Title VII;

To foster issues advocacy for systems change within each State;

To organize and plan for elder rights issues advocacy;

To examine the potential of the four Title VII chapters within the context of an overall system of protecting the rights of the vulnerable elderly;

To foster coordination and collaboration among Title VII programs between and among States;

To facilitate the development of State elder rights plans.

The following key players from each State are to participate in the bi-regional meetings: The State Unit on Aging Director, the State Elder Rights Unit Director (from those States that have one), the State Long-Term Care Ombudsman, the Adult Protective Services Director, the Legal Assistance Developer, the Benefits Counselor, the Information & Referral Specialist, a regional member of the National Association of Area Agency on Aging Board, and a regional member of the National Association of Title VI Grantees Board.

The Assistant Secretary for Aging planned to attend several of the meetings along with other AoA Headquarters and Regional staff. The meetings were to be facilitated by faculty members who are experts in each of the Title VII program areas.

On the final day of each bi-regional meeting, AoA will hold open hearings on the Title VII proposed regulations.

SECTION VIII—SERVICES TO OLDER NATIVE AMERICANS

Under Title VI of the Older Americans Act, AoA annually awards grants to provide supportive and nutritional services for older Native Americans. Title VI is divided into two parts, Part A (Indian Program), and Part B (Native Hawaiian Program). The 1992 Amendments to the Older Americans Act provided a directive for

coordination between Title VI and Title III and a "hold harmless" clause for all current Title VI grantees (subject to the availability of appropriations). Of the total amount appropriated to carry out Part A and 10 percent to carry out Part B.

In Fiscal Year 1994, under Title VI, Part A, 227 grantees were awarded funds. The Amendments required that AoA hold harmless all current grantees at their Fiscal Year 1991 level and that AoA increase any grantee who received greater funds in Fiscal Year 1980 to their 1980 level. The funding increase was from $13,599,130 for 1993 to $15,211,800 for 1994. One grant was awarded under Title VI, Part B. The funding increased from $1,511,014 for 1993 to $1,690,200 for 1994.

Congregate and home-delivered meals and a variety of supportive services were provided by Indian Tribes under Title VI, Part A. All grantees provided the required service of information and referral unless other arrangements existed. Other supportive services included transportation, counseling and home assistance services.

The most recent service delivery data available is for FY 1992. Approximately 2,441,392 meals were provided under Title VI, Part A in FY 1992, including 1,173,082 congregate meals, and 1,268,310 home-delivered meals. Approximately 41,294 meals were provided under Title VI, Part B in 1992.

A proposed monitoring policy for Title VI grants were developed in FY 1992. The "Title VI Compliance Monitoring Instructions and Guide" was implemented in FY 1993 and continues to be used successfully. One third of the Title VI grantees were monitored on site by staff from the Regional AoA offices in FY 1994. All Regions continue to receive feedback and ongoing training on monitoring Title VI grantees from the AoA Central Office in Washington, D.C. Technical assistance to the grantee is consistently being offered by the Regional staff and Three feathers Associates, an organization funded to provide training and technical assistance to Title VI program directors. A relationship of trust and assistance is continuing to evolve. Continued monitoring will occur in 1995.

In FY 1993, grantees were asked to include information on Title III/Title VI coordination in their area in the grant applications. In FY 1994, a Title III/Title VI Coordination Task Force was formed. There were representatives from the central office, the regional offices, the State Area Agencies on Aging, the Area Agencies on Aging and Title VI Program Directors. The Task Force has met several times via conference calls and is currently developing a definition for "coordination." The long-term goal of this group is to provide recommendations to the Assistant Secretary for Aging on necessary action to improve service delivery, outreach, coordination to address particular problems faced by older Native Americans.

The National Title VI Directors Association was awarded a grant by AoA in FY 1991 to conduct a public awareness campaign on the needs of "at risk" Native American, Native Alaskan, and Native Hawaiian elders. The purpose of the grant is to educate individuals, agencies, organizations, and businesses on the needs of these at-risk groups, to secure resources to improve the quality of services to these populations. In FY 1992, a video and information packet on the needs of this population was developed. Film presentations have been delivered at the national, regional, and local levels. In FY 1993, the Association included the State Indian Councils on Aging to promote coalition building. This project ended in August 1994. The Association is currently completing their final report of their collaborative efforts. They will continue to develop more effective community networks for Indian Elders.

In Fiscal Year 1994, the Three Feathers Associates was provided a grant for the training and technical assistance of the Title VI program directors. A very successful National Conference was held in Salt Lake City, Utah in June 1994. The conference was attended by a majority of the Title VI program directors. The Association has continued to provide training and technical assistance to the 228 Title VI grantees as needed on site, through teleconferences and cluster meetings. Another National Conference to be held in Washington, D.C. is being planned for 1995.

Also established in FY 1994 were two Native American Resource Centers. The Universities of North Dakota and Colorado were selected for this grant. Meetings with the representatives from the two Resource Centers have been held to discuss their work plans and research agenda. The Resource Centers were developing an approach and methodology to gather valid data to address issues related to community-based long-term care among the Indian community on reservations. The final analysis will help to develop strategies to meet the needs of Indian Elders. Also being explored are ways that the work of the Interagency Task Force on collaboration can be supported through the Resource Centers capacities and mission. Possible ways that resource centers can support the work of Interagency Task Force are also being explored.

ACTIVITIES UNDER TITLE II

In FY 1993, two Roundtables on Native American Elders were held to identify the priority needs of older Native Americans, including those from Federally Recognized Tribes, State Tribes and urban areas. In FY 1994, AoA addressed many of the recommendations from the Roundtables, particularly issues around transportation and other service delivery components. Another Roundtable is scheduled in December 1994. Community Based Long Term Care will be the topic of this forum which will provide another opportunity to dialogue with the network. Proceedings will be available from the three Roundtables to share with the Assistant Secretary for Aging and the aging network at-large.

FEDERAL INTERAGENCY TASK FORCE ON OLDER INDIANS

Section 134 of the 1987 Amendments to the Older Americans Act (OAA) directed the Assistant Secretary for Aging to establish a permanent Interagency Task Force comprised of representatives of Federal departments and agencies with "an interest in older Indians and their welfare." The purpose of the Task Force is to improve services to older Indians. The Director of the Office of American Indian, Alaskan Native and Native Hawaiian Programs is mandated to chair the Task Force. Participation on the Task Force is voluntary for other representatives.

The Task Force is required to report to the Assistant Secretary for Aging semi-annually, including recommendations designed to facilitate coordination among Federally-funded programs and to improve services to older Indians. The Assistant Secretary, in turn, is directed to include these recommendations in the Administration on Aging's Annual Report to Congress as required by section 207 of the Act.

While the Act specifically mandates the Assistant Secretary for Aging to establish an Interagency Task Force on Older Indians, the Task Force also has its genesis in the requirements specified under Section 203 of the Act which requires consultation between the Assistant Secretary for Aging and the heads of "each Federal agency administering any program substantially related to the purposes of this Act."

CURRENT STATUS

As a result of past work by the Task Force and recommendations from Indian constituents, Task Force members decided to focus on three areas of concern to older Indians: health, transportation and data. Three subcommittees were formed to gather and analyze salient information; make recommendations for action to the Task Force that would further interagency collaboration and enhance services to older Indians; and highlight problems, issues and/or barriers that prevent or diminish collaboration. These subcommittees have continued their efforts in FY 1994.

The Health Subcommittee has met with key people from the Department of Veterans Affairs, the Department of Transportation and the Office of Minority Health on three separate occasions. There was an opportunity at this meeting to become familiar with the major initiatives being undertaken by each department or agency, to promote specific collaboration, and/or to focus on the importance of including Indian elders in the planning and implementation of programs. The Health subcommittee has also decided to focus on promoting collaboration and coordination regarding initiatives on elder abuse.

The Transportation Subcommittee in coordination with the Health Subcommittee, is promoting transportation as a significant issue affecting access to health care.

SECTION IX—AOA DISCRETIONARY PROGRAMS

A. Objectives of the Title IV Program

The Discretionary Funds Program, authorized by Title IV of the Act, constitutes the major research, demonstration, training and development effort of the Administration on Aging. The Title IV mandate is aimed at enhancing the field of aging through building knowledge, developing innovative model programs, training personnel for service in the aging arena, and matching these resources to the changing needs of older persons and their families in the coming decades. In particular, AoA's research, demonstrations, training and other discretionary projects are focused on:

Advancing the knowledge and understanding of current program and policy issues (e.g., community and in-home long term care service systems and programs) that is significant to the well-being of the older population;

Improving the effectiveness of the Older Americans Act programs by testing new models, systems, and approaches for enhancing the provision and delivery of services to older persons; and

Providing training, technical assistance, and information that will increase the ability of providers to serve older Americans with skill, care, and compassion.

New Title IV project grant awards are made through a competitive review of applications submitted under an annual AoA Discretionary Funds Program Announcement. For Fiscal Year 1994, the announcement was published in the *Federal Register* on May 13, 1994, and had two major emphases: (1) the major strategic priorities of the Assistant Secretary for Aging; and (2) the specific mandates of the Older Americans Act, which are directed toward the needs of vulnerable older population and certain aging program areas.

The next section on New Program Initiatives in Fiscal year 1994 describes the projects that were initiated in FY 1994 in response to these two program directions. Title IV funds were also used to continue support for activities that began in prior years and were still active in FY 1994. The second section on Continuation Activities in Fiscal Year 1994 describes a wide variety of activities utilizing Title IV funds to further such priorities as home and community-based long term care; transportation demonstration projects; intergenerational bonding; expanded access to services with special attention to the most vulnerable elderly; and dissemination of information to professionals, the elderly, and the lay public.

B. New Program Initiatives in Fiscal Year 1994

1. AoA's major strategic priorities

The Secretary of Health and Human Services charged the Assistant Secretary for Aging with primary responsibility within the Department for several strategic initiatives (priority areas): home and community-based long term care; older women; an aging blueprint for future generations; and nutrition and malnutrition. These initiatives were accorded priority consideration in the funding of new grant awards in FY 1994. Each Initiative is described in Section V of this Report. Below is a brief account of the new projects which scored high enough to be funded under priority area(s) responsive to some of these initiatives. The *Compendium of Active Grants Under Title IV of the Older Americans Act,* which accompanies this Annual Report, provides abstracts of each project.

A. Home and Community-Based Long Term Care Agenda

Through the FY 1994 Discretionary Funds Program (DFP) new grant award competition, AoA provided leadership for the continued development of consumer-driven home and community-based systems of care for older persons and other persons with disabilities. Funded project included:

1. Consumer participation in home and community-based care

AoA awarded five grants for 5-year projects to develop model strategies that will enable States and localities to promote the informed participation of consumers in the planning and development of systems for home and community-based care (HCBC).

Coalition of Wisconsin Aging Groups.—This project will build upon and improve the existing state HCBC system by : (1) increasing consumer participation in community-based care; (2) revitalizing Wisconsin's formal structure for requiring consumer participation; and (3) establishing three model cross-disability coalitions mobilized around expanding HCBC programs.

Mountain States Group.—This project (which will demonstrate a model of consumer involvement that has proven successful in resolving rural health care issues) will create HCBC Councils made up of consumers and others invested in HCBC in each of Idaho's six service regions. The Councils, after being trained in decision making skills, will set priorities and goals for HCBC, analyze obstacles, research strategies, and prepare recommendations.

Virginia Commonwealth University.—This project will initiate and coordinate a grassroots movement in four regions in Virginia to promote the informed participation of older adults and family caregivers in the planning, development, and delivery of home and community based care. Through a partnership of state and local organizations, this project will: (1) educate 300 consumers regarding the complex issues inherent in the HCBC system, (2) construct a framework for alliances between consumer groups and service providers; and (3) develop the capacities of consumers and family caregivers to informally provide competent HCBC to the members of their communities.

Portland State University.—In this project, individuals in all 18 planning and service areas in Oregon will be trained to participate in a process that can provide

on-going and systematic consumer/stakeholder input into decisionmaking around the planning, development, and delivery of the state's community care system. The process, called the "Negotiated Invention Strategy" (NIS), involves a mechanism for input from five major groups who have a stake in the service system: disability advocates, senior advocates, service providers, AAA staff, and staff from the Oregon State Unit on Aging (Senior and Disabled Services Division, SDSD).

Public Interest Center on Long Term Care.—The project will establish 11 Regional Advisory Groups (RAGs) in California which will be the core organizations for project dissemination and consumer input. The RAGs (e.g., long-term care consumers, family caregivers, individuals from senior and disease specific groups, advocates, researchers, and service providers) will bind diverse long term care interests into a cohesive movement to develop the Long Term Care Vision for California document, the project's shared plan and organizing tool.

2. AGING AND DISABILITY: MODELS FOR COORDINATED SERVICE SYSTEMS

Four grants for 3-year projects were awarded to encourage closer collaboration among the aging, disability and rehabilitation communities through models for coordinating the delivery of services to the final elderly and the disabled.

Massachusetts Executive Office of Elder Affairs.—The goal of this project is to coordinate the aging, disability and rehabilitation networks to provide better long-term care services to their target populations. This will be accomplished by developing a model strategy and an action oriented *Blueprint for Autonomy.* The *Blueprint* will be designed for the use of State and local policy makers, the media, national, State and local aging and disability networks.

Kentucky Department for the Blind.—The goal of this project is to demonstrate a model for the expansion and enhancement of services to aged blind persons. This will be accomplished by developing and pilot testing a model for collaboration of services between the networks serving the aging and blind of Kentucky. The project will be conducted jointly by the State Department for the Blind and the State Division of Aging Services.

George Washington University.—The goal of the project is to improve the delivery of services to aging individuals who have mental and physical disabilities. This will be accomplished by establishing a system of continuous information dissemination about existing networks of successful community based partnerships among mental health and aging professionals and supporting agencies. The target population includes older adults with dementia or other late onset mental disorders and older adults with a history of long term mental illness, such as schizophrenia.

The American Society on Aging.—The goal of this project is to create changes in the existing system for delivering assistive technology and home accessibility services that will result in more effective strategies for independent life styles. This project will demonstrate new models, and increase national awareness of existing models proven effective in coordinating aging and disability systems.

3. NATIONAL POLICY AND RESOURCE CENTER FOR HOUSING AND LONG TERM CARE

AoA made a three-year cooperative agreement award to the Andrus Gerontology Center, University of Southern California, to establish and carry out the activities of a policy and resource Center which will act as a focal point for the development of home- and community-based long-term care services specializing in elderly housing and supportive services. The Center will support the development of community-based systems of services for older persons, and assist AoA to develop successful strategies and approaches for coordinating program efforts with HUD programs. In addition, the Center will conduct research, provide training and technical assistance to the Aging Network, disseminate housing information, and provide policy analysis oriented toward results and outcomes that have practical applications to those working on housing and long-term care issues.

4. ELDERCARE LOCATOR

The Eldercare Locator is designed to help direct both local and long-distance caregivers to the appropriate source of information about services for older persons in every locality in the United States. Begun in 1991, the Eldercare Locator along with the National Aging Information and Referral (I&R) Support Center are part of an Administration on Aging initiative to improve access to and quality of I&R assistance that older people and their caregivers receive.

In FY 1994, the Assistant Secretary for Aging made a 3-year cooperative agreement award to continue the Eldercare Locator and the National Aging I&R Support Center. Under the cooperative agreement, the National Association of Area Agencies on Aging will work in conjunction with the National Association of State Units on

Aging to strengthen and expand the Locator Service, increase public awareness and understanding of the Locator, and enhance the access of older people and their caregivers to community-based long term care services. In addition, the National Aging I&R Support Center will provide training and technical assistance to State and local I&R programs so that the latter can better serve as links between Locator callers and local services.

The Administration on Aging also conducted two other grant competitions under the home and community-based long term care initiative, one for a project to conduct a *Capacity Building and Mentoring Program in Home and Community Based Care,* the second for two to three projects to test models of *Employment of Public Assistance Recipients in Home Care.* Awards under these competitions will be made in early 1995.

B. Older Women's Initiative

1. PROTECTING OLDER WOMEN AGAINST DOMESTIC VIOLENCE

Under this priority area, AoA funded five projects for two years. The purpose of these projects is to link organizations at State and local levels that work to combat domestic violence together with aging agencies. The collaborating agencies will demonstrate effective model projects aimed at protecting older women against domestic violence.

The key elements of these domestic violence prevention projects include: (1) safe housing, advocacy, and support of women, (2) criminal justice system action, (3) effective civil protection, (4) counseling/education groups for the men who batter, (5) systems cooperation, and (6) coordination, participation by, and accountability to battered women. The five funded projects are listed below.

Wisconsin Coalition Against Domestic Violence.—This project will develop a statewide program to improve services and support for older battered women by building upon an existing system of advocacy, technical assistance, policy development and education in the area of domestic violence. The program will include a training and education program, cross-training for domestic violence, and elder abuse practitioners, advocacy, technical assistance, policy and legislative development, housing and support services, a statewide public awareness campaign, and self-defense training for older battered woman.

Vermont Network Against Domestic and Sexual Assault.—This project will develop a statewide response to domestic violence against older women by linking the 14 domestic violence programs and the 14 Adult Protective Service (APS) teams in Vermont. The project will develop a statewide model protocol for serving older battered women, specialized safehomes to provide shelter for older battered women, and a training curriculum for domestic violence advocates, APS teams, and health care professionals.

Mount Zion Institute on Aging.—This project will build upon the Mt. Zion Institute on Aging's Consortium for Elder Abuse Prevention to establish linkages between San Francisco area elder abuse and domestic violence networks aimed at creating a more integrated approach to serving elderly battered women. Program objectives are: improve services for elderly victims of domestic violence; enrich community understanding of domestic violence; adapt such services as shelters, support groups, and crisis counseling to the specific needs of older women; and develop a training curriculum and community outreach/public awareness materials and events.

Massachusetts Health Research Institute.—The Massachusetts Health Research Institute, the State Department of Public Health, the State Executive Office of Elder Affairs, and the Massachusetts Association of Older Americans will collaborate on this project to build a statewide system of services to educate and ensure shelter, counseling, and other care for older battered women. The project will develop a resource guide of materials and services for older battered women in Massachusetts, cross-training for service providers, an media campaign, a peer outreach worker component, evaluation and national dissemination of results.

Women's Center.—This project will involve coordination between the Women's Center and the local Area Agency on Aging to improve services to older battered women in rural Bloomsburg, Pennsylvania. The project will develop a safe home system and conduct support groups, provide legal advocacy and representation, conduct public education and outreach, and provide training to professionals within the local community service systems.

The Administration on Aging also conducted another grant competition under the Older Women Initiative's to establish a *National Policy and Resource Center on Older Women.* The award under this competition will be made in early 1995.

C. Nutrition and Malnutrition Initiative

(1) In support of the nutrition and malnutrition initiative, the Assistant Secretary for Aging is investing approximately $2.8 million dollars in an evaluation of the National Nutrition Program for the Elderly funded under Title III of the Older Americans Act. A contract to perform the evaluation has been awarded to Mathematica Policy Research, Inc., of Princeton, N.J.

(2) The Administration on Aging also conducted a grant competition under the Nutrition and Malnutrition Initiative to establish a *National Resource and Policy Center on Nutrition and Aging.* The award under this competition will be made in 1995.

D. Blueprint for an Aging Society

1. NATIONAL ACADEMY ON AGING

In September 1994, the Assistant Secretary for Aging awarded to The Gerontological Society of America the future development and operation of a National Academy on Aging. National Academy on Aging serves as a national forum for policy analysis and debate on the major issues of our current and future aging society.

The goals of The Gerontological Society of America in carrying out the functions of the Academy are to encourage greater national leadership on the attention to aging issues through (1) the clarification of critical issues in the field of aging, (2) the thoughtful analysis and informed discussion of those issues in public forums, and (3) the reporting of those policy analyses and debates to key decisionmakers. A major outcome of Academy events and activities will be an analytical and educational framework for better informing leaders, policy officials, and the public about the need to plan comprehensively for the growing and diversifying numbers of older Americans in the 21st century.

E. Other Older Americans Act Mandates

Other areas of emphasis in AoA's new FY 1994 awards derive from certain specific mandates of the Older Americans Act, which concentrate discretionary funding resources on making specific aging programs more effective in serving vulnerable population groups. the priority program area (in addition to long-term care, nutrition, older women, and a future aging society) include gerontology education and training, housing, multigenerational and intergenerational programs, volunteerism, and minority aging.

1. GERONTOLOGY EDUCATION AND TRAINING

a. Gerontological Training & Education Programs in Institutions of Higher Education with High Minority Student Enrollment—Gerontology Program Improvement Grants

The purpose of these project awards is to improve and strengthen established education and training programs at institutions of higher education with high minority student enrollment. The ultimate goal is to help gerontological education and training resources keep pace with the needs of the growing minority aging populations.

The Assistant Secretary for Aging has made six awards for 2 year projects under this priority area:

Grambling State University (LA): The project goal is to increase the pool of adequately trained African-American professionals and paraprofessionals sensitive to and knowledgeable of the specific needs of African-American elderly. The project will develop a multidisciplinary, multi-institution gerontology program in cooperation with the aging network in Louisiana (and surrounding States).

University of the District of Columbia: The grantee, an Historically Black College/University (HBCU), will improve, strengthen, and expand undergraduate and graduate gerontological education and training across academic disciplines. Expected improvements include: increased number and better coordination of departments/disciplines with concentration in gerontology; expanded and enhanced university-wide curricula with gerontological content; homemaker/home health aid certification program expanded to include Spanish and Chinese-speaking trainees; and improved services for at-risk minority elderly.

Howard University (DC): This project will establish a consortium of six HBCUs in partnership with six AAAs to increase the capacity of the Aging Network to meet the needs of low-income minority older persons. Expected outcomes include: a model replicable strategy for linking HBCUs with AAAs; a model curriculum; 120 trained, credentialed minority students; faculty development for faculty coordinators at six HBCUs; and an expanded service system for at-risk elderly.

University of Hawaii at Manoa: This project will improve and better coordinate gerontological education at the University of Hawaii at Manoa, with a special emphasis on Asian/Pacific Islander (A/PI) elderly. A few objectives of the project are: new courses, such as the physiology of aging (at the School of Nursing), geriatric nutrition (at the School of Public Health), and working with A/PI elders (at the School of Social Work); a Geriatric Nurse Practitioner Program; a Native Hawaiian Elder Focus Clinical Program (at the School of Law); and wider availability of courses via television.

Association for Gerontology and Human Development in HBCUs (AGHD/HBCUs), (DC): The grantee, in collaboration with the Association for Gerontology in Higher Education (AGHE), will implement a national gerontology education improvement program among 10 selected minority and non-minority institutions in rural and urban areas. The project goal is to greatly enhance academic programs, faculty development, and curricula in gerontology/geriatrics, with a focus on community-based support systems.

Roybal Institute for Applied Gerontology at California State University, Los Angeles, CA: The purpose of this project is to augment the gerontological training of Hispanics and to enhance the provision of health and human services to Hispanic older adults. The grantee, in partnership with Hispanic students and faculty, community agencies, and key academicians at local colleges and universities, will address the acute need for more Hispanic service providers with formal education and training in applied gerontology.

b. Gerontological Training and Education Programs in Institutions of Higher Education with High Minority Student Enrollment (Program Development Grants)

The purpose of these four awards is to *develop* gerontological training and education programs in academic institutions with substantial enrollments of students from one or more of the four racial and ethnic minority populations. Each of the 2-year projects funded by AoA will focus on establishing gerontological programs through which students will graduate with an educational emphasis, specialty, certificate or degree in gerontology/aging.

University of New Mexico: The University of New Mexico Center on Aging will create an ethnically focused gerontological education program which offers certificates in Indian Aging. Some of the objectives of the project include: (1) developing a multidisciplinary program which targets graduate, undergraduate and non-degree students; (2) creating multiple options for certifications with an emphasis on Indian aging; and (3) develop a resource center on Indian Aging.

Charles R. Drew University of Medicine and Science (CA): The Charles Drew University of Medicine and Science, with Martin Luther King, Jr. Hospital as its teaching hospital, and in cooperation with the University of California, Los Angeles, will develop a gerontological training and education program focused on improving the quality of gerontologic and geriatric practice in Central, South East and South Central Los Angeles. The project will create a network of trainers and specialists on ethnogeriatrics.

Tuskegee University (AL): Tuskegee University will establish a Multidisciplinary Training Program in Gerontology with a special focus on minority rural elderly. The goal of this new Tuskegee University program is to increase the number of minorities trained in gerontology and specifically trained to address the needs of rural minority elderly.

Central State University (OH): Central State University will develop a structured program in gerontology that is designed to increase the number of African Americans who are trained in gerontology. The program of training will lead to a minor in gerontology consisting of 30 quarter hours of courses including a practicum.

c. Faculty and Curriculum Program Development in Gerontology

The Administration on Aging continued to support grants to institutions of higher education for gerontological training and development projects in FY 1994. These institutions of higher learning are in a position to greatly benefit the elderly now and in the future. They have at their disposal information, know-how, manpower and other resources, that, when applied to the problems facing the elderly, could greatly retard the loss of independence in the at-risk older population.

Highly-trained faculty members are needed to help students understand the aging process, gain sensitivity about the needs and values of older persons, and most importantly, to discover ways for our society to meet the challenges of an aging society. Five new projects were funded in FY 1994, for 2 years each, that focused on key areas including faculty development in gerontology, community immersion, replication of successful curricula in institutions where gerontology has not been exten-

sively taught, development of gerontological faculty, and development of programs in minority institutions. These projects included:

San Diego State University Foundation (CA): This project will utilize the Total Immersion method to enable 12 faculty to study various minority populations in depth. Aided by community elders, the participants will visit churches, clinics, and senior centers. They will spend a minimum of two periods of 24-consecutive hours each with the older adults in their primary living environment. They will develop curricula materials to improve the content of the courses they are scheduled to teach.

Bowman Gray School of Medicine, Wake Forest University (NC): The focus of this project is to extend the expertise of Wake Forest University in conducting faculty in-service training in gerontology to Winston-Salem State University, an HBCU, and Forsyth Technical Community College, a community college that places emphasis on the training of allied health professionals. Twenty faculty will be selected from the two institutions for participation in a 1 year in-service training program that will teach basic principles and concepts of gerontology. The participants will then be taught methods for integrating gerontology principles and concepts into their curricula.

AIA/ASCA Council (DC): This project will develop comprehensive guidance for architectural faculty on how to teach design for aging in a studio setting. The design studio is at the core of the architectural curriculum and constitutes a major vehicle for reaching and influencing the 35,000 students and faculty in North American schools of architecture with respect to eldercare issues and their impacts on facilities. No such comprehensive guidance currently exist, and the completed module will be the first resource of its kind available to architecture schools.

Hunter College of CUNY: Ten faculty members from two colleges of the City University of NY system will participate in a geriatric education program and then develop curriculum on aging for implementation at their colleges. Faculty with geriatric experience will assist as mentors and an advisory board will be formed consisting of faculty and representatives of the aging network services to forge links between the two systems for purposes of student placements and future career opportunities.

University of Washington: This project proposes embedding geriatric content into (rather than appending it as one course) to an entry-level Occupational Therapy (OT) program. Results will be an increase in the quality and quantity of Occupational Therapists trained to work with older adults in rehabilitation, long-term care, home health, and wellness programs with a focus on the special needs of low-income and minority elderly.

d. Gerontology Instructional Programs for Career Development in Two-Year Academic Institutions

The Older Americans Act authorizes the development of comprehensive and coordinated non-degree education, training programs, and curricula at institutions of higher education, including long-term educational activities to prepare personnel for career in the field of aging. A recent survey of 2,000 academic institutions found more than 600 graduate level programs on more than 40 campuses, but less than 60 programs at an equal number of 2-year institutions. This represents nearly a zero rate of growth in training programs at 2-year schools during a period of time when consumer demand for in-home, community, and institutional services for frail elderly has increased dramatically.

In order to stimulate interest in gerontology training in 2-year colleges or institutions which provide more than 25 percent of the trained paraprofessional and professional workforce in the United States, AoA solicited proposals for the establishment or strengthening of certificate program models which would comply with quality standards and guidelines established by the Associations for Gerontology in Higher Education. The Assistant Secretary for Aging has made five new awards for 2-year projects based on this competition:

Community College of Denver: The Division of Health and Human Services of the Community College of Denver will develop the first community college gerontology certificate program in the State with a special focus on recruitment of American Indian, Asian, Hispanic and African American students living in the metropolitan area of Denver. The certificate program will feature service learning, a form of cooperative work education, to fulfill the practicum experience called for in national standards for two-year gerontology programs.

Valencia Community College (FL): The Department of Health and Human Services of Valencia Community College will build upon its Kellogg Foundation gerontological nursing curriculum model by integrating gerontology into the college's eight allied health programs. A replicable training model will be developed through train-

ing partnership activities in community-based settings, faculty development, and revision of allied health curriculum and instructional strategies.

Saddleback Community College (CA): The Division of Health Sciences and Human Services of Saddleback Community College will expand its existing gerontology certificate program to significantly increase the number of job-ready graduates available to work in community and in-home service settings. A new community advisory board will help expand the nursing and psychology technician programs, increase linkages to employers in the region, and advise on student learning outcomes that affect on-the-job performance. The number of courses will be increased to make the program consistent with Association for Gerontology in Higher Education standards and guidelines.

Miami-Dade Community College (FL): The Division of Business/Technology of Miami-Dade Community College, in coordination with Florida International University, will develop a 30-credit hour certificate program to expand opportunities for gerontology education to low-income, ethnic minorities. The certificate program will be developed in accordance with the standards and guidelines of the Association for Gerontology in Higher Education, with articulation to Associate Degree programs at all campuses of the college and 4-year programs in the Miami area, with guidance from a gerontology coordinating council and community advisory committee.

Lehigh Carbon Community College (PA): A new certificate program in gerontology will be developed at Lehigh Carbon Community College by social science, nursing biology, allied health and gerontology faculty in accordance with Association for Gerontology in Higher Education standards and guidelines. A minimum of 20 students will be recruited and enrolled in evening courses for three semesters during the grant. The program is expected to attract both new students and paraprofessionals and professionals already employed in aging service related jobs.

e. Employment Training of Older Adults in Two-Year Academic Institutions

The Older Americans Act authorizes the Assistant Secretary for Aging to award grants that provide education and training to older individuals designed to enable them to lead more productive lives by broadening their education, occupation, cultural or social awareness. In response to their geographic location, governance and funding, most 2-year academic institutions provide both vocational and academic instruction and community education services, making them a unique resource for older adult education and training.

The Assistant Secretary for Aging made five awards for 2-year projects to encourage these institutions to develop and improve model employment training programs for low-income older workers whose needs are not adequately addressed by other training and employment programs, with special emphasis on: (1) programs that support recruitment, counseling, and employment placement of older students receiving instruction in age-integrated classrooms; and (2) programs that work with employers to retrain and employ workers who have recently lost their jobs due to corporate downsizing, plant shutdowns or facility relocation.

Grand Rapids Community College (MI): Grand Rapids Community College will draw upon its past experience as a training subcontractor with the Senior Employment and Senior Community Service Employment Programs to develop its own older worker training program with a major focus on displaced homemakers and older workers losing employment through industry downsizing and relocation. Sixty to ninety participants each year will be given counseling and training on job search, application and interview techniques. Thirty to forty adults, age 50 and over, will be recruited for job training courses using the colleges occupational training facilities at the main campus and at its new Applied Technology Center in neighboring Bid Rapids.

Hawaii Community College, University of Hawaii: The Older Hawaiian Human Services Certification Demonstration Program will develop and implement training for low-income older native Hawaiians and assist them in finding employment in human service programs. The curriculum will include existing age-integrated classes modified for program participants and a new core course and practicum. The project adapts a model training program for training kupuna (knowledgeable Hawaiian elders) as substance abuse counselors developed by ALU LIKE, Inc., a major service provider for Native Hawaiian elders.

Westchester Community College (NY): The Mature Work Options project of Westchester Community College's Mainstream Program—the Retirement Institute, will expand training opportunities for low income, minority, and high risk unemployed older adults through the creation of curricula to be developed in collaboration with local industry and faculty. Forty-five persons, age 50 and over, will be trained in instructional programs targeted to unemployed older workers including individuals displaced by the impending relocation of a major automobile assembly plant in the

county served by the college. Two new curricula will be developed in advanced computer-based office skills and computer-assisted drawing (CAD) applications.

Lane Community College (OR): The Division of Training and Development will develop and implement a model job training program at the Lane Community College main campus in Eugene and at the Florence Center on the coast of Oregon. Older low-income, minority, rural adults, age 50 and higher will be offered information, training and support for re-entry into employment or to enhance employment skills for greater advancement. The program will feature career and life planning, individualized action plans and case management, peer support, age-integrated classes, computer training, and job search training and assistance.

Northern Virginia Community College: The Community Education and Services Departments at the Alexandria and Woodbridge campuses of Northern Virginia Community College, will develop a unified training program for certified Personal Care Aides, Homemaker-Home Health Aide, and Nurse Aides. Outreach and recruitment for this training program will collaborate with local Title V Older Americans Act and Job Training Partnership Act senior employment and training programs. An emphasis will be placed on reaching out to low-income adults aged 50 and over whose primary language is not English, and older workers who have recently lost their jobs due to corporation downsizing, plant shutdowns, or facility relocation.

f. Research and Technology: Innovation in Gerontological Education and Training

The three projects funded for 17 months under this priority, as described below, have two principal objectives: (1) to develop and demonstrate new uses of instructional technology in gerontological education and training; and (2) to convert research findings and state-of-the-art materials more effectively and more expeditiously into gerontology course curricula and classroom teaching for students preparing for careers in the field of aging.

American Society on Aging (CA): Under this project, the American Society on Aging will develop a state-of-the-art training program on late-life depression and suicide, using multimedia and computer technology, and incorporating research and practice focused on culturally diverse elders. Target audiences are primary care physicians and nurses, hospital discharge planners/case managers, social workers, home care and adult day care workers, "gatekeepers" such as utility company personnel, and family caregivers.

Oregon Health Sciences University: This project will link the Oregon Geriatric Education Center in the School of Medicine to four community colleges in rural areas of the state using teleconferencing technology to deliver continuing education to practicing health professionals regarding health promotion and aging topics.

University of Montana: The University of Montana's Center for Continuing Education will work with the School of Pharmacy and Allied Health Science, the Rural Institute on Disabilities, and the Gerontology Education Committee to develop and evaluate core courses delivered through distance education technology for a certificate program designed to meet the needs of persons working with the elderly throughout the State.

2. HOUSING PROGRAMS FOR THE ELDERLY

a. Supportive Services in Federally Assisted Housing Demonstrations Projects

The purpose of the projects funded under this priority area is to develop and test model supportive service programs to frail residents in federally assisted housing projects. These projects involve the network of State and Area Agencies on Aging in the development and operation of these model supportive services programs, working in collaboration with local housing agencies. The Assistant Secretary for Aging made five awards for 2-year projects.

Multnomah County Department of Human Services (OR): This project, a collaboration between Multnomah and Clackamas County social services, builds on a current model elderly housing program which works directly with residents to identify needs and broker services. Three new components will be initiated: (1) special outreach to link minority residents to community services; (2) recruitment of teams of senior resident I&R volunteers in two rural communities; and (3) targeting a wide array of in-home services to frail residents by an intensive services team.

Chicago Department on Aging: This project, a joint effort between the Chicago Department on Aging and United Charities, will demonstrate a collaborative method of providing case management and supportive services to 350 low-income minority elderly in HUD 202 or Section 8 housing. Four different elderly housing developers will work together to share resources and to examine different techniques of case management delivery.

New Jersey Department of Community Affairs: This project will develop, implement, evaluate, and make policy recommendations based upon an assisted living, supportive services demonstration project in two subsidized senior housing developments. The project will develop effective outreach, education, and training techniques to encourage participation of low-income tenants.

New York City Department for the Aging: This project, a collaboration of the NYC Department for the Aging, the NYC Housing Authority and the Henry Street Settlement, will provide coordinated, community-based services to frail, low-income minority elderly at Vladeck Houses, a public housing authority site. The project will provide data on—the most effective methods to reach and serve frail, minority populations, the degree to which informal volunteer support can lessen isolation and augment services; and the identification of services and supports which may be significant in assisting frail elderly to age-in-place.

Alliance for Aging, Miami, FL: This project will develop a model for correcting deficiencies in the present level of support services to frail older individuals currently facing premature institutionalization with the expectation that they can be appropriately maintained in their current housing units. The project hopes to develop policy and practical cost-saving implications of its model. The project will target elderly individuals affected by Hurricane Andrew.

b. Housing Ombudsman Demonstration Projects

The purpose of the 2-year projects funded under this priority area is to demonstrate the effectiveness of the housing ombudsman approach in protecting the rights, safety and welfare of older people living in publicly-assisted housing and in resolving issues related to their care and services. These five demonstration projects involve the network of State and Area Agencies on Aging, as well as other nonprofit entities in developing and operating model programs in collaboration with local housing agencies. The findings, results, and products of these projects are expected to significantly advance our capacity to develop and implement comprehensive systems of housing ombudsman programs.

Connecticut Department of Social Services: Building on the Connecticut Department of Social Services' current ombudsman program, this project will show that the housing ombudsman approach is an optimal model of service coordination. The project will educate residents, enhance service accessibility through coordination, foster group activism, establish dialogue between residents and management, and facilitate conflict resolution through a Site-Based Resolution Council.

City of Portland (OR): This project, conducted by the Portland/Multnomah Commission on Aging, will develop, implement and evaluate a training program for the housing ombudsman to serve low-income seniors residing in and applying for subsidized housing in Multnomah County, OR. Using the Oregon Long-Term Car Ombudsman program as a model, the project will produce standards and training for the certification of volunteer housing ombudsman.

Volunteer Center of Greater Riverside (CA): The project will develop and manage a Senior Ombudsman Service (S.O.S.) project in Riverside County. This service will provide information and referral, advocacy, complaint resolution, and assistance for low-income seniors residing in or seeking publicly-assisted housing. In addition to recruiting and training volunteers, the project will also hire a bilingual S.O.S. Project Coordinator to compile up-to-date information about the complex public housing system and form a development team of key community leaders and seniors to analyze needs and corresponding services.

National Caucus and Center on the Black Aged, Inc. (NCBA) (DC): This project will train Title V older workers to act as Housing Ombudsman Aides. NCBA's community-building approach emphasizes the development of relationships between housing and social service providers, the provision of training and technical assistance to housing managers, service providers, and resident councils, and the expansion of linkages to local volunteer networks.

Southwestern Illinois Area Agency on Aging: This project will be administered by a "coalition" which includes an Area Agency on Aging, a local senior service provider, a mid-size and diverse public housing authority, and a State University. The focus is on helping frail and aging seniors living in or wanting to live in federally assisted housing to maintain an independent living arrangement longer by improving the quality and suitability of their housing situation through advocacy, intervention in problems and complaints, counseling and/or referral assistance, and effective coordination of services.

c. Foreclosure and Eviction Assistance and Relief Services Demonstration Program

The projects funded under this priority area are aimed at demonstrating effective and timely strategies/approaches for formulating or implementing laws, regulations and programs that:

(1) Prevent or delay the foreclosure on housing owned and occupied by older persons or the eviction of older individuals from housing the individuals rent;

(2) Assist older individuals to obtain alternative housing as a result of such foreclosure or eviction;

(3) Assist older individuals to understand the rights and obligations of individuals (including lessor and lessee) under laws relating to housing ownership and occupancy; and

(4) Address the effects of land use/zoning restrictions, as well as escalating property values and the resulting property tax increases, on the housing options of older persons.

The Assistant Secretary for Aging made six awards for 2-year projects as listed below:

New Hampshire Legal Assistance: This statewide project, a collaboration between the New Hampshire Legal Assistance and the New Hampshire Department of Elderly and Adult Services, will demonstrate a program to prevent foreclosures, property tax sales and evictions of the elderly. The project will enhance linkages with the aging and federally assisted housing networks to advance housing options and create new networks with bankers and tax assessors through training on property tax relief.

Legal Assistance for Seniors (CA): This citywide project will demonstrate a strategy to address the problem of foreclosures on homes of the elderly as a result of fraud, abuse, and exploitation. The project will study neighborhoods where lenders foreclose on elderly homeowners as a result of "scams" and develop a profile of "at risk" neighborhoods for use in other communities. The project will: develop a *pro bono* attorney panel, develop and produce community education materials about deceptive home remodeling practices; train the aging network in techniques for identification of "at-risk" neighborhoods; and mobilize the community to develop an action agenda of legal and regulatory reforms.

Housing Counseling Services, Inc. (DC): This citywide project, a collaboration of Housing Counseling Services, Inc., and the Legal Counsel for the Elderly, will demonstrate a program to prevent or delay evictions and foreclosures against elderly individuals. Expected outcomes will include efforts to pass legislation in the District of Columbia to protect elders against foreclosures and redress abuses by unscrupulous lenders; curriculum for training of homeowners and tenants concerning their rights; legal services and housing counseling for elderly tenants and homeowners facing foreclosure and eviction.

The Salvation Army (CA): This countywide project is a joint effort of the Salvation Army Senior Meals & Activities Program and the San Francisco Sheriff's Department. The project will demonstrate a model of bilingual services on the days preceding evictions by the Sheriff's Department. Expected outcomes include an information campaign to increase awareness of elderly tenants and homeowners on how to avoid the problems of foreclosure and eviction, and a training "how to" manual for use by other agencies in replicating the program.

North Carolina Housing Finance Agency: This statewide project will identify information, actions, and resources needed by older consumers to avoid or delay eviction and foreclosure. The project will develop training models for housing managers, developers, and providers of legal and supportive services, and the State's 18 Area Agencies on Aging in order to increase their knowledge of older adults' housing rights and their capacities to advocate, inform, and assist older persons.

National Consumer Law Center (MA): This statewide project is a collaboration of four organizations: (1) the National Consumers Law Center, the Homeowners Options for Massachusetts; (2) the Ecumenical Social Action Committee; and (3) the Greater Boston Legal Services. It is designed to demonstrate a model of coordination of services to recognize and respond to foreclosure threats to elderly homeowners. The project will design training on how to avoid foreclosure for Area Agencies on Aging, elderly homeowners, housing advocates, social service providers, attorneys, and lenders.

3. MINORITY AGING

a. Minority Management Training Program Projects

Minority Management Training Programs are special training projects that increase the number of qualified minority individuals in key management and/or administrative positions in the Aging Network. The four racial and ethnic minority

populations targeted are African-Americans, Hispanics, Native Americans and Pacific Islanders/Asians.

The program goal is to increase the professional credentials and experiences of project trainees by helping them to make the transition from staff level positions to managerial and/or administrative positions. Five awards for 2-year projects were funded under this priority area as described below:

National Caucus & Center on Black Aged, Inc. (DC): The project objectives are: (1) to secure the participation of seven long-term care facilities willing and able to train African American professionals as interns in all phrases of nursing home operations; (2) to prepare the interns to pass state and national nursing home administrator licensure examinations; (3) to obtain employment for the newly licensed nursing home administrators; and (4) to expand the very small network of minority administrators nationwide.

Association Nacional Pro Personas Mayores (The National Association for Hispanic Elderly, (CA): The project objectives are: (1) to select and place eight Hispanic graduates or professionals in paid, 6-month, administrative and managerial traineeships in public and private aging-related agencies; (2) to place four interns each year of the 2-year traineeship; (3) to give administrative and management training to the interns and guide host agencies in providing the on-site training; (4) to place interns in permanent positions; and (5) to strengthen cooperative links between the Aging Network and the program sponsor in designing appropriate services for the elderly and for professional Hispanics.

Area Agency on Aging, Region One, Inc. (AZ): The project will increase the professional credentials of Native American trainees by: helping them to make the transition from staff-level to managerial and administrative positions; and enhancing their work experience, knowledge base and career opportunities. The traineeship for two groups of four trainees provides 6 months of structured, culturally-sensitive opportunities for innovative, hands-on, educationally meaningful experiences in aging services management and administration. Trainees are based with the sponsoring agency, and will intern at training agency sites including: the Inter-Tribal Council of Arizona; Maricopa County Department of Social Services; Maricopa Association of Governments; the Governor's Advisory Council on Aging; and public and nonprofit providers in the statewide aging services network.

Louisiana Association of Councils on Aging: The project will increase the number of qualified minority gerontologists in key management and/or administrative positions in the aging network agencies in Louisiana, which have an impact on older persons, especially minority elderly who are at risk of losing their independence. Five minority persons with specified qualifications are selected for a 12-month training session. The trainees receive two intensive seminars and on-the-job instruction at host agencies. Host agencies will be selected from Parish Councils on Aging or Area Agencies on Aging that are members of the Association.

University of Southern California, School of Public Administration: The project will enable 10 minority individuals to move from staff, professional, or paraprofessional occupations into management positions or management career tracks in the field of aging. The School of Public Administration and the Leonard Davis School of Gerontology at the University of Southern California (USC) will collaborate with host agencies in the public and private sectors to: (1) identify minority individuals with commitments to the field of aging; (2) enroll these individuals in a training program combining on-the-job experience with intensive classroom work to develop strong management capabilities; and (3) help place these trainees in management positions or tracks in the Host Agencies or elsewhere.

b. Responding to the Needs of the Minority Elderly Through National Minority Aging Organizations

The initiatives of the Assistant Secretary on Aging (i.e., *(1) Home and Community-Based Long Term Care, (2) Special Concerns of Older Women, (3) Nutrition and Malnutrition Among the Elderly, and (4) Developing a Blueprint for Future Aging)* have special relevance to low income minority older persons. This priority area is intended to support the efforts of national minority aging organizations in representing the interests of minority aging in long-term care, older women issues, nutrition and malnutrition, and the future aging society.

Each of these 2 year projects is expected to develop culturally specific models for coordinating the delivery of services to minority older persons and their families. These models should produce strategies for more responsive, cost-effective programs that will assist the minority aged, their families and communities to maintain life styles of maximum independence through access to comprehensive community based services, enhanced personal autonomy and greater opportunities for consumer choice.

The National Indian Council on Aging (NICOA) (NM): The goal of this project is to positively impact public policy and increase public awareness to affect improvement in strategies for the provision of home- and community-based long-term care to the minority elderly, especially Indian elders.

National Caucus & Center on the Black Aged, Inc. (DC): The project goal is to improve the response of health and social support systems to older residents of public housing experiencing problems related to alcohol and drug abuse. This will be accomplished by developing a model strategy to identify problems and provide assistance through the delivery of home and community-based services.

Asociacion Nacional Pro Personas Mayores (CA): The goal of this project is to make the formal Aging Network accessible to the Hispanic elderly and their families and to broaden the base of agencies and groups involved in providing aging services to the Hispanic elderly. The project will demonstrate a model of home and community-based long-term care for the Hispanic elderly by developing linkages between the formal and informal long term care systems.

National Hispanic Council on Aging (DC): The goal of this project is to increase the positive life chances of older Latinos by reducing the factors that lead to economic disadvantage. This will be accomplished by educating Latino older women about advocacy strategies designed to positively impact their economic security. Project activities include a series of educational and informational materials; conducting training to provide empowerment skills; and establishing linkages and collaborative relationships with national organizations, coalitions and networks focused on issues related to income security.

National Asian Pacific Center on Aging (WA): The project goal is to improve the quality of life for Asian and Pacific Island elders. This will be accomplished by strengthening the national network of Asian Pacific elderly community based service systems. Project objectives include: implementation of two pilot projects focused on long-term care; documentation of best practices; development a culturally-sensitive training manual; publication of a bimonthly newsletter; synthesis of findings and development of objectives based on recommendations from the 1995 Mini-White House Conference on Aging entitled, *Respect for the Elderly: An Asian Pacific Legacy.*

4. INTERGENERATIONAL PROGRAMS AND VOLUNTEERISM

a. National Volunteer Senior Aides/Family Friends Demonstration Projects

In Fiscal Year 1991, AoA implemented Section 10404 of the 1989 Omnibus Budget Reconciliation Act which authorized a community-based, intergenerational demonstration program. The purpose of the program is to determine to what extent basic medical assistance and support, provided by volunteer senior aides, can reduce the costs of care for disabled or chronically-ill children. The prototype program upon which the authorizing provisions were based is "Family Friends," an intergenerational program established in 1986 by the National Council on the Aging, Inc. (NCOA), with funding support provided by the Robert Wood Johnson Foundation.

To implement the Volunteer Senior Aides Program (VSA), in FY 1991 AoA awarded demonstration grants to six Area Agencies on Aging to collaborate with local organizations, over a 3-year period in their respective communities to: (1) determine the impact of the older volunteers' services on the costs of care for disabled/chronically ill children; (2) promote the self-sufficiency of individuals and families vulnerable to a loss of independence; and (3) increase the volunteer senior aides' feelings of self-worth. Increased collaboration is expected among private, voluntary, and public sector organizations in establishing and operating programs from which children, families, and older persons gain mutual support and benefits.

Last fiscal year, AoA awarded continuation grants to all six projects to continue these demonstrations for a third and final year. AoA also provided support to NCOA to provide technical assistance and training to these VSA grantees, based upon their "Family Friends" expertise. In addition, a summary evaluation of outcomes has been designed and is being conducted by one of the grantees, the Mid-America Regional Council Commission on Aging (Kansas City, MO). This summary evaluation should be completed in the Spring of 1995. These six demonstration projects were being carried out by the following agencies:

The Los Angeles County AAA (Los Angeles, CA), in collaboration with Jewish Family Services of Los Angeles and Huntington Memorial Hospital of Pasadena;

The CrossRoads of Iowa Area AAA (Des Moines, IA), in collaboration with the Easter Seals Society of Iowa;

The Mid-America Regional Council AAA (Kansas City, MO), in collaboration with the Children's Mercy Hospital in Kansas City and the University of Missouri's University Affiliated Program for Developmental Disabilities;

The Region IV AAA (St. Joseph, MO), in collaboration with the local Foster Grandparents Program;

The Philadelphia Corporation for Aging (Philadelphia, PA), in cooperation with Temple University's Center for Intergenerational Learning and the Institute on Disabilities; and

The County of Riverside Office on Aging (Riverside, CA), in cooperation with V.I.P. Tots of Temecula, California.

Because of the continuing need for and the proven success of the VSA program model, during FY 1994, AoA awarded funds for six new VSA demonstration projects to public or nonprofit community-based organizations in communities which previously had not had VSA projects. The six new demonstration projects are;

Action for Community Development (Boston, MA) in partnership with Boston Children's Hospital and the Medical Foundation.

Clara Barton Hospital Foundation (Hoisington, KS) in partnership with the retired senior Volunteer Program (RSVP).

Easter Seal Society for the Redwood Coast, Inc. (Eureka, CA) in cooperation with RSVP to operate the Northern California Family Friends Project.

Eastern Seal Society of Utah, Inc. (Salt Lake City, UT) in partnership with the Intermountain Health Care Pediatric Respite Program, State Aging and Adult Services and three Area Agencies on Aging to serve rural Utah counties.

Elwyn, Inc. (Elwyn, PA) in collaboration with the Center for Intergenerational Learning at Temple University to serve Delaware County.

Generations Together, University of Pittsburgh (Pittsburgh, PA) in collaboration with the Diabetes Center at Children's Hospital of Pittsburgh and the Allegheny County Department of Aging to serve children with insulin dependent diabetes and their families.

The National Council on Aging (NCOA) has received a grant to provide training, technical assistance, research and summary evaluation efforts for the six new VSA demonstration projects. NCOA will disseminate information on the VSA program to the 32 projects operating nationwide and to other interested communities.

b. Volunteer Service Credits Demonstrations

The purpose of the five projects funded under this priority area is to test new models and replicate existing models of the volunteer service credits concept. The basic service credit concept is to give volunteers a unit of credit for each service hour performed, regardless of the type of service, in the expectation that accrued credits will be redeemed for services by the volunteers at some future time of need. Grantees are expected to test the feasibility of implementing service credit projects in new areas and to replicate existing models in new sites. These five demonstration projects, funded for 17 months each, involve two Area Agencies on Aging and several nonprofit organizations.

Foundation on Aging, (KS): The grantee will establish a volunteer service credit bank in Kansas, in conjunction with several participating agencies across the State. The project will improve the effectiveness of and access to home and community based long-term care services by targeting frail, minority, and rural elderly. The cooperative efforts of the coalition will: provide short-term respite for caregivers; assist frail older persons to maintain their independence and prevent premature institutionalization; and train and utilize an estimated 100 to 200 older and younger volunteers to provide respite services. Also, an *innovative* Kansas/Missouri *interstate model* program will be established through a cooperative agreement with the Missouri Volunteer Service Credit Bank. As a result, volunteers will be able to accumulate credit hours in one State and donate them to residents of the adjoining State.

Area IV Agency on Aging and Community Services, Inc. (IN): This project has two main objectives: (1) to enable rural elderly and others who are at-risk to avoid becoming homeless or prematurely institutionalized by providing them with needed non-medical, non-professional services through the use of volunteers; and (2) to allow the volunteers to earn service credits for the time they spend helping others so that they, in turn, can "buy" services when they need them.

Senior Citizens of Greater Minneapolis, Inc: This project will establish a cooperative venture among senior volunteer organizations to test new ways to care for frail, elderly people. Grantee will test the feasibility of: (1) incorporating volunteers from a variety of organizations into a single Time Bank; and (2) establishing a volunteer package that will be attractive to elders of color.

County of Bucks Area Agency on Aging (PA): This project will implement a senior service project in low income and minority housing units to provide in-home support

services to at-risk persons age 60 and over to avoid premature and inappropriate institutionalization. Approaches include: working collaboratively with low-income apartment complexes to establish the sites for the project; and working cooperatively in the Area Agency on Aging with Aging Care Managers, VISTA Volunteers, and Retired Senior Volunteer Program.

Time Dollar Network (DC): This project will: (1) develop a replicable, church-based program utilizing service credits as the currency to generate services that meet the economic and social needs of minority, low-income elderly; and (2) enable seniors to gain entitlement advocacy in exchange for volunteer service they perform.

5. LEGAL SERVICES FOR THE ELDERLY

1. Statewide Legal Hotlines for Older Americans

Statewide Legal Hotlines utilize paid, specially-trained, and experienced attorneys to provide: (1) answers to legal questions; (2) brief assistance (such as letters or phone calls to third parties, and document review); and (3) referrals to older persons needing legal advice at no charge. Referrals are made, as appropriate, by the Statewide Legal Hotline to legal service providers or to lawyers working either *pro bono* or at reduced fees.

AoA made three awards under this priority area for 3-year projects.

Legal Services of Northern California: This project will establish and operate a Statewide Legal Hotline to serve thirty-nine (39) counties in Northern California. Through targeted outreach and cooperation with other service providers the project will serve low-income minority seniors and those seniors in greater economic and social need. The project will be able to serve non-English speaking older people through the use of both multilingual staff and expert translators.

Puerto Rico Legal Services, Inc: This project will establish and operate an Island-wide Legal Hotline to serve Puerto Rico. The project will bring legal services directly to the at-risk elderly, maximizing the delivery of service to the great number of older people who reside in isolated geographic areas.

American Association for Retired Persons: Legal Counsel for the Elderly (DC): The project will use a variety of approaches to helping the new and previously-funded AoA hotlines to develop strong and continuing projects. A high priority will be placed on developing future funding to insure that Statewide Legal Hotlines become self-supporting.

6. DISSEMINATION AND UTILIZATION PROJECTS

Title IV of the Older Americans Act calls upon AoA to support a broad range of research, demonstration, and training projects to improve the well being of older persons. In order for these efforts to be effective, it is critical that the information developed by Title IV projects be disseminated as widely as possible. In recent years, there has been considerable interest in this issue by those in the field of aging as well as members of Congress. In response to this interest, AoA has increased its efforts to insure that up-to-date information is widely available to those addressing the issues of an aging society.

a. The National Aging Dissemination Center

Grant and contract activities supported by the Older Americans Act Title IV Discretionary Funds Program have produced a wide range of usable findings and products. In order to appropriately utilize program results, AoA established the National Aging Dissemination Center at the National Association of State Units on Aging in Washington, D.C. The Center, through a cooperative agreement with AoA, promotes more effective dissemination of findings and products to a larger number of potential users.

The Center engages in a number of activities designed to promote the dissemination of Title IV project findings and products. These activities include: (1) Developing a database that contains information on Title IV program projects and approaches to retrieving this information upon request; (2) selecting the most promising projects and providing assistance in disseminating their results to Eldercare coalitions, aging network agencies, national aging organizations, and others; (3) providing technical assistance to Title IV grantees to help them expand their dissemination activities; (4) publishing a yearly compendium of Title IV program products; (5) conducting, jointly with AoA, a National Dissemination Forum and a mini-forum to bring the results of Title IV projects to the attention of practitioners; and (6) developing a range of general dissemination channels which can be used by Title IV grantees.

b. The National Aging Information Center

The Administration on Aging is supporting the development of a National Aging Information Center (NAIC) in order to increase its ability to serve as an information resource on aging issues to a broad, national audience. The NAIC is being established in response to Section 202(e)(1)(A) of the 1992 Amendments to the Older Americans Act, and will provide information about a wide range of topics concerning the Nation's older citizens. The NAIC will meet the needs of the aging field through easy access to a variety of information that will support their efforts in planning, program development, and implementation, as well as data collection analysis.

The NAIC will be established through a contract and preparatory work including the development of a Statement of Work the receipt of all necessary clearances, and the issuance of a Request For Proposals on August 17, 1994 in the Commerce Business Daily. The solicitation deadline will be October 25, 1994 and a pre-proposal conference was held with prospective offerors on September 13, 1994. The purpose of this conference was to provide information concerning the Government's requirements which could facilitate the preparation of proposals, as well as to answer any questions which prospective offerors may have had regarding the solicitation. The conference was well attended and there appeared to be a great deal of interest in this solicitation. An award is expected in 1995.

c. AoA Dissemination Projects

Substantial resources are invested each year in Title IV research, demonstration, and training projects to improve the availability and quality of services vital to the at-risk elderly. To maximize the utility of this program to older Americans, AoA funded 14 Dissemination Projects in FY 1993. The goal of these projects is to significantly expand, beyond that of the original projects, the dissemination and utilization of existing Title IV products and results. Some of the projects enhanced dissemination of previously developed products that were exceptionally useful and for which there was a continuing demand or need. Other projects were continuations of numerous products/results of earlier Title IV project "clusters" (groups of projects sharing a common theme). The 1993 AoA Dissemination Projects are briefly outlined below.

Four of the Dissemination Projects focus on health or health care. The American Medical Association (AMA) is replicating a clinical education model in several States to train physicians in the practical implementation of the AMA's Title IV-supported "Guidelines for the Medical Management of the Home Care Patient." The Harvard University Medical School is using enhanced dissemination of culturally/linguistically adapted products from the Massachusetts Elderly Injury Prevention Project to prevent injuries and medication misuse among ethnic minority elderly. Florida A & M University will expand dissemination of products from their Diabetic Retinopathy Education Program to a National audience, including a range of health professionals to educate high risk ethnic elderly. The National Hispanic Council on Aging will expand the use of a training-of-trainers product from an earlier project and include elderly Promotores de Salud in a strategy for empowerment to improve the health and well being of vulnerable Hispanic elderly.

Elder rights are the concern of three of the Dissemination Projects. The National Committee for the Prevention of Elder Abuse is synthesizing results of relevant Title IV projects/research to produce six Elder Abuse Briefs and a compendium of products to disseminate to the array of practitioners who come into contact with victims. The Center for Social Gerontology is maximizing the utility of critically important findings from the National Study of Guardianship Systems by adapting and repackaging the products to foster judicial education, research, and system change. The Illinois Department on Aging will synthesize and disseminate results of three of their elder abuse research projects to offer knowledge of best practices to a variety of audiences that can be applied to preventing abuse as well as serving victims.

Two projects, in addition to some projects already mentioned, target ethnic minorities. The National Indian Council on Aging is adapting recent Indian aging research/demonstration findings to formats which will be useful to tribal leaders, tribal service providers, Indian elders and their caregivers, and the aging network. The National Asian Pacific Center on Aging is facilitating the utilization of their training module on Supplemental Security Income from a prior project to address the low rate of participation by eligible Asian and Pacific Islander elderly.

Community-based services, linkages, and information and referral (I&R) are addressed in the following: (1) the American Society on Aging's "Aging in Place—Enhanced Dissemination" and utilization of its previously developed multimedia package, "A Good Place To Grow Old;" (2) the Portland (Oregon) Multnomah Commission on Aging's replication of four Project CARE Coalition models addressing needs such as crime prevention, telephone reassurance, and an urgent help telephone line; (3)

Catholic Charities, USA's network-building dissemination (and translation into Vietnamese and Korean) of their guidebook, "Linking Your Congregation with Services for Older Adults;" and (4) the National Association of State Units on Aging's promotion of aging I&R products to enhance the capacity of military I&R specialists to meet the needs of a growing number of military personnel with long distance caregiver responsibilities and other aging related family problems.

Finally, unique among these set of projects is "Enhancing Awareness of Aging Issues among Television Industry Leaders: The Sequel." The grantee, the University of California, Los Angeles, is facilitating the utilization of products from an earlier project to assist television professionals in depicting aging issues more effectively and portraying older adults in an informed, sensitive manner.

In FY 1994, AoA funded six new projects to maximize the dissemination and utilization of Title IV project products and results that can directly benefit older Americans in need of services. To accomplish this goal, two types of projects were funded: (1) enhanced dissemination of product(s) of significant value; and (2) synthesis and dissemination of the results of a project "cluster," a group of projects sharing a common purpose.

Five of the projects were funded under Part A, to support enhanced dissemination/utilization of exemplary Title IV products of demonstrated value to older Americans. Enhanced dissemination will: (1) promote understanding of certain laws and programs affecting older persons, especially those dealing with health and financial decisionmaking and planning for incapacity; (2) increase diabetes-related symptom recognition, help seeking, and adherence among ethnic minority elderly; (3) improve access to community services for at-risk older Vietnamese, Korean, and Hispanic Americans and their families; (4) educate consumers about their choices for home care, when to use it, and how to select, hire, and supervise a home-care worker; and (5) educate older Hispanic American women about the nature of osteoporosis and how to prevent it. A sixth project, funded under Part B, will synthesize and disseminate materials to increase the capacity and effectiveness of Title VII of the Older Americans Act vulnerable elder rights protection programs to reach and serve minority elders.

D. AGING Magazine

The Administration on Aging's magazine, AGING, continued this year to report on innovative programs throughout the United States that serve the elderly. AGING is circulated to 720 State and Area Agencies on Aging, national organizations concerned with the elderly, professionals who work with them, university and public libraries, and to older constituents and their families. A key goal of the magazine is to inspire staff who work with the elderly to find better ways to meet their clients' needs and to insure that they receive up-to-date information on prevention and treatment of health problems. A "Health Watch" section in each issue covers subjects of special interest to older people.

The most recent issue, for example, included articles on warning signs of heart attack and stroke, the role of vitamins in preventing disease, the dangers of sleeping pills, the vital importance of getting the one-time shot that protects against pneumonia, how to read the new FDA-required food labels in order to develop much healthier eating habits, and new Federal guidelines for cataract surgery.

Although prevention of health problems is routinely covered, this was a special 88-page double issue that focused on a topic neglected in an aging field—the need to "Nurture the Creative Spirit" in the years after 50. The goal of the issue, which had an outstanding design and used photos, drawings, and paintings either of or done by older people, was to defy the common presumption that individuals become less creative as they age. Included in this issue were articles: on a well-known artist who began drawing in her 60's; an exciting program that brings art appreciation and discussion groups to nursing homes; an art center for the disabled; and arts and humanities programs of interest to seniors that have been developed by the National Council on the Aging, the Smithsonian Institution, and other organizations.

In addition to featuring the arts, this issue included articles on a rural Community Mental Health Center that uses 72 volunteer peer counselors to help older people with mental illness; programs throughout the country that assist grandparents raising grandchildren; and a Baltimore project that equipped a row house as a showcase for adaptive devices that enable frail elderly people to remain in their homes. Regular sections also keep agencies up to date on new State and community programs, and on the latest publications and books can help staff to enhance services to constituents.

3. CONTINUATION ACTIVITIES IN FISCAL YEAR 1994

This Section of the Title IV Discretionary Program Report describes a wide variety of activities funded prior to FY 1994, but were still active in FY 1994 which carry out general mandates of the Act and support priority initiatives of the Assistant Secretary for Aging.

A. HOME AND COMMUNITY BASED LONG TERM CARE FOR AT-RISK ELDERLY

(I) NATIONAL RESOURCE CENTERS FOR LONG TERM CARE

Pursuant to Section 407 of the Older Americans Act Amendments of 1992, four National Resource Centers for Long Term Care were awarded continuation grants in Fiscal Year 1994. The Centers are responsible for conducting research, disseminating information, and providing training and technical assistance to improve national, State, and local systems for the provision of home and community-based long-term care. Each Center is focused on one or more specialty areas and is described below.

University of Minnesota.—This Center assists the aging network to develop, administer, and refine current community-based long-term care systems and services, with special emphasis on ethical issues and case management.

Brandeis University.—This Center conducts research and training, provide technical assistance, and disseminate information about the increasing diversity among the frail elderly and other disabled and chronically ill with respect to their race and ethnic background, economic status, gender, the communities in which they live, and types of disability or disease they encounter.

National Association of State Units on Aging.—This Center develops and improves community-based long-term care infrastructures and their components to better meet the needs of long-term care consumers, including the aged and disabled.

University of Kansas Medical Center.—This Center improves the availability of, and access to effective, appropriate community-based, long-term care services for the rural elderly.

(II) NATIONAL LONG TERM CARE OMBUDSMAN RESOURCE CENTER

In FY 1994, AoA continued support for the National Long Term Care Ombudsmen Resource Center which was established in 1993 through a Cooperative Agreement with the National Citizens Coalition For Nursing Home Reform for a project period of 4 years. The Center acts as a resource for policy analysis. It promotes the more effective organization and operation of Federal, State, and local long-term care ombudsman programs through technical assistance, consultation and information dissemination. The Center provides training modules and materials, volunteer recruitment efforts and cooperative activities with other agencies. In addition, the Center emphasizes preventing abuse and neglect and extending services to non-institutional settings.

(III) SPECIAL PROJECTS IN COMPREHENSIVE LONG-TERM CARE

Consistent with Section 407—Special Projects in Comprehensive Long Term Care, as enacted by the 1992 Amendments, the Administration on Aging made 13 17-month awards for demonstration projects to improve the delivery of long-term care to the at-risk elderly. The findings, results and products from these projects are expected to advance significantly the Nation's capacity to develop and implement comprehensive systems of home and community-based, long-term care. These currently active projects include:

Rhode Island Department of Elderly Affairs.—Will reduce duplication of State-level administrative functions and decrease fragmentation of case managed services.

Oklahoma Department of Human Services.—Will develop and demonstrate a plan that builds on the Aging Network's capacity to assume a significant role in the State's newly mandated long-term care system which places increased emphasis on providing home and community-based care services.

Cherokee Nation.—Will establish a comprehensive system of services based on the PACE Model of care and financing developed by On Lok Senior Health Services in San Francisco, California.

Ohio Department of Aging.—Will implement innovations including: (1) flexible case management; (2) a modified assessment and care planning process that takes greater account of client autonomy; and (3) an expanded model of service delivery to expand our thinking about, and knowledge of, the home-care system and ways to best enhance client autonomy and functioning within reasonable cost constraints.

Marin County Department of Health and Human Services.—Will bring private agencies into one system that screens and refers home care workers for the aged and young adults with disabilities.

Philadelphia Corporation for Aging.—Will produce, evaluate and disseminate 12 protocols for care management in community-based long-term care.

Baylor College of Medicine.—Will demonstrate, along with other community organizations, the feasibility of forming an alliance for at-risk elderly known as ALTCARE.

Senior Focus of Burlingame, California.—Will establish and evaluate a medication counseling project for at-risk older persons in two managed-care settings.

Huntington Memorial Hospital of Pasadena, California.—Will develop and test an in-home medications management program which decreases threats to the health and independence of high risk older persons and fills a gap in the care continuum.

Wisconsin Department of Health and Social Services.—Will improve care management for older clients by incorporating techniques into the assessment, care planning and monitoring processes that will prolong their ability to remain in their own homes.

Vermont Department of Aging and Disabilities.—Will set up and evaluate a single point-of-entry model for long-term care services for the elderly and adults with disabilities through Regional Service Centers.

Area Agency on Aging 1–B of Southfield, Michigan.—Will develop a Performance Management System that (1) defines service standards in measurable terms; (2) uses benchmarks to encourage providers to focus on excellence rather than mere compliance; (3) creates consumer-based definitions of quality; and (4) trains other States and Area Agencies on Aging to develop their own systems.

New York State Office for the Aging.—Will replace a fragmented and duplicative long-term care assessment process by developing a consensus plan based on input from various professionals and agencies that assist the at-risk elderly.

B. National Center on Elder Abuse

AoA continued support for the National Center on Elder Abuse, which was funded in response to the legislative mandate in the Older Americans Act Amendments of 1992, Section 202(d)(1). The Center supports efforts under Title VII of the Act which calls attention to the problem of elder abuse, neglect, and exploitation at home and in institutional settings and which stresses the need to take coordinated action on behalf of those elderly who are least able to advocate for themselves.

The Center award was made to the American Public Welfare Association (APWA) for a 4-year project period. The National Association of State Units on Aging, the National Committee for the Prevention of Elder Abuse, and the University of Delaware will collaborate with APWA in carrying out the work of the Center.

With joint funding from AoA and the Administration for Children and Families, the National Center on Elder Abuse began in late FY 1994 a national study to accurately estimate the incidence of elder abuse. Other activities of the Center include: (1) performing clearinghouse functions by providing information about best practices in the organization, planning and delivery services to combat elder abuse; (2) compiling, publishing and disseminating training materials for personnel working in the field; (3) providing training and technical assistance to public and private agencies to assist in improving programs to combat elder abuse, neglect, and exploitation; and (4) conducting research and demonstration projects regarding elder abuse, neglect, and exploitation with an emphasis on causes, prevention, identification and treatment.

C. Training and Technical Assistance for Title VI Grantees

AoA continued its support for the project conducted by the Three Feathers Associates of Norman, Oklahoma to provide training and technical assistance that is consistent with Section 411(a)(4) of the Older Americans Act. The project will strengthen the capacity of Title VI program directors and staff to provide comprehensive and coordinated systems of nutritional and supportive services for older American Indians, Alaskan Natives, and Native Hawaiians. The project is focusing particular attention on coordinating resources under Title VI and Title III of the Older Americans Act and strengthening Title VI program accountability

D. National Leadership Institute on Aging

The Administration on Aging, under the Title IV discretionary funds program, has a cooperative agreement with the University of Colorado at Denver for the continued funding of the National Leadership Institute on Aging. The Leadership Institute

was established to enhance the leadership capacity of women and men in the aging network and others with a stake in aging America. The goal is to encourage greater creativity and innovative solutions to the complexities of an aging society. The leadership development curriculum including modules on the context of leadership in a changing society; the concepts of leadership for the future executive; the goals and tools of leadership in community systems building; and self-development for enhancing effectiveness.

The Institute provides an intensive and supportive residential learning environment, for a select number of executives from State and Area Agencies on Aging, Tribal Units, national organizations. Its goal is to enhance leadership development and increase the competence of agents responsible for social change. Since its inception in 1988, the Leadership Institute has conducted 17 residential Leadership Development Programs for close to 600 participants from all areas across the Nation. It has also conducted a number of Mini-Institutes in several States, provided a number of refresher events for alumni and staff have staged several pre-intensive, leadership-development workshops in conjunction with national meetings and conferences.

E. Senior Transportation Demonstrations

The Older Americans Act Amendments of 1992 include several provisions which recognize the transportation barriers which older persons often face. The Amendments directed AoA to carry out a Senior Transportation Demonstration Program. AoA funded five 2-year awards in Fiscal Year 1993 to demonstrate innovative approaches to improve older persons' access to services, to develop comprehensive, integrated senior transportation services, and to leverage resources for senior transportation services through coordination with other funding sources. The five project grantees, refunded in FY 1994, were:

Central Plains Area Agency on Aging (KS).—The Central Plains AAA will produce a model senior transportation program that improves the effectiveness of and access to a community-based long-term care system through an enhanced multi-county (urban and rural) coordinated transportation network.

CARE-A-VAN, INC. (CO).—CARE-A-VAN, Inc., will develop a rural-to-urban transportation demonstration model project to benefit seniors by bringing frail, disadvantaged elderly from as many as seven rural communities to urban services in Fort Collins, Colorado.

Portage Area Regional Transportation Authority (PARTA) (OH).—PARTA will demonstrate how agencies providing housing, nutrition, adult day care, and related services can work effectively with a regional transportation authority to improve the quality and increase the level of transportation services that are responsive to the critical needs of the area's elderly.

District III Area Agency on Aging, Inc. (MO).—The District III AAA project will help meet the documented transportation needs of those rural elders who require health, nutrition, and supportive services by demonstrating a comprehensive approach to coordinating transportation. The project will establish a special organization for coordinating transportation services; implement a pilot project covering two counties; formulate solutions to barriers to coordination; and raise awareness regarding rural elders' transportation needs.

Florida Department of Elder Affairs.—The Florida State Agency on Aging, in cooperation with the Mid-Florida Area Agency on Aging, the Center for Gerontological Studies, and the Florida Transportation Disadvantaged Commission, will demonstrate a senior transportation services program servicing rural dwelling, minority, low income elders, in Hamilton, Suwannee and Lafayette Counties. The model project seeks, in particular, to establish several Inter-County Alliances among rural churches to improve and expand current transportation service delivery.

F. Demonstration Projects for Older Individuals With Developmental Disabilities

Consistent with Section 415 of the 1992 Amendments to the Older Americans Act, AoA made five 2-year awards in Fiscal Year 1993 to support the efforts of agencies that serve older and developmentally disabled persons. The grantees, all State agencies, are leading efforts to collaborate on State and local planning, coordination, and programs that will improve services to older persons with developmental disabilities as well as those older persons who care for younger family members with developmental disabilities. The five State agnecies, re-funded in FY 1994, were:

Hawaii Department of Health.—This project seeks to combine two pertinent areas: the identification of current issues in the care of aging persons with developmental

disabilities in Hawaii and the cross-training of personnel involved in integrated programs for aging persons.

New York Research Foundation for Mental Hygiene, Inc.—This project will test the feasibility of incorporating low-cost and low-tech methods into the daily practice of an Area Agency on Aging to conduct outreach to adults with developmental disabilities, link AAA programs with those of developmental disabilities agencies, and support family caregivers of adults with developmental disabilities. From this experience, implications will be drawn for use in replicating the AAA model in other parts of New York State and the Nation.

Illinois Department on Aging.—This Illinois project is designed to (1) bolster supports for family caregivers of individuals with developmental disabilities; (2) encourage future planning activities to prevent crises from occurring when they are no longer able to provide care; and (3) improve access to Older American Act programs and services for older adults with developmental disabilities.

Rhode Island Developmental Disabilities Council.—This project is developing a collaborative agency network in Rhode Island to design an educational workshop program and interdisciplinary support team to assist elderly parents with adult sons/daughters with developmental disabilities in making family-centered plans for their futures, including residential, financial, and service-related dimensions.

Virginia Department for the Aging.—This project is drawing upon practice and policy innovations in Virginia and Maryland in order to build and test an integrated model program that will improve services to older persons with developmental disabilities and older persons who care for younger family members with developmental disabilities.

G. Linking Generations—Intergenerational and Multigenerational: Demonstrations

In response to Sections 406 and 409 the Older Americans Act Amendments of 1992, in FY 1993 AoA funded eight projects to develop and implement intergenerational and multigenerational programs designed to assist families at-risk. The currently active projects are:

Action for Boston Community Development (MA).—The Boston Reaching Across Generations (BRAG) project is focusing on aspects of social support needs among elders and at-risk youth which have not been fully addressed in other intergenerational mentoring programs. The project will respond, specifically, to the exceptional isolation experienced by low-income, minority elders with functional impairments by training frail and disabled elders as mentors to at-risk youth. In return, youth will volunteer to assist elderly mentors with services such as shopping or escorting elderly individuals to the doctor.

Eastern Michigan University.—The Teaching-Learning Communities: Multigenerational Family Empowerment Project of Eastern Michigan University aims at demonstrating a model that links three programs found in many communities: (1) older adults (senior aides) participating in the U.S. Department of Labor Senior Community Service Employment program; (2) children, youth and their parents receiving Section 8 housing support; and (3) the local school district.

Easter Seal Society for Disabled Children and Adults (DC).—The Easter Seal Society for Disabled Children and Adults and Family Friends of the National Capital Area are collaborating to develop a model program to link senior volunteers with at-risk families of children with disabilities. The project will develop an intergenerational model program for national dissemination that utilizes senior volunteers to teach at-risk families how to access existing health care services, community resources and support networks.

New York City Department for the Aging.—As a collaborative effort of the New York City Department for the Aging and the Division of Adoption and Foster Care Services of the Child Welfare Administrations, the Kinship Foster Care Support Project is working with "skipped generation" families linking kinship foster parents, 50 and older, and their foster children with senior volunteers. The project will recruit, select, train, and supervise 50 senior volunteers to provide in-Home assistance and support to 100 kinship foster care families.

Pennsylvania Department of Aging.—"Skip Generation" families are emerging as grandparents become full or part-time caregivers of pre- and school-age children. This project links those increased caregiving responsibilities with the need for children to be immunized by establishing immunization clinics in six senior centers in different regions of Pennsylvania. The clinics will operate through a collaborating between health, aging and community agencies, volunteer physicians and nurses, and child advocacy groups. The project aims to improve immunization levels of chil-

dren who cannot access services in traditional ways and to enhance the roles of older people in family systems.

University of North Texas.—This Seniors for Childhood Immunization project, to be demonstrated in partnership with the Retired Senior Volunteer Programs (RSVP), is an intergenerational and multigenerational project designed to improve the immunization rate for preschool children. The objectives of the project are to: (1) develop a system-integrated intergenerational model to link senior volunteers and college students to immunization-providing agencies, and hospitals within a community; (2) field test the model in 16 sites within the Denton and Dallas counties of Texas; (3) evaluate the demonstrations for their impact on immunization schedule completion and model effectiveness; and (4) disseminate project results through the senior volunteer aging and public health networks.

North Carolina Central University.—The goals of the Hand in Hand: Multigenerational Assistance Exchange Project are to improve service to at-risk minority elderly and children and to recruit and train minority students for service employment. The project will employ minority college students as outreach aides to inform and assist older people in applying for public benefits and obtaining aging services. In exchange, elders will be invited to volunteer as mentors, tutors, and companions for at-risk children in the Head Start and Youth Enrichment Experience Programs.

Generations United (Child Welfare league of America) (DC).—Generations United, in conjunction with its partners, the National Council on the Aging, the University of Pittsburgh's Generations Together Program, and the Temple University Center for Intergenerational Learning, will carry out a program of comprehensive technical assistance, training, and information dissemination focused on intergenerational/multigenerational linkages. This project will assist the newly-funded AoA intergenerational projects, create a national public awareness campaign, and provide support for strategic planning at the local and national levels.

H. Rural Mental Health Care Training of Services Providers

The Administration on Aging (AoA) with the support of the Center for Mental Health Services (CMHS), part of the Public Health Service's Substance Abuse and Mental Health Services Administration, made three 2-year awards in FY 1993 to increase detection of mental illness of rural elderly, and to provide for the appropriate referral of those elderly for treatment. The projects will test the feasibility and effectiveness of training non-mental health care providers in meeting the needs of older persons suffering from, or at risk of mental health impairment in areas underserved by mental health professionals. In addition, additional funding will be provided by CMHS for coordination, evaluation and dissemination of technical assistance materials which will be used by State mental health and aging authorities in planning future programs and budgets to better serve the growing number of older persons living in rural areas.

The three new project grants jointly funded by AoA and CMHS are as follows:

The Center for Mental Health Policy and Services Research at the University of Pennsylvania (Philadelphia) is working with representatives of agencies, organizations and the public in three rural counties (Berks, Franklin, and Fulton) to develop a curriculum and training model to increase the knowledge and ability of non-mental health human services workers, caregivers, and community volunteers to recognize the symptoms and functional indicators of mental disorders.

The Center on Rural Elderly at the University of Missouri at Kansas City is developing and testing a model mental health training program for non-mental health service providers to improve their recognition and assessment of mental health problems and communications with mental health professionals. In addition to testing the materials with nearly 2,000 providers of services to rural elderly, the Center will facilitate collection and analysis of information and data from other project sites for dissemination to local, State, and national officials in mental health and aging.

The Center on Aging at the University of Arizona (Tucson) is developing and pilot testing training materials for providers of health and social services to rural Hispanics, American Indians, and Anglos. Material sensitive to cultural differences in mental health illness will be developed with the consultation of the Indian Health Service and the assistance of the InterTribal Council of Arizona and Chicanos por La Causa.

I. Pension Information and Counseling Demonstration Program

Recognizing the large unmet need to provide older Americans with information and counseling in the area of pension benefits, Congress provided in Section 419 of the Amendments to the Older Americans Act of 1992 for the funding of Pension In-

formation and Counseling Demonstration Projects. AoA made seven 17-month awards in fiscal year 1993 for demonstration projects that seek to provide outreach, information, counseling, referral and assistance in the area of pension benefits. A national training and technical assistance project that will strengthen the role of the demonstration projects, State and Area Agencies on Aging and legal services providers, both public and private, in providing pension assistance and encouraging coordination among these groups was also funded to run concurrently with the model projects.

Legal Services for the Elderly (NY).—This model project provides telephone service to individuals to enable them to learn about their pension and other retirement benefit rights. Retirement benefit claimants receive the following information: (1) How to apply for benefits and exhaust plan remedies by appealing a denial of benefits within their respective plans; (2) how to assess whether a retirement plan complies with ERISA's minimum standards; and (3) referrals to private attorneys and bar associations for representation and litigation. The project will serve as a resource center with an expert attorney on call to answer individual's questions and offer guidance to pensioners on how to obtain their rights.

National Senior Citizens Education and Research Center (DC).—This project involves a statewide pension information, counseling and advocacy program in Minnesota which is addressing pension problems of retirees and their families. The goals of this project include: (1) Informing seniors about pension rights and personal pension management by utilizing trained volunteer and paid staff comprised principally of retirees; (2) assisting seniors to obtain essential pension information and resolve widespread problems such as disputes about expected benefits, survivors's rights, records, integration with Social Security, etc., and identify effective courses of action to secure full right and benefits; (3) gather data and analyze experience to increase replicability; and (4) design permanent local models of pension information and advocacy centers.

Michigan Office of Services to the Aging.—This project is demonstrating a comprehensive program model for assisting older people to understand, obtain and wisely use their pension benefits. The project is being tested in two of Michigan's most urban counties and four of its most rural counties and will provide individual pension counseling services to a minimum of 320 seniors. Legal advice and counsel are available to as many as 50 of those individuals. The project also provides financial counseling services. The project builds on a proven model for providing health insurance counseling to older people and uses intensively trained volunteers who are supported by regional coordinators.

Older Women's League (DC).—This project sponsors a pension information and counseling center in St. Louis to maximize retirement income and access to pension information among working and retired persons with a particular emphasis on low-income and minority elders and older women. Through an information and counseling service, a pension hotline, financial workshops, consumer materials, and volunteer training, the project strengthens financial independence, increase access to retirement income and serves as a unique resource on women's retirement issues.

University of Massachusetts, Boston.—This project, a cooperative effort with the Massachusetts State Unit on Aging, is engaged in: (1) educating older workers, retirees and the community about different types of pensions and retirement income as well as issues affecting eligibility and benefit levels; (2) increasing older persons's awareness of their financial status with regard to their pension and Social Security eligibility and benefit level; (3) assisting individuals in exercising their rights to protect their pensions and challenge unfavorable decisions; and (4) maximizing an individual's retirement standard of living through counseling and referrals to appropriate programs and professionals.

National Committee to Preserve Social Security and Medicare (DC).—This project is establishing a model local Pension Information and Counseling Program in Tucson, Arizona. The goals of this project are to: (1) Determine the degree of need for pension information and counseling particularly among older persons of low and moderate means; (2) learn what types of information are most useful and necessary for such persons to ensure that they secure the full level of benefits to which they are entitled and make the best use of these assets within the context of their own financial standing; and (3) determine what resources are available and/or lacking on a national basis which could be used to help meet the needs of locally based pension counseling programs.

California Advocates for Nursing Home Reform.—This project is adding pension counseling to its current program of consumer counseling and professional attorney and estate planning training. It includes development of a consumer pension handbook, a professional estate planner training package, and development of a pension

data base. Special outreach attempts are being made to low income minorities, especially Hispanics and Chinese.

Pension Rights Center (DC).—This project supports the AoA funded Pension Information and Counseling Demonstration projects as well as other groups providing pension assistance. Activities include staff and volunteer training, development of local technical assistance support systems, provision of day-to-day technical assistance, and facilitation of coordination between the demonstration projects and other national and local sources of assistance. A secondary objective is to offer recommendations for future pension assistance programs based on a assessment of the demonstration projects.

J. Activities in Support of the National Eldercare Campaign

During fiscal year 1994, the Title IV program continued to support the National Eldercare Campaign and its goals to increase advocacy, collective planning, and action on behalf of the most vulnerable older Americans. Several components of the National Eldercare Campaign, initiated in fiscal year 1991, concluded in fiscal year 1994: (1) Project CARE grants to State and Area Agencies on Aging to encourage development of coalitions of local organizations and businesses; and (2) grants to National Eldercare Institutes to advance our knowledge base in several important issue areas and to provide technical assistance and training.

1. PROJECT CARE: COMMUNITY ACTION TO REACH THE ELDERLY

The Administration on Aging launched Project CARE (Community Action to Reach the Elderly) in Fiscal Year 1991 as a major component of the National Eldercare Campaign. The goal of Project CARE is to tap the expertise, energy, and experience of individuals and organizations and encourage new ideas and approaches for meeting the needs of vulnerable older Americans through formation of State and local community coalitions.

By Fiscal Year 1994, more than 900 eldercare coalitions were operational through AoA grants to State and Area Agencies on Aging. About 30 States had also started statewide coalitions. The statewide coalitions were formed to support the work of the community coalitions. State coalitions provide a mechanism for building widespread public awareness about the needs of older persons. They also provide a way to focus attention on the need for State-level, comprehensive strategies to help vulnerable older persons.

Continuation funding was provided in Fiscal Year 1993 to the community coalitions which are implementing practical, immediate service projects to help vulnerable older persons. Each is working to broaden the base of support for eldercare concerns by empowering local community leadership to take greater responsibility for their vulnerable older persons. The coalitions include a significant number of nonaging organizations which traditionally have not been involved with aging concerns.

2. NATIONAL ELDERCARE INSTITUTES

As part of the National Eldercare Campaign, AoA has supported a number of specialized National Eldercare Institutes located in national organizations and academic institutions. In Fiscal Year 1991, 12 National Eldercare Institutes were awarded project grants under the terms of a 3-year cooperative agreement.

In 1992, an additional award was made to establish a second National Eldercare Institute in the area of long-term care. Each Institute has focused on a critical substantive area relevant to improving eldercare services, both in the home and community.

In Fiscal Year 1994, working in close collaboration with eldercare coalitions across the Nation, the Institutes also undertook a variety of activities designed to support and assist State and Area Agencies on Aging in carrying our their missions as planners and coordinators of aging services within their jurisdictions.

The National Eldercare Institutes active in 1994 are described below by subject area:

a. Long Term Care

The National Eldercare Institute on Long-Term Care and Alzheimer's Disease at the Suncoast Gerontology Center, University of South Florida designed activities that would provide the aging network with current, practical information on critical long-term care issues, especially Alzheimer's disease. The Institute also focused on the areas of home and community-based model long-term care programs and services, and caregivers and caregiving.

b. Older Women

The National Eldercare Institute on Older Women is directed by the National Council of Negro Women (Washington, D.C.). The Institute was designed to address issues affecting diverse populations of older women with special attention to those most at-risk. The Institute conducted training and technical assistance at a variety of conferences, symposia, forums, and workshops. A major focus of the Institute was to serve as a catalyst and encourage national women's organizations to adopt an older women's issues agenda in their national and local program activities.

c. Multipurpose Senior Centers and Community Focal Points

The National Eldercare Institute on Multipurpose Centers and Community Focal Points is conducted through the National Council on Aging (Washington, DC). The Institute's mission was to encourage communities to develop senior centers to serve at-risk older people in their homes as well as in congregate facilities, and, conversely, to encourage existing senior centers to expand their services for at-risk elderly and increase their linkages to non-traditional community groups.

d. Transportation

The National Eldercare Institute on Transportation was conducted by the Community Transportation Association of America, (CTAA) in collaboration with the National Association of Area Agencies on Aging (NAAA), the National Center and Caucus on Black Aged (NCBA) and the National Council on the Aging (NCOA) (all located in Washington, DC). The goals of the Institute were to increase public awareness and commitment to the transportation and mobility needs of at-risk older persons; to serve as a resource institute on aging and transportation/mobility issues to the National Eldercare Campaign and its Project CARE coalitions; to gather, analyze and disseminate data on aging and transportation issues; and to provide training and technical assistance on aging and transportation issues.

e. Housing and Supportive Services

The National Eldercare Institute on Housing and Supportive Services was operated by the University of Southern California (Los Angeles, CA) in collaboration with the National Association of Area Agencies on Aging and the Federal National Mortgage Association (both in Washington, DC). The Institute mobilized public, private and voluntary sector resources to better link elderly housing with supportive services and increase supportive housing options for the at-risk elderly population.

f. Nutrition Services

The National Eldercare Institute on Nutrition was a joint effort conducted by the National Association of Nutrition and Aging Services Programs (Grand Rapids, MI) in collaboration with the National Association of Meals Programs, the National Association of State Units on Aging, the National Meals on Wheels Foundation (all located in Washington, DC), the DuPont Corporation (Wilmington, DE), Ross Laboratories (Columbua, OH) and the Nestle Corporation (Washington, DC). The Institute focused on nutritional issues concerning the at-risk elderly and their impact on improving nutritional services and product development in community settings.

g. Human Resources Development

The National Eldercare Institute for Human Resource Development was operated by the Brookdale Center on Aging, Hunter College of the City of New York in collaboration with the American Society on Aging in San Francisco, California. The purpose of the Institute was to help State Units on Aging, Area Agencies on Aging, and eldercare coalitions promote the most effective use of human resources in programs serving the elderly.

The Institute provided training and technical assistance in such areas as training techniques, staff recognition, and team building and management; solicitation, evaluation, and dissemination of best practice in human resource development for use in aging programs; presentation of human resource best practice awards to exemplary staff development programs in health and long-term care organizations; and preparation and dissemination of Institute training calendars and newsletters.

h. Health Promotion

The National Eldercare Institute on Health Promotion was conducted by the American Association of Retired Persons (Washington, DC) in collaboration with Meharry Medical College (Nashville, TN). The purpose of the Institute was to encourage healthy behaviors among older persons and their caregivers and serve as a knowledge base and program resource on health promotion and disease and disability prevention for vulnerable older persons.

The Institute collected and disseminated information about successful health promotion program models which assist older persons in maintaining their well-being and independence and provided information on overcoming barriers to reaching low-income minority populations. Research findings and best practice information on health promotion was incorporated into technical assistance guides and training materials for use in conjunction with the work of national, State, and community Eldercare Coalitions and disseminated to health care networks.

i. Income Security

The National Eldercare Institute on Income Security was administered by Families USA, Foundation, Inc. (Washington, DC). The Institute focused on the living standards of the low-income elderly and their access to benefits and entitlement programs that meet their needs. It conducted analyses on selected topics related to income security to identify key factors that served as the basis for a public awareness campaign and stimulated interest among Eldercare Coalitions, such as examination of the elderly poverty rate, a study of the "Medicaid Gap" as it relates to coverage of health services and nursing home care, the affordability of long-term care insurance, and the proportion of out-of-pocket health costs not being paid by Medicare and Medicaid.

The Institute worked with other interested organizations to promote outreach activities to make low income older persons aware of their possible eligibility as "Qualified Medicare Beneficiaries". Under this program, Medicaid pays their Medicare premiums and deductibles. The Institute also promotes public education to increase the participation of the low-income elderly in the Supplemental Security Income (SSI) program.

j. Employment and Volunteerism

The National Eldercare Institute on Employment and Volunteerism was conducted by the Center on Aging, University of Maryland (College Park, MD) in collaboration with the National Council on the Aging (Washington, DC), the National Retiree Volunteer Center (Minneapolis, MN), and the American Association of Retired Persons (Washington, DC). The Institute's overall mission was to improve the quality of life for older persons by enhancing and increasing volunteer and employment opportunities. The Institute operated a clearinghouse on volunteerism designed to synthesize knowledge and information on curriculum and training models, effective programming, and policy analysis which was designed to enhance the effective use of volunteers in eldercare service organizations.

k. Business and Aging

The National Eldercare Institute on Business and Aging was conducted by the Washington Business Group on Health (Washington, DC) in collaboration with the American Society on Aging (San Francisco, CA). The Institute developed and disseminated many useful products and programs to business organizations, foundations, and the aging network, including Project Care Coalitions. These included several publications, a regular newsletter, fact sheets and a board game which teaches the steps in developing public/private partnerships. The Institute also conducted seminars at the major national aging conferences on such topics as public/private partnerships and working with the business community on eldercare programs. In addition, the Institute has gradually increased its role in providing technical assistance through teleconferences, on-site presentations and telephone consultation.

K. Supporting Resources for Legal Assistance to the Elderly

The new Title VII, established by the 1992 Amendments to the Older Americans Act, mandates support for legal assistance programs funded through State and Area Agencies on Aging. In addition, Section 424 of Title IV requires the Administration on Aging to establish a national legal assistance support system that provides State and Area Agencies and local legal assistance programs with case consultations, training, legal advice, and assistance in the design and implementation of delivery systems by local providers. Under this mandate, the Administration on Aging has supported technical assistance grants to national, nonprofit legal assistance organizations for a number of years through multi-year grant projects on the basis of periodic national competitions.

In Fiscal Year 1992, eight 3-year project awards were made in support of the national legal assistance support system and these projects received continuation awards in FY 1994. Continuation funding was also awarded to three demonstrations of statewide legal hotlines. The projects are summarized below:

1. NATIONAL SYSTEM OF LEGAL ASSISTANCE PROJECT GRANTS

The National Senior Citizens Law Center (Washington, DC).—The Center is providing legal assistance support services to State and local legal assistance programs for the elderly, legal assistance developers, ombudsmen, and State and Area Aging Agencies. Assistance focuses on case consultation, legal assistance, technical assistance (TA), training, and joint sponsorship of the National Law and Aging Conference.

The Commission on Legal Problems of the Elderly of the American Bar Association (Washington, DC) is engaged in strengthening the capacity of State and Area Aging Agencies and legal services providers to develop accessible and responsive systems of legal assistance for older persons. The Commission is providing technical assistance on legal assistance systems related to subjects such as private bar involvement, senior attorney *pro bono* services, aging network linkages with disability networks, offices of attorney generals, and eldercare coalitions.

The Commission is also providing substantive legal advice on aging law issues, such as grandparent visitation/kinship care, health care decisionmaking, age discrimination, and others. The Commission is a joint sponsor of the National Law and Aging Conference.

The Mental Health Law Project of Washington, D.C. provides training, technical assistance, and case consultation to advocates to meet the legal needs of elders with mental disabilities. The project emphasizes protection of the rights of elders to age in place and promote community-based alternatives to nursing homes and appropriate care for the mentally disabled in nursing homes and hospitals, including options for community placements.

The Pension Rights Center (Washington, DC) is expanding its Legal Outreach Program, targeted to the needs of at-risk elderly and the legal services providers that serve them. The Center is also developing new case consultation, training and *pro bono* resources and establishing a Clearinghouse to collect and disseminate pension information to eldercare providers.

The Legal Counsel for the Elderly (LCE) of the American Association of Retired Persons (Washington, DC) provides training and technical assistance on substantive law and advocacy skills to past recipients of "training the trainers" in 20 States. The project also provides training to volunteers, staff of legal assistance and aging advocacy agencies, substantive experts who want to become trainers, and advocates in multidisciplinary coalitions who will, in turn, serve as trainers. It is also providing training and assistance to States interested in passing new protective services legislation (guardianship, health care decisionmaking, durable powers of attorney, living will) and in expanding legal services programs for Disability, Medicare and Veterans benefits based on documents maintained in its clearinghouse on these topics. LCE is a joint sponsor of the annual National Law and Aging Conference.

The LCE project is also continuing previous activities to test, and, if successful, replicate methods for providing free legal assistance through the use of: (1) private practice paralegals as volunteers, (2) retired and semi-retired attorneys as volunteers, and (3) bar-sponsored lawyer referral programs to provide low cost wills and advance directives.

The National Clearinghouse for Legal Services (Chicago, IL) provides a full range of publications and information services to agencies funded through AoA to provide legal assistance to older persons. Services include: computer-assisted legal research, Clearinghouse Review, Brief Bank services, and a computer newsletter.

The Center for Social Gerontology, Inc. (Ann Arbor, MI) provides training and technical assistance, and substantive legal advice and assistance to enhance the capability of the State and Area Agencies on Aging and legal services providers to plan and deliver legal assistance to at-risk elderly. Through an application process, the Center selected 16 to 18 States to receive technical assistance and training programs, designed specifically for each State and which focus on such tasks as developing statewide standards for legal assistance elder rights planning, setting priorities, and coordinating statewide legal assistance program activities. The Center is a joint sponsor of the annual Joint Law and Aging Conference.

The National Consumer Law Center, Inc. (Boston, MA) provides legal support to local practitioners (attorneys, legal services providers, legal service developers and eldercare advocates) in applying consumer law to resolve legal problems facing elderly clients. The project will develop a series of educational materials and guides, including model pleadings and defenses, model legislation, legal practice guides, newsletters and consumer education materials, with a special focus on threats to loss of shelter and financial exploitation.

The project is developing a series of educational materials and guides, including model pleadings and defenses, model legislation, legal practice guides, newsletters

and consumer education materials. The project is focusing on (1) threats to shelter, in such areas as problems with home equity, mobile home park tenancy issues, or utility services; and (2) financial exploitation, such as fraudulent sales of medical and emergency response products and unfair debt collection defenses.

2. IMPROVEMENT OF ACCESS TO LEGAL ASSISTANCE

The current legal assistance network for older persons has been operational for a number of years and has won general acceptance as an effective resource for older persons needing legal assistance. Experience has indicated, however, that barriers persist in reaching selective populations of older persons who area at-risk for a variety of reasons and could be aided if access were improved.

STATEWIDE LEGAL HOTLINES

In Fiscal Year 1990, the AoA entered into a memorandum of understanding with the American Association of Retired Persons (AARP), (Washington, DC) to expand the availability of Legal Hotlines for older people. With the support of AoA and AARP, Legal Hotlines are in operation in nine States/Regions (Pennsylvania—the prototype, the District of Columbia, Texas, Florida, Michigan, Ohio, Main, New Mexico, and Arizona), with nearly one-third of the Nation's older people having access to free or low cost legal advice. When an older person with a legal problem calls the Hotline, specially-trained lawyers either provide step-by-step advice on how to resolve their problems immediately, or, on more difficult issues, consult with local legal aid specialists or a panel of attorneys in private practice who agree to charge reduced fees.

Three Legal Hotline projects were awarded start-up grants by AoA in Fiscal Year 1991 and received continuation funding in FY 1993:

The Maine hotline, operated by the Legal Services for the Elderly (Augusta) is serving as the primary intake mechanism for their statewide network of legal assistance offices.

The Arizona hotline, operated by Southern Arizona Legal Aid (Tucson), is testing new outreach strategies for the State's Native American and Hispanic populations.

In New Mexico, the hotline is operated by the State Bar of New Mexico (Albuquerque) that is expanding and improving its current *pro bono* program.

L. MULTIDISCIPLINARY CENTERS AT HISTORICALLY BLACK COLLEGES AND UNIVERSITIES

The Administration on Aging initiated support, in Fiscal Year 1992, to establish Multidisciplinary Centers of Gerontology at Historically Black Colleges and Universities (HCBU's). This initiative responds to Executive Order No. 12677, which encourages the Department of Health and Human Services to support the involvement of HCBU's in the health and social service concerns of low-income, socially disadvantaged and minority older persons by initiating efforts to increase the number of minorities trained in the health, allied health and supportive services professions.

Three grants for 3-year project periods were made by AoA under the Historically Black College and University Initiative. The Multidisciplianry Centers are:

Howard University (Washington, DC) has established its Multidisciplinary Center of Gerontology in the School of Social Work. Center efforts focus on education, training, curiculum development, research, information dissemination and development of a repository of information on minority elders, especially the African American elderly. The Center's activities are concentrated on education and training, a minority aging research agenda, and a campaign for sustained support of the Center's operation initiated. Anticipated products include models for a multidisciplinary center on gerontology at an Historically Black College or University; curricula for professionals and service providers; a directory of gerontological courses and curricula offered at Washington area colleges and universities, public service announcements and a research agenda for HBCUs.

Lincoln University (Philadelphia, PA) has established a Multidisciplinary Center of Gerontology under the coordination of the Master of Human Services Program. Center activities are concentrated in the areas of: (1) development of gerontology faculty and curriculum; (2) development of an advanced certificate in gerontology; (3) establishment of gerontology and geriatrics continuing education institutes; (4) research in gerontology and geriatrics; and (5) restructuring the undergraduate certificate in gerontology as a formal undergraduate program. The Center plans to serve as a resource center for professionals and

aging service providers in the Mid-Atlantic region by providing training and technical assistance and disseminating information. Anticipated products include a model for a multidisciplinary center on gerontology at an HBCU and curricula for professionals and services providers and other technical assistance materials.

Morehouse School of Medicine (Atlanta, GA) has established a Multidisciplinary Center of Gerontology that serves as Coordinator of a Consortium of HBCUs in Georgia. Particular attention is being paid to the needs of the rural elderly. Center activities are concentrated on: (1) developing an infrastructure for interdisciplinary collaborative efforts; (2) faculty developing in curriculum and clinical skills; (3) continuing education with a rural focus; (4) stimulating research on minority aging issues to provide technical assistance to policy makers and service providers; and (5) establishing a clearinghouse and resource center. Anticipated products include a model consortium approach for establishing a multidisciplinary center on gerontology at an HBCU and curricula for professionals and services providers that focus on the rural minority elderly and other technical assistance materials.

M. Small Business and Aging

The market for goods and services for vulnerable non-institutionalized elderly is especially suited for small businesses who are willing to take risks that larger companies will not until market information supports their capital investment. The Administration on Aging has been a participant in the Small Business Innovation Research Program (SBIR) coordinated by the U.S. Small Business Administration since Fiscal Year 1990.

In FY 1994, three AoA-funded SBIR projects were active. As described below, these projects address applications of technology to meet the needs of older persons for devices which assist them to perform tasks of daily living:

TechnoView, Inc. (Newport Beach, CA) is establishing the technical feasibility for developing an Intravenous Drug Delivery Monitor for use by elderly patients being treated for serious diseases at home via home health care service providers and family members when nurses are not present.

American Research Corporation of Virginia (Radford, VA) is developing the specifications for a personal communication system to permit caregivers to monitor the well-being of homebound elderly family members.

Kinophase, Inc. (Nashua, NH) is developing a visual/audio system that will investigate the use of a kinoform lens to overcome the effects of macular degenerative visual problems often found among the elderly.

SECTION X—WHITE HOUSE CONFERENCE ON AGING

The 1995 White House Conference on Aging was authorized under the terms of P.L. 102–375, the Older Americans Act Amendments of 1992 and later amended by P.L. 103–171 to change the dates of the Conference from December 31, 1994 to no later than May 31, 1995. President Clinton officially called the White House Conference on Aging on February 17, 1994, and it was formally scheduled for May 2–5, 1995 by virtue of a vote by the Congressionally-mandated, 25-member Policy Committee. This Policy Committee includes HHS Secretary Donna E. Shalala, HUD Secretary Henry Cisneros, and VA Secretary Jesse Brown.

This will be the fourth White House Conference on Aging in history, the first since 1981, and the final one of the 20th century. Historically, the White House Conference on Aging is intended to produce policy recommendations to guide national aging policy over the next decade. Under the terms of P.L. 102–375, Congress specifically identified specific primary purposes for the White House Conference on Aging which include the increase of public awareness of the interdependence of generations and the essential contributions of older individuals to society for the well-being of all generations, and the identification of the problems facing older individuals and the commonalities of the problems with problems of younger generations.

On the same day that President Clinton was formally announcing the Conference in February of 1994, the White House Conference on Aging was holding its first local event in Tampa, Florida. In the ensuring months since then, the White House Conference on Aging has recognized approximately 600 pre-conference events in all 50 States. In addition, there have been 24 funded Mini-White House Conference on Aging events that have been issue specific. More than 13,000 individuals have attended pre-WHCOA events to date with approximately 75 percent being seniors.

There will be approximately 2,000 delegates participating in the 1995 White House Conference on Aging. The majority of these delegates are to be named by Members of Congress (one each) and by each Governor (in proportion to each State's

senior population). This number was decided by the FY 1994 appropriation and agreed to by the Policy Committee. These delegates will be focusing on issues of importance to seniors across the Nation, including health care, long term care, crime, independence, income security and retirement. These issues were decided as a result of public comments from a proposed list published in the October 12, 1994 Federal Register.

Upon adjournment of the 1995 White House Conference on Aging, a post-Conference implementation strategy will take effect to bring the recommendations from the Conference to the attention of lawmakers and the general public. It is hoped that the recommendations from this Conference will guide our rapidly growing senior population into the 21st century and beyond, and prepare the baby boomers for their retirement. On October 23, 1993, the President announced his intention to appoint an Executive Director for the White House Conference on Aging. Internal departmental activities are ongoing in preparing for the announcement of the Conference, and its planning, development, and implementation.

SECTION XI—FEDERAL COUNCIL ON THE AGING

I. Background

Authorized under Section 204 of the Older Americans Act, the Federal Council on the Aging (FCoA) is the citizen advisory agency within the executive branch of the Federal Government charged with advising and assisting the President on the special needs of older Americans.

Created under the 1973 amendments to the Act, the FCoA is comprised of 15 members, 5 of whom are appointed by the President, 5 by the U.S. Senate, and 5 by the U.S. House of Representatives. Council members serve 3-year terms and are chosen from among individuals with expertise in the field of aging who represent a diverse cross-section of rural and urban communities, national organizations with an interest in aging, business, labor, Indian tribes, minorities, and the general public. By statute, at least nine of the members must themselves be older persons.

Mandates of the FCoA include: advising the President on matters related to the special needs of older Americans; serving as spokespersons on behalf of older persons by making recommendations about Federal policies and programs; advising the Assistant Secretary for Aging on matters affecting the special needs of older individuals for services and assistance under the Older Americans Act; reviewing and evaluating policies to assess their effectiveness and to promote better coordination between and across government agencies; informing the public by conducting or commissioning studies and by issuing reports; holding public hearings and conducting or sponsoring conferences, workshops, and meetings; serving as appointees to the Advisory Committee of the White House Conference on Aging; and issuing an annual report to the President of its findings and recommendations.

II. Development of a Strategic Plan

In carrying out its mandate to comprehensively review and evaluate Federal policies and programs affecting older Americans, the FCoA developed a multi-year strategic plan. This plan is designed to advocate for the needs of older Americans and their families who are particularly vulnerable so that they are better able to lead productive and dignified lives.

The Council's plan was formulated on the following major objectives: Providing a voice for older persons and their families, with particular attention on frail persons in need of long-term care supports; compiling information on the special characteristics of older persons with mental health needs; developing strategies for protecting and assisting older individuals who are the victims of crime and abuse; generating recommendations for targeting assistance to persons living alone; examining the needs and characteristics of economically vulnerable older Americans; developing a series of informational materials and policy recommendations in the areas of health care, long-term care, mental health and aging, the Older Americans Act (with an emphasis on nutrition and elder abuse), and the 1995 White House Conference on Aging.

III. Quarterly Meetings

The FCoA is mandated to meet quarterly, at the call of the Chairman. With the appointment by the President of a new Chairman, Mr. John Lyle from Houston, Texas, the Council's meetings focused on developing and implementing a targeted strategy designed to make policy contributions to the White House, the Office of the

Assistant Secretary for Aging, the White House Conference on Aging, and other Federal agencies.

A. January 24 & 25, 1994.—The Council met in Washington, D.C. to participate in the "Health Care University" sponsored by the Administration on Aging. During this meeting, the Council undertook an extensive discussion of health care reform in general, and long-term care in particular. These discussions helped to lay the foundation for the development of an issue brief and series of policy recommendations on long-term care. The Council also met with the Assistant Secretary for Aging to share their thoughts and concerns on a number of issues, and to hold a constructive dialogue on future initiatives of the Administration on Aging and the Federal Council on the Aging.

B. April 27 & 28, 1994.—One of the major outcomes of this meeting was the unanimous approval of a book on mental health and aging to be developed in conjunction with the National Institute of Mental Health. The purpose of the publication, as discussed at the meeting, is to help educate health, behavioral, and social service practitioners in community mental health centers who have limited training in gerontology or mental health and aging. The publication is also designed to include strong recommendations as to what should be occurring in the country regarding mental health and aging.

The structure for a focused and multi-year action plan was developed, including: (1) preparing for the 1995 White House Conference on Aging; (2) improving the effectiveness of mental health assistance, particularly in community mental health centers; (3) advocating for long-term care with a focus on home- and community-based care; and (4) making recommendations related to the reauthorization of the Older Americans Act.

C. September 13 & 14, 1994.—This quarterly meeting was the first one convened under the newly appointed Chairman, John E. Lyle. The major focus of this discussion was participation in activities related to the White House Conference on Aging. Council members have participated in, or are scheduled to participate in nearly two dozen local, State, and regional conferences throughout the country. The Council also strongly urged the Assistant Secretary for Aging and the President that its members be appointed as delegates to the WHCoA in May 1995 and proposed a series of options for the Council to play a leadership role during and after the Conference. The Council strongly expressed its interest in working toward a strategy which seeks to follow through on enacting key recommendations arising from the Conference.

IV. Reports

A. 1993 Annual Report to the President. The Council distributed its twentieth annual report to the President. The report detailed information along two major themes. The first was examining issues and characteristics within the nation's diverse older population that are particularly critical to the most vulnerable and at-risk older persons. The second was to begin to develop background information on issues related to planning for the aging of the "baby boom" cohort and the next generation of older Americans. Issues covered in the report include: income security; health care; housing and living arrangements; older women; minority elders; mental health; and intergenerational perspectives.

B. Mental Health and Aging. In conjunction with the National Institute of Mental Health and the Center for Mental Disorders and Aging Research, the FCoA worked to prepare a book entitled: "Community-Based Mental Health Services/Behavioral Health Care for Older Persons." The purpose of this book is to help educate practitioners in community mental health centers and to provide a wide range of specific recommendations as to what should be occurring in the country regarding mental health and aging.

Chapters include: (1) an overview of aging and mental health; (2) psychopathology and treatment of the elderly; (3) assessment of the elderly; (4) psychopharmacology and the elderly; (5) health promotion; (6) dementia and the elderly; (7) caregiving; (8) ethics; (9) religion; (10) suicide; (11) special populations; (12) cost and financing of mental health services to the elderly; and (13) depression in the elderly.

V. Issue Briefs

A. "The Need for Home and Community-Based Long-Term Care: A Rural Perspective". This issue brief continued the Council's twenty year history of focusing on matters associated with the provision and delivery of long-term care. The purpose of the issue brief was to provide planners, policy makers, legislators, and delegates to the White House Conference on Aging with a summary overview of some key characteristics and factors surrounding the need for long-term care assistance in

rural areas, to develop a series of policy recommendations, and to highlight many of the important areas where more information is needed.

Its major conclusion is that rural elders and their families are significantly less likely than their urban counterparts to have access to a range of community-based, long-term care assistance. This lack of options tends not only to place increased burdens on rural families and caregivers, but also has serious implications for taxpayers. Rural elders were found to be more likely to reside in nursing homes when they may not need 24-hour nursing. Medicaid picks up the tab for this assistance once an individual's resources are depleted.

The Council pointed out that with the aging of the nation's rural population, consideration will need to be given to developing a comprehensive strategy for addressing this growing need before it increasingly overburdens families, caregivers, and taxpayers. Its major policy recommendations included: (1) health care reform which includes long-term care assistance is crucial; (2) a support system that has a comprehensive range of choices and alternatives in rural as well as urban areas; (3) a system to recognize the dignity of persons in need, promote independence in the least restrictive settings whenever possible, and recognize the diversity of States and communities by allowing flexibility of development.

B. Mental Health and Aging. The Council gathered background information for an issue brief to be released in early 1995 on the special mental health characteristics and needs of older persons. Specific policy recommendations were developed to inform and assist professionals in community mental health centers, policymakers, and the general public.

VI. Joint Partnerships

A. Coalition on Mental Health and Aging. The FCoA joined in partnership with the Mental Health and Aging Consortium to plan a mini-conference to the White House Conference on Aging pertaining to mental health and aging issues. The mini-conference is scheduled to take place in February 1995, and will focus on four general themes: (1) strengths and weaknesses in current research; (2) positive examination of mental health; (3) services and training needs; and (4) the question of parity between physical health and mental health. Outcomes are expected to include a series of research topics, a series of recommendations, and a set of video tapes that will be shared with people throughout the country.

B. Developments in Aging. The FCoA provided a section on issues and activities for the Senate Special Committee on Aging publication, "Developments in Aging." This report describes actions taken by the Congress and the Administration which are of particular relevance to older Americans. It also summarizes and analyzes Federal policies and programs that are of importance to older individuals and their families.

C. Administration on Aging's Initiative on Older Women.—The Council worked in partnership with the AoA to develop issues and activities related to its special initiative on older women, particularly the economic insecurity of present and future older women living alone.

D. White House Conference on Aging.—Council members participated in more than two dozen local events officially sanctioned by the White House Conference on Aging. The Council also: provided significant recommendations regarding the theme, structure, and issue priorities for the Conference; provided recommendations as a representative to the Advisory Committee; developed a proposal for a leadership role at the Conference in May; and urged the formation of a structure and action plan for working to implement and enact priority recommendations arising from the Conference. The Council developed a strategy for helping to assist with this process and provided specific policy recommendations to the President.

Background materials on long-term care, mental health and aging, and the Older American Act were prepared in order to be distributed to delegates at the Conference, as well as policymakers, the press, and other interested individuals.

VII. Resolutions and Recommendations

A. LONG-TERM CARE

The FCoA recognizes that health care reform is critically necessary for America.

A long-term care program must recognize the dignity of persons in need. To the extent feasible, it should promote independence in the least restrictive setting. It must recognize the diversity of States and communities and allow flexibility of development.

The Home and Community-Based Care program, as proposed in the Health Security Act, embodies the above principles. Therefore, the FCoA strongly endorses the Home and Community-Based Care provisions of the Health Security Act.

Rural long-term care delivery and accessibility issues are a growing national problem that need to be addressed in a comprehensive manner given the rapid growth of persons aged 85 and over. Health care reform which includes long-term care assistance is critical for addressing this growing need.

Consideration should be given to strategies which encourage the use of modern technology, such as telecommunications and telemedicine. Such systems have the potential for linking information and care between a patient, primary care physician, and a specialist at long distances.

Communication should be enhanced between States, area agencies on aging, and related service providers which encourage information sharing on innovative and cost-effective programs.

B. CAREGIVING

Policies and programs should be encouraged which assist in the formation of informal support groups designed to help alleviate the individual stress of family caregivers and which help to share caregiving responsibilities.

C. ANTI-FRAUD AND ABUSE PROVISIONS AND HEALTH CARE

The Council reviewed a recent report of the Special Committee on Aging which reveals that the current policies of Medicare, Medicaid, and private insurers have left their doors wide open to fraud, costing the health care system more than $100 billion yearly. The Council urged that immediate action be taken to strengthen the criminal laws and enforcement tools to stop fraud and abuse of the Nation's health care system, and that tough anti-fraud and anti-abuse provisions be build into the foundation of any health care reform enacted by the Congress.

D. SOCIAL SECURITY

The Council expressed its concern with a number of proposals by the Chairman of the Ways and Means Committee to reduce cost-of-living adjustments, increase taxation of beneficiaries, expedite the proposal to increase in the age at which persons can receive full Social Security benefits, and adjust the Social Security tax rate.

While understanding the need to address the long-term financing shortfalls projected by the Social Security Trustees, the Council expressed particular concern that these proposals had not been subjected to a national debate. A resolution was unanimously passed and sent to the President urging him to vigorously oppose these significant changes to Social Security unless there is opportunity for national debate on these issues to take place. The Council also expressed its concern that the Ways and Means Committee Chairman had unnecessarily alarmed many older persons in their communities through the unexpected manner in which the proposals were raised.

E. TRANSPORTATION

Federal policymakers should more aggressively pursue coordination of national policies affecting the provision of transportation services to older individuals, particularly frail persons.

Federal policy must review existing data on alternative modes of transportation services for rural communities. Since fixed route services are not always the most efficient in rural areas and demand/response is often too costly, alternatives such as service routes and volunteer services should be studied and encouraged if found to be cost-efficient.

State and Federal resources which are available for training and technical assistance in the transportation field should be actively marketed and utilized by the rural aging community, with support from the State and area aging network.

F. SPECIAL POPULATIONS

Greater attention and resources should be focused on gathering data and initiating outreach to particularly vulnerable subgroups of rural elders, such as persons living alone, individuals with health or mobility problems, the "old old," racial and ethnic minorities, and older women.

More resources should be provided to encourage the training of professionals and support of informal caregivers in rural settings.

The Council found that many Filipino veterans face critical problems such as a lack of adequate living arrangements, no health benefits, poor physical and mental

conditions, no financial assistance, a greater susceptibility to crime victimization, and increased separation anxieties from family members. In addition, the U.S. Government has denied Filipino World War II veterans the same status accorded to other U.S. veterans by denying them veterans benefits. The Federal Council on the Aging, by unanimous vote during its quarterly meeting in Washington, D.C., on September 13, 1994, recommended that a meeting be convened consisting of representatives from the Federal Council on the Aging, the Veterans Administration, the Immigration and Naturalization Service, and the Administration on Aging in order to seek coordinated strategies for addressing the problems faced by Filipino veterans.

PRESS RELEASES ISSUED BY THE ASSISTANT SECRETARY FOR AGING

10/07/93 Assistant Secretary for Aging and Secretary Shalala announced that Medicare will now pay for flu shots for older Americans.

10/22/93 Assistant Secretary for Aging announced that $65 million in relief contingency funds are being provided in nine States impacted by flooding this summer.

10/27/93 Assistant Secretary for Aging announces grants of $4.3 million for demonstration projects in the area of long-term care.

10/27/93 Assistant Secretary of Aging announces AoA's support of National Consumer's Week. (Also released in Spanish)

10/27/93 Assistant Secretary for Aging announces an award to the Institute of Medicine to conduct a national effectiveness study of State Long Term Care Ombudsman Programs.

10/29/93 Assistant Secretary for Aging announced that AoA has awarded grants totaling approximately $4.3 million for 13 demonstration projects in area of long-term care and four long-term care resources centers.

11/09/93 Assistant Secretary for Aging announces the FY 1994 appropriations for Older Americans Act programs.

11/10/93 Assistant Secretary for Aging joins the President in recognizing Veterans Day.

11/16/93 Assistant Secretary for Aging joins the President and Secretary Shalala in celebrating National Family Caregivers Week.

11/16/93 Assistant Secretary for Aging announces a $2.4 million contract to Mathematica Policy Research to evaluate the Administration on Aging's Nutrition Program for the Elderly.

11/16/93 Assistant Secretary for Aging joins the NIA and the Alzheimer's Association in recognizing November as National Alzheimer's Disease Month.

11/19/93 Assistant Secretary for Aging issues breast cancer awareness release (as it relates to older women).

11/24/93 Assistant Secretary for Aging joins the Secretary in celebrating November as National American Indian Heritage Month (as it relates to Indian elders).

12/01/93 Assistant Secretary for Aging joins the Department in recognizing December 1, 1993, as World AIDS day (as it relates to older Americans).

12/09/93 Assistant Secretary for Aging issues a special warning about hypothermia.

12/09/93 Assistant Secretary for Aging joins the Secretary and President in recognizing December as National Drunk and Drugged Driving Prevention Month (as it relates to older Americans).

01/21/94 Assistant Secretary for Aging will convene the U.S. Administration on Aging's Health Care University (as it relates to older Americans).

01/29/94 Assistant Secretary for Aging announced that DHHS is making available almost $28 million to respond to earthquake-related needs at HHS-supported facilities in the Los Angeles area.

01/31/94 Assistant Secretary for Aging announced that AoA is providing $100,000 in immediate disaster relief assistance to the California Department of Aging (as it relates to older Americans).

02/01/94 Assistant Secretary for Aging announces grants totaling $449,997 in the area of supportive services in federally assisted housing.

02/07/94 Assistant Secretary for Aging joins Secretary Shalala in announcing the AoA Budget for FY 1995.

02/17/94 Assistant Secretary for Aging will present keynote address at the Colorado Department of Social Services Aging and Adult Services Leadership Symposium: "Planning for the 21st Century."

01/18/94 Assistant Secretary for Aging announces grants totaling $500,000 to the University of Colorado and the University of North Dakota to establish and conduct two National Resource Centers for Older Indians, Alaskan Natives and Native Hawaiians.

4/14/94 Assistant Secretary for Aging will address Russian delegates attending a training Institute on Aging in the United States on "The History of Social Welfare in the United States".

May 1994 Aging America: Priority Initiatives of the Administration on Aging.

05/06/94 Assistant Secretary for Aging joins Commissioner of Social Security, Assistant Secretary of Labor for Pension and Welfare Benefits, and the Women's Pension Policy Consortium to launch a campaign to promote public awareness of the critical importance of pensions (as it relates to older women).

05/06/94 Betty Friedman to receive Older Americans Month Award.

05/13/94 Assistant Secretary for Aging announces the availability of AoA's discretionary program funds for FY 1994.

05/13/94 Assistant Secretary for Aging announces the honoring of four individuals as recipients of the first annual Older Americans Month Congressional Award.

05/23/94 Assistant Secretary for Aging will convene the first annual Administration on Aging Media Roundtable.

06/01/94 Assistant Secretary for Aging joins the President and the Nation in recognizing the 50th anniversary of the D-Day invasion.

06/07/94 Assistant Secretary for Aging announces the collaboration with NIH in support of research and research-related activities to study and improve the delivery of health and social services to the elderly.

06/23/94 Assistant Secretary for Aging announces the signing of two Interagency agreements between AoA and ASPE to support research, development and evaluation activities to benefit older Americans.

07/14/94 Assistant Secretary for Aging joins NIA, Department of Veterans Affairs, and the American Lung Association in a nationwide fight against pneumonia.

07/25/94 Assistant Secretary for Aging announces the release of $160,000 in disaster relief funds to aid elderly victims in Arkansas.

07/15/94 Assistant Secretary for Aging will address the National Council of LaRaza (NCLR) Hispanic Senior Citizens Day Opening Plenary Session.

07/19/94 Assistant Secretary for Aging pays tribute to the fourth anniversary of the enactment of the Americans with Disabilities Act (ADA).

08/22/94 Assistant Secretary for Aging will address National White House Conference on Indian Aging.

08/06/94 Assistant Secretary for Aging joins the Nation in celebrating National Grandparenting Day.

09/15/94 Assistant Secretary for Aging announces Elder Abuse Study to be conducted by AoA and ACF.

09/20/94 Assistant Secretary for Aging will receive the Claude Pepper Award.

09/23/94 Secretary Shalala to kick off AoA's Celebration of Older Women.

09/29/94 AoA/HUD joins forces on behalf of Elderly and Disabled.

TABLES AND CHARTS

TABLE 1. TITLE III–B Composition of Persons Served, Selected Categories (Not mutually exclusive)

	Percent
Frail/Disabled	36
Low-Income Minority	12
Rural	30
Minority	19
Low Income	39

CHART 1

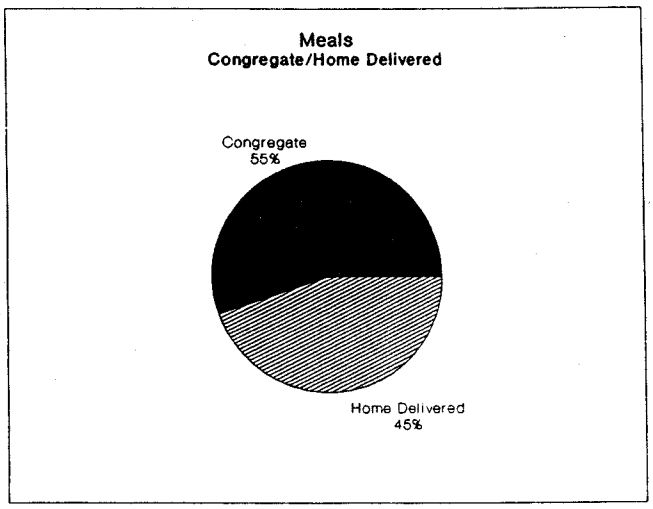

Meals
Congregate/Home Delivered
Congregate
55%
Home Delivered
45%

CHART 2

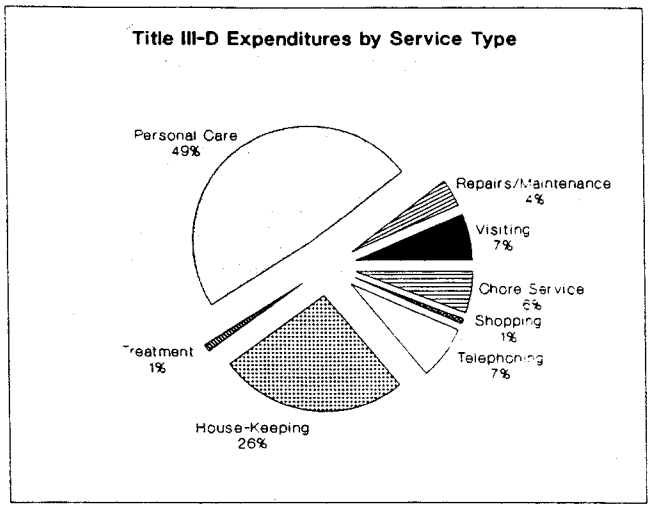
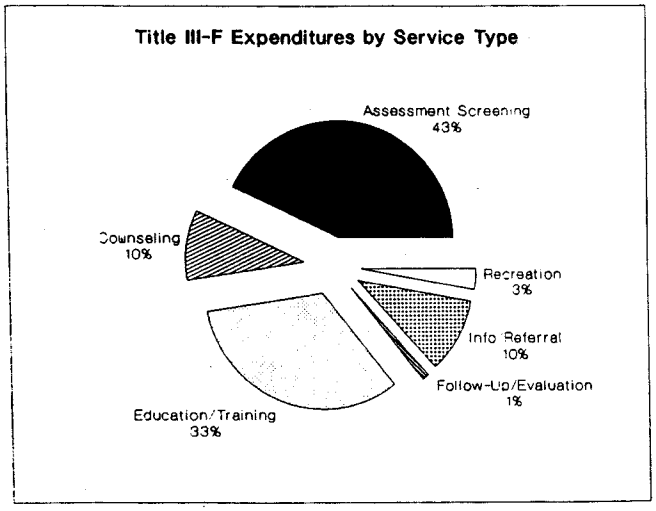


CHART 3



ADMINISTRATION FOR CHILDREN AND FAMILIES

TITLE XX SOCIAL SERVICE BLOCK GRANT PROGRAM

The major source of Federal funding for social services programs in the States is Title XX of the Social Security Act, the Social Services Block Grant (SSBG) program. The Omnibus Budget Reconciliation Act of 1981 (PL 97–35) amended Title XX to establish the SSBG program under which formula grants are made directly to the 50 States, the District of Columbia, and the eligible jurisdictions (Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands) for use in funding a variety of social services best suited to the needs of individuals and families residing within the State. Public Law 97–35 also permits States to transfer up to 10 percent of their block grant funds to other block grant programs for support of health services, health promotions and disease prevention activities, and low-income home energy assistance.

Under the SSBG, Federal funds are available without a matching requirement. In fiscal year 1994, a total of $2.8 billion was allotted to States. The same amount has been appropriated for these activities in fiscal year 1995. Within the specific limitations in the law, each State has the flexibility to determine what services will be provided, who is eligible to receive services, and how funds are distributed among the various services within the State. State and/or local Title XX agencies (i.e., county, city, regional offices) may provide these services directly or purchase them from qualified agencies and individuals.

A variety of social services directed at assisting aged persons to obtain or maintain a maximum level of self-care and independence may be provided under the SSBG. Such services include, but are not limited to adult day care, adult foster care, protective services, health-related services, homemaker services, chore services, housing and home maintenance services, transportation, preparation and delivery of meals, senior centers, and other services that assist elderly persons to remain in their own homes or in community living situations. Services may also be offered which facilitate admission for institutional care when other forms of care are not appropriate. Under the SSBG, States are not required to submit data that indicate the number of elderly recipients or the amount of expenditures provided to support specific services for the elderly. States are required, prior to the expenditures of funds under the SSBG, to prepare a report on the intended use of the funds including information on the type of activities to be supported and the categories or characteristics of individuals to be served. States also are required to report annually on activities carried out under the SSBG. Beginning with fiscal year 1989, the annual report must include specific information on the numbers of children and adults receiving services, the amount spent in providing each service, the method by which services were provided, i.e., public or private agencies, and the criteria used in determining eligibility for each service.

Based on an analysis of pre-expenditure reports submitted by the States for fiscal year 1992, the list below indicates the number of States providing certain types of services to the aged under the SSBG.

	Number of States [1]
Services:	
Home-Based Services [2]	46
Adult Protective Services	33
Transportation Services	26
Adult Day Care	28
Health Related Services	29
Information and Referral	30
Home Delivered/Congregate Meals	20
Adult Foster Care	11
Housing	15

[1] Includes 50 States, the District of Columbia, and the five eligible territories and insular areas.

[2] Includes homemaker, chore, home health, companionship, and home maintenance services.

In enabling the elderly to maintain independent living, most States provide Home-Based Services which frequently includes homemaker services, companion and/or chore services. Homemaker services may include assisting with food shopping, light housekeeping, and personal laundry. Companion services can be personal aid to, and/or supervision of aged persons who are unable to care for themselves without assistance. Chore services frequently involve performing home maintenance tasks and heavy housecleaning for the aged person who cannot perform these tasks.

Based on the FY 1992 data, 33 States provided Adult Protective Services to persons generally 60 years of age and over. These services may consist of the identification, receipt, and investigation of complaints and reports of adult abuse. In addition, this service may involve providing counseling and assistance to stabilize a living arrangement. If appropriate, Adult Protective Services also may include the provision of, or arranging for, home based care, day care, meal service, legal assistance, and other activities to protect the elderly.

In addition to the $2.8 billion in on-going funding for social services programs under title XX described above, the Act was amended in 1993 to authorize a total of $1 billion in funds for activities to be undertaken in communities that are designated as Empowerment Zones or Enterprise Communities by the Secretary of Housing and Urban Development and the Secretary of Agriculture. One billion dollars was appropriated for these activities in the Labor/HHS Appropriations Act for FY 1994. Two grants will be made to States for activities in each Empowerment Zone in the State—one on the day of the designation and the second on the first day of the following fiscal year. One grant will be made to States for each Enterprise Community. The initial grants will be made in FY 1995 and the remainder in FY 1996. No additional appropriations under this amended section of title XX are expected.

LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

The Low Income Home Energy Assistance Program (LIHEAP) is one of six block grant programs administered within the Department of Health and Human Services (HHS). LIHEAP is administered by the Office of Community Services (OCS) in the Administration for Children and Families.

LIHEAP helps low income households meet the cost of home energy. The program is authorized by the Omnibus Budget Reconciliation Act of 1981, as amended most recently by the Augustus F. Hawkins Human Services Reauthorization Act of 1990, the NIH Revitalization Act of 1993 (P.L. 103–43), and the Human Services Amendments of 1994 (P.L. 103–252). In fiscal year 1989, Congress appropriated $1.383 billion for the program. Congress appropriated $1.443 billion for LIHEAP in fiscal year 1990. In fiscal year 1991, Congress appropriated $1.415 billion plus a contingency fund of $195 million, which went into effect when fuel oil prices went above a certain level. For FY 1992, $1.5 billion was appropriated, plus a contingency fund of $300 million that would have been triggered if the President had declared an emergency and had requested the funds from Congress. Congress appropriated funding of $1,346,049,760 for FY 1993 and funding of $1,437,408,000 for FY 1994, of which $141,950,240 could be used by grantees to reimburse themselves for FY 1993 expenses. The FY 1994 appropriations act provided advance FY 1995 funds of $1.475 billion. The FY 1995 HHS appropriations act rescinded part of the advance FY 1995 appropriations included in the FY 1994 appropriations law, leaving funding of $1,319,204,000 for FY 1995. It also provided for advance FY 1996 funding of the same amount.

Block grants are made to States, territories, and eligible applicant Indian Tribes. Grantees may provide heating assistance, cooling assistance, energy crisis interventions, and low-cost residential weatherization or other energy-related home repair to eligible households. Grantees can make payments to households with incomes not exceeding the greater of 150 percent of the poverty level or 60 percent of the State's median income.[1] Most households in which one or more persons are receiving Aid to Families with Dependent Children, Supplemental Security Income, Food Stamps or need-tested veterans' benefits may be regarded as categorically eligible for LIHEAP.

Low income elderly households are a major target group for energy assistance. They spend, on average, a greater portion of their income for heating costs than other low income households. Grantees are required to target outreach activities to elderly or handicapped households eligible for energy assistance. In their crisis intervention programs, grantees must provide physically infirm individuals the means to apply for assistance without leaving their homes, or the means to travel to sites where applications are accepted.

In fiscal year 1993, about 35 percent of households receiving assistance with heating costs included at least one person age 60 or over, as estimated by the March 1993 Current Population Survey.

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[1] Beginning with fiscal year 1986, States are prohibited from setting income eligibility levels lower than 110 percent of the poverty level.

OCS is a member of the National Energy and Aging Consortium, which focuses on helping older Americans cope with the impact of high energy costs and related energy concerns.

No major program and policy changes for the elderly occurred in the 1990 or 1993 reauthorization legislation. The 1994 reauthorization legislation specifically allows grantees to target funds to vulnerable populations, mentioning by name "frail older individuals" and "individual with disabilities". No other new initiatives commenced in 1994 or are planned for 1995 that would impact on the status of older Americans.

THE COMMUNITY SERVICES BLOCK GRANT (CSBG) AND THE ELDERLY

I. Community Service Block Grant—The Community Service Block Grant Act (Subtitle B, Public Law 97–35 as amended) is authorized through fiscal year 1998. The Act authorizes the Secretary, through the Office of Community Services (OCS), an office within the Administration for Children and Families in the Department of Health and Human Services, to make grants to States and Indian tribes or tribal organizations. States and tribes have the authority and the flexibility to make decisions about the kinds of local projects to be supported by the State or tribe, using CSBG funds. The purposes of the CSBG program are:

(A) to provide a range of services and activities having a measurable and potentially major impact on causes of poverty in the community or those areas of the community where poverty is a particularly acute problem.

(B) to provide activities designed to assist low-income participants including the elderly poor—

(i) to secure and retain meaningful employment;

(ii) to attain an adequate education;

(iii) to make better use of available income;

(iv) to obtain and maintain adequate housing and a suitable living environment;

(v) to obtain emergency assistance through loans or grants to meet immediate and urgent individual and family needs, including the need for health services, nutritious food, housing, and employment-related assistance;

(vi) to remove obstacles and solve problems which block the achievement of self-sufficiency;

(vii) to achieve greater participation in the affairs of the community; and

(viii) to make more effective use of other programs related to the purposes of the subtitle,

(C) to provide on an emergency basis for the provision of such supplies and services, nutritious foodstuffs and related services, as may be necessary to counteract conditions of starvation and malnutrition among the poor;

(D) to coordinate and establish linkages between governmental and other social services programs to assure the effective delivery of such services to low income individuals; and

(E) to encourage the use of entities in the private sector of the community in efforts to ameliorate poverty in the community; (Reference Section 675(c)(1) of Public Law 97–35, as amended).

It should be noted that although there is a specific reference to "elderly poor" in (B) above, there is no requirement that the States or tribes place emphasis on the elderly or set aside funds to be specifically targeted on the elderly. Neither the statute nor implementing regulations include a requirement that grant recipients report on the kinds of activities paid for from CSBG funds or the types of indigent clients served. Hence, it is not possible for OCS to provide complete information on the amount of CSBG funds spent on the elderly, or the number of elderly, or the numbers of elderly persons served.

II. Major Activities or Research Projects Related to Older Citizens in 1994 and 1995—The Office of Community Services made no major changes in program or policy related to the CSBG program in 1994 and none is planned for 1995.

The Human Services Reauthorization Act of 1986 contained the following language: "each such evaluation shall include identifying the impact that assistance . . . has on . . . the elderly poor."

III. Funding Levels—Funding levels under the CSBG program for States and Indian Tribes or tribal organizations amounted to $385.5 million in fiscal year 1994. For fiscal year 1995, $391.5 million has been appropriated.

AGING AND DEVELOPMENTAL DISABILITIES PROGRAM

CRITICAL AUDIENCES PROJECT

Grantee: Institute for the Study of Developmental Disabilities, Indiana University

Project Director: Barbara Hawkins, Ph.D., (812) 855–6506; Fax (812) 855–9630
Project Period: 7/1/90–6/30/94, FY '90–$90,000, FY '91–$90,000, FY '92–$90,000, FY '93–$90,000, FY '94–$90,000
The project provides training in a late-life functional-developmental model for audiences that are critical to effective planning and care of older persons. Activities include developing training modules and instructional videos for interdisciplinary university credit courses, and illustrating the model by demonstration projects in community retirement settings.

CENTER ON AGING AND DEVELOPMENTAL DISABILITIES/CADD

Grantee: University of Miami/CADD, Miami, FL
Project Director: John Stokesberry, Ph.D., (305) 325–1043
Project Period: 7/1/90–6/30/94, FY '90–$90,000, FY '91–$90,000, FY '92–$90,000, FY '93–$90,000, FY '94–$90,000
CADD is providing education and training to service providers, parents and families; advocacy and outreach for consumers, information to the public on aging and developmental disabilities; networking, policy direction and community-based research. Materials will include a manual for parents/caregivers, a resource guide and a handbook on developing a peer companion project.

INTERDISCIPLINARY TRAINING CENTER

Grantee: UAP, Institute for Human Development, University of Missouri-Kansas City
Project Director: Gerald J. Cohen, J.D., M.P.A., (816) 235–1770; Fax (816) 235–1762
Project Period: 7/1/90–6/30/94, FY '91–$90,000, FY '92–$90,000, FY '93–$90,000, FY '94–$90,000
The Center addresses personnel preparation needs with a focus on administration, interdisciplinary training, exemplary services, information/technical assistance/research; and evaluation. Materials include training guide for aging, infusion models, inservice fellowship curriculum, resource bibliography, guide for training volunteers, and course syllabus.

TRAINING MODELS FOR RURAL AREAS

Grantee: Montana University Affiliated Rural Institute Disabilities, Missoula, MT
Project Director: Philip Wittekiend, M.S., (406) 243–5467; Fax (406) 243–2349
Project Period: 7/1/90–6/30/94, FY '90–$90,000, FY '91–$90,000, FY '92–$90,000, FY '93–$90,000, FY '94–$90,000
Montana's focus is on linking existing networks and expertise to meet the unique needs of a rural area with sparse populations and limited professional resources. The project will develop audio conference packages with simultaneous long distance training for remote areas and involve nontraditional networks such as churches and senior groups.

CONSORTIUM OF EDUCATIONAL RESOURCES

Grantee: UAP, University of Rochester Medical Center, Rochester, NY
Project Director: Jenny C. Overeynder, ACSW, (716) 275–2986; Fax (716) 256–2009
Project Period: 7/1/90–6/30/94, FY '90–$90,000, FY '91–$90,000, FY '92–$90,000, FY '93–$90,000, FY '94–$90,000
An inter-university interdisciplinary consortium of educational resources in gerontology and developmental disabilities is being established in western New York, to be linked to local and state networks. The project will develop and implement preservice and inservice education curriculum for direct care and nursing home staff.

AGING AND DEVELOPMENTAL DISABILITIES CLINICAL ASSESSMENT, TRAINING AND SERVICE

Grantee: Waisman Center UAP, University of Wisconsin-Madison
Project Director: Gary B. Seltzer, Ph.D., (608) 263–1472; Fax (608) 263–0529
Project Period: 7/1/90–6/30/94, FY '90–$90,000, FY '91–$90,000, FY '92–$90,000, FY '93–$90,000, FY '94–$90,000
Waisman Center operates an interdisciplinary clinic, provides training to health care and other professionals, and disseminates information and technical assistance to director care networks. Materials include a functional assessment instrument and curricula for medical students, geriatric fellows and physician assistants.

INTERDISCIPLINARY TRAINING MODELS (IDT)

Grantee: UAP, College of Family and Consumer and Consumer Sciences
Project Director: Zolinda Stoneman, Ph.D., (404) 542–4827; Fax (404) 542–4815
Project Period: 7/1/90–6/30/94, FY '91–$90,000, FY '92–$90,000, FY '93–$90,000, FY '94–$90,000

This project is using IDT models for graduate and undergraduate training; developing community-based internship and practicum sites; collecting audiovisual materials for dissemination; and providing information to the UAP regional information and referral service. Products will include training videotapes and modules, course materials, and radio program recordings.

TRAINING INITIATIVE IN AGING AND DEVELOPMENTAL DISABILITIES

Grantee: Institute for the Study of Developmental Disabilities, University of Illinois at Chicago
Project Director: David Braddock, Ph.D., (312) 413–1647
Project Period: 7/1/93–6/30/96, FY '93–$90,000, FY '94–$90,000, FY '95–$90,000, FY '96–$90,000

The project addresses *three priority areas* emerging from the UAP's research activities and clinical programs: (1) advocacy and futures planning for older adults with developmental disabilities and their families; (2) to maintain functioning and promote community inclusion for aging persons with cerebral palsy; and (3) to enhance the psychosocial well-being of aging persons with Down's Syndrome and bolster older families' caregiving efforts.

COMMUNITY MEMBERSHIP THROUGH PERSON-CENTERED PLANNING

Grantee: Eunice Kennedy Shriver Center, Inc., Shriver Center UAP
Project Director: Karen E. Gould, Ph.D., (617) 642–0238
Project Period: 7/1/92–6/30/95, FY '92–$89,999, FY '93–$89,999, FY '94–$89,999, FY '95–$89,999

The Center has two primary goals which are: (1) to implement a service delivery model that creates a new vision for individuals who are labeled "old" and "developmentally disabled" in Massachusetts, one in which entry into valued adult roles is expected and capacities and interests form the basis for structuring support; and (2) to provide training to persons with developmental disabilities, family members and friends, graduate students, professionals and community members so that they can develop the skills necessary to support community entry and inclusion in valued roles and relationships for older adults with developmental disabilities, and learn to use these skills in other settings.

A COLLABORATIVE INTERDISCIPLINARY TRAINING APPROACH TO IMPROVE SERVICES TO AGING PERSONS WITH DEVELOPMENTAL DISABILITIES

Grantee: Institute for Disability, University of Southern Mississippi
Project Director: Valerie M. De Coux, (601) 266–5163
Project Period: 7/1/93–6/30/96, FY '93–$90,000, FY '94–$90,000, FY '95–$90,000, FY '96–$90,000

The project develops a collaborative interdisciplinary training approach to meet pre-service, in-service, and consumer needs. Training of professionals and paraprofessionals occurs at both the pre-service and in-service levels and focuses on cross-network training in best practices which ensures an optimal quality of life for older persons with developmental disabilities.

NORTH DAKOTA PROJECT FOR OLDER PERSONS WITH DEVELOPMENTAL DISABILITIES

Grantee: North Dakota Center for Disabilities, Minot State University
Project Director: Dr. Rita Curl and Dr. Demetrios Vassiliou, (701) 857–3580
Project Period: 7/1/93–6/30/96, FY '93–$90,000, FY '94–$90,000, FY '95–$90,000, FY '96–$90,000

The project seeks to upgrade the training opportunities available to North Dakotans: (1) project staff works with pre-service geriatric programs to develop strong DD components; (2) project staff expands on an existing inservice training program to provide information on aging DD service provision; and (3) the project supports the development of training opportunities for secondary consumers and advocates.

INTERDISCIPLINARY TRAINING INITIATIVE ON AGING AND DEVELOPMENTAL DISABILITIES

Grantee: Graduate School of Public Health, University of Puerto Rico—Medical Sciences

Project Director: Dr. Margarita Miranda, (809) 758–2525, ext. 1453, (809) 754–4377

Project Period: 8/2/94–6/30/97, FY '94–$90,000, FY '95–$90,000, FY '96–$90,000, FY '97–$90,000

The project provides pre-service training including practical experience on best practices in serving the older population with developmental disabilities to three graduate and to three undergraduate students from different disciplines per year (from the second funding year on); provides culturally adapted inservice training to the Catano Family Health Center's interdisciplinary team and to at least 40 professionals in the aging service per year through the Graduate School and implementation of five regional Seminars on Aging and Development Disabilities throughout Puerto Rico.

TEAMING TO PROMOTE THE FULL INCLUSION OF AGING PERSONS WITH DEVELOPMENTAL DISABILITIES

Grantee: Hawaii Department of Health

Project Director: Ronald Quarles

Funding: FY '93–$99,243, FY '94–$109,243

This project identifies current issues in the care and development of aging persons with developmental disabilities in Hawaii (day care programs and services, senior programs, and family care givers). Project providers cross-training of personnel in integrated programs for aging persons. The project is undertaken cooperatively with the Hawaii Developmental Disabilities Council, State Executive Office of Aging, the Hawaii University Affiliated Program.

SUPPORTING CAREGIVERS: A DEMONSTRATION OF LINKAGES TO HELP OLDER CAREGIVERS OF FAMILY MEMBERS WITH A DEVELOPMENTAL DISABILITY

Grantee: New York State Developmental Disabilities Planning Council, Albany, NY

Project Director: Matthew Janicki, Ph.D., (518) 473–7855

Project Period: 10/01/93–9/30/95, FY '94–$99,751, FY '95–$99,878

A series of demonstration programs were established at the local level which model strategies for conducting outreach and coordinating services to older individuals with caretaker responsibilities for family members with a developmental disability. The project tests the feasibility of incorporating into daily practice at the area agency on aging, low-cost methods for conducting outreach, linking developmental disability agencies, and supporting family caregivers of adults with developmental disabilities.

COLLOQUIUM ON ALZHEIMER'S DISEASE AND MENTAL RETARDATION

Grantee: Research Foundation for Mental Hygiene (New York State Developmental Disabilities Planning Council, Albany, NY

Project Director: Matthew Janicki, Ph.D., (518) 473–7855

Project Period: 7/25/94–6/30/95, FY '94–$37,500

A project designed to convene a group of experts on aging, Alzheimer's disease and mental retardation to determine diagnostic criteria, epidemiology, and practice guidelines to be used by researchers, providers, and clinicians. Final products include a project report and a series of peer-reviewed journal articles on diagnostic criteria and practice guidelines on Alzheimer's disease and mental retardation to appear in the journals of the American Association for Mental Retardation and the International Association for the Scientific Study of Intellectual Disability and a consumer information booklet on Alzheimer's disease and developmental disabilities developed and published in conjunction with the New York State Developmental Disabilities Council.

HEALTH CARE FINANCING ADMINISTRATION

LONG-TERM CARE

The mission of the Health Care Financing Administration (HCFA) is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 70 million aged, disabled, and poor Americans.

Medicaid and Medicare are the principal sources of funding for long term care in the United States. The primary types of care reimbursed by these programs of HCFA are a variety of institutional (e.g., skilled nursing facilities (SNFs), intermediate care facilities for the mentally retarded (ICFs/MR), inpatient rehabilitation), and home and community-based care services.

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

RESEARCH ACTIVITIES

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

Assessing and evaluating long term care programs in terms of costs, effectiveness, and quality;

Examining the effect of the hospital prospective payment system (PPS) on subacute and long term care providers;

Examining alternative payment systems for long term care; and

Supporting data development and analyses.

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

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

Several research studies by ORD are examining the course and outcomes of post-hospital care. After the implementation of PPS, there was increased interest in the post-acute care area because the resulting shorter average hospital stays were expected to increase patients' post-acute care utilization. In addition, another purpose of funding this research was to gather information about decisionmaking at the point of hospital discharge and the types of patients who are referred to the various post-acute modalities of care. These research studies involve collection and analysis of data in order to provide Medicare payment, quality assurance, and coverage policy recommendations relating to subacute care (e.g., home health care, nursing homes, and rehabilitation hospitals).

Efforts are also underway to improve the data bases, statistics, and baseline information upon which future assessment of needs, problem identification, and policy decisions will be based. HCFA continues to support the National Long Term Care Survey, the Disability Supplement to the 1994 and 1995 National Health Interview Survey, the Medicare Current Beneficiary Survey, and the National Recurring Data Set project.

DEMONSTRATION ACTIVITIES

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

Alternative methods of service delivery for post-acute and long term care, focusing on service systems that integrate acute and long term care;

Alternative payment systems for post-acute and long term care services; and

Innovative quality assurance systems and methods.

In 1994, HCFA continued the operation of a major demonstration testing the effectiveness of community-based and in-home services for victims of Alzheimer's disease and other dementia. This project focuses on the coordination and management of an appropriate mix of health and social services directed at the individual needs

of these patients and their families. In 1994, HCFA also continued operation of a major demonstration aimed at testing prospective payment for Medicare home health agencies. This program is being conducted in two phases. The first phase involves testing of prospectively established per-visit payment rates for Medicare covered home health visits. A second phase, scheduled to begin in 1995, will test per-episode payment rates for an entire episode of Medicare covered home health services. Substantial effort also was devoted to the design and development of a multi-State demonstration program testing innovative case-mix payment and quality assurance methods for nursing homes that participate in Medicare and Medicaid. This project is scheduled to begin in 1995. ORD also continued work on several other major initiatives to test innovative reimbursement strategies to promote cost containment and foster quality of care. ORD has devoted extensive effort to the testing of capitated payment systems for a combination of acute and long term care services, including conducting and evaluating the demonstration of Social/Health Maintenance Organizations (Social HMOs) and conducting the Program for All-inclusive Care for the Elderly (PACE). The purpose of the PACE demonstration has the purpose of replicating a unique model of managed care service delivery for very frail community dwelling elderly, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. Work is continuing to develop a "second generation" model of the Social HMO that can be tested in a future demonstration. HCFA also awarded contracts to four community nursing organizations (CNOs) in 1992. This demonstration will test the feasibility and effect on patient care of a capitated, nurse-directed service delivery system. The CNO sites completed a 1-year developmental period and began a 3-year operational period in January 1994. HCFA also is working with United HealthCare Corporation, Inc. to implement the EverCare demonstration. This demonstration tests the effectiveness of managing acute care needs of nursing home residents by pairing physicians and geriatric nurse practitioners who will function as primary medical care givers and case manager. Payment is on a prepaid, capitated basis.

Information follows on specific HCFA research and demonstrations.

Community Nursing Organization Demonstration

Period: September 1992–September 1996

Contractors: See Below.

The purpose of the Community Nursing Organization (CNO) Demonstration is to develop and evaluate a nurse-managed health care delivery system that provides Medicare-covered home health services, ambulatory care services, and durable medical equipment, in addition to nurse case management, to eligible beneficiaries. Section 4079 of Public Law 100–203 directed the Secretary to conduct this demonstration at four or more sites. The authorizing legislation identified a package of mandatory services that each CNO has to provide. It also required that the demonstration have a capitated payment method modeled after the adjusted average per capita cost payment used with health maintenance organizations. Another provision of the legislation stipulated that an alternative capitation formula be implemented in at least one of the four sites. The participating organizations will assume full financial risk for the demonstration's mandatory service package. In addition to these services, CNOs may provide optional services such as homemaker/home health aide services. The project's evaluation will examine the feasibility and viability of a capitated nurse-coordinated service model.

Contractors:

Carle Clinic Association, 307 East Oak No. 3, Mahomet, IL 61853

Carondelet Health Services, Inc., Carondelet St. Mary's Hospital, 1601 West St. Mary's Rd., Tucson, AZ 85745

Living at Home/Block Nurse Program, Ivy League Place, Suite 225, 475 Cleveland Ave. North, St. Paul, MN 55104

Visiting Nurse Service of New York, 107 East 70th St., New York, NY 10021–5087

Four sites were awarded contracts on September 30, 1992. During the project's developmental year, these CNO sites established their operational protocols, marketing and enrollment plans, service delivery systems, and data collection plans. The 3-year operational phase of the demonstration began in January 1994 and sites expect to enroll 6,000 beneficiaries in the demonstration. Abt Associates Inc. was selected to evaluate the project and to provide technical assistance to the four CNO sites.

Evaluation of the Community Nursing Organizations Demonstration

Period: September 1992–February 1997

Funding: $2,414,634
Contractor: Abt Associates Inc., 55 Wheeler St., Cambridge, MA 02138–1168
Investigator: Robert Schmitz, Ph.D.

Section 4079 of Public Law 100–203 directs the Secretary of Health and Human Services to conduct a 3-year community nursing organization (CNO) demonstration designed to increase access to needed services as well as promote timely and appropriate service use. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services, in addition to nurse case management. The evaluation of the CNO demonstration will test the feasibility and effect on patient care of a capitated, nurse case-managed service delivery model. Both qualitative and quantitative components are included in the evaluation design. The qualitative component will use a case study approach to examine the operational feasibility and financial viability of the CNO model. The quantitative component will use a randomized design and assess patient-level impacts on such measures as mortality, hospitalization, physician visits, nursing home admissions, and Medicare expenditures.

The four CNO demonstration sites have undergone a 1-year developmental period and began a 3-year operational period in January 1994.

Social Health Maintenance Organization Project for Long-Term Care

Period: August 1984–December 1997
Grantees: See Below.

In accordance with Section 2355 of Public Law 98–369, this project was developed and is currently implementing the concept of a social health maintenance organization (Social HMO) for acute and long-term care. A Social HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the Social HMO at a fixed annual prepaid capitation sum. Four sites have been selected to participate in this project.

Of the four Social HMO demonstration sites selected, two are HMOs that have added long-term care services to their existing service packages and two are long-term care providers that have added acute care service packages. The demonstration sites utilize Medicare and Medicaid waivers, and all initiated service delivery by March 1985. During the first 30 months of operation, Federal and State governments shared financial risk with the sites. This risk sharing ended August 31, 1987. This demonstration was extended three times by legislation. The current legislation (P.L. 103–66) extends the demonstration period through December 31, 1997. The Social HMO sites are:

Elderplan, Inc.

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

Seniors Plus

Grantee: Health Partners, and Ebenezer Society, 8100 34th Avenue South, Minneapolis, MN 55440–1309

Medicare Plus II

Grantee: Kaiser-Permanente Center for Health Research, 3800 North Kaiser Center Drive, Portland, OR 97227–1098

SCAN Health Plan

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

Evaluation of the Social Health Maintenance Organization

Period: September 1985–July 1991
Funding: $3,533,396
Contractor: Institute for Health and Aging, University of California, San Francisco, 201 Filbert Street, San Francisco, CA 94133
Investigator: Robert Newcomer, Ph.D.

The social health maintenance organization (Social HMO) seeks to enroll, voluntarily, persons 65 years of age or over in an innovative prepaid program that integrates medical, social, and long-term care delivery systems. The Social HMO merges the health maintenance organization concepts of capitation financing and provider risk sharing developed by the Health Care Financing Administration under its Medicare capitation and competition demonstrations with the case management and support services concepts underlying the long-term care demonstrations serving the chronically ill aged, which are sponsored by the Department of Health and Human Services.

An interim report was forwarded to Congress in August 1988. A copy of the report, "Evaluation of the Social/Health Maintenance Organization Demonstration," may be obtained from the National Technical Information Service (NTIS), accession number PB89–215446. The evaluation and data collection plan for the demonstration is available from NTIS as a technical appendix and may be obtained by using accession number PB89–191779. The data collection phase has been completed. Data analysis has been completed and findings are under review. The following papers and book chapters have been published:

Harrington, C., Newcomer, R., and Moore, T. 1988. Factors that contribute to Medicare HMO risk contract success. *Inquiry,* 25(2):251–262.

Harrington, C., and Newcomer, R.J. 1990. Social health maintenance organizations as innovative models to control cost. *Generations,* 14(2):49–54.

Newcomer, R.J., Harrington, C., and Friedlob, A. 1990. Awareness and enrollment in the Social HMO. *The Gerontologist,* 30(1):86–93.

Newcomer, R.J., Harrington, C., and Friedlob, A. 1990. Social health maintenance organizations: Assessing their initial experience. *Health Services Research,* 25(3):425–454.

Harrington, C., and Newcomer, R.J. 1991. Social health maintenance organization service use and costs, 1985–1989. *Health Care Financing Review,* 12(3):37–52.

Harrington, C., Lynch, M., and Newcomer, R. 1993. Medical services in the social health maintenance organizations. *The Gerontologist,* 33(6):790–800.

Harrington, C., Newcomer, R., and Preston, S. 1993. A comparison of S/HMO disenrollees and continuing members. *Inquiry,* 30(4):429–440.

Manton, K.G., Newcomer, R., Vertrees, J., Lowrimore, G., and Harrington, C. 1993. Social health maintenance organization and fee-for-service health outcomes over time. *Health Care Financing Review,* 15(2):173–202.

Manton, K., Newcomer, R., Vertrees, J., Lowrimore, G., and Harrington, C. 1994. A method for adjusting capitation payments to managed care plans using multivariate patterns of health and functioning: The experience of social health maintenance organizations. *Medical Care,* 32(3):277–297.

Newcomer, R., and Harrington, C. 1994. Health plan satisfaction among S/HMO members and disenrollees, and Medicare beneficiaries in fee for service care. In *HMOs and other Health Care Systems for the Elderly* (Luft, H. ed), Health Administration Press.

Newcomer, R., Manton, K., Harrington, C., Yordi, C., and Vertrees, J. 1995. Case mix controlled service use and expenditures in the social health maintenance organization demonstration. *Journal of Gerontology: Medical Sciences,* forthcoming.

Three additional articles are under review. A second Report to Congress is being prepared, based on the published evaluation findings.

Site Development and Technical Assistance for the Second Generation Social Health Maintenance Organization

Period: September 1993–January 1998

Funding: $1,777,189

Contractor: University of Minnesota, School of Public Health, Institute for Health Services Research, Box 197, D–351 Mayo Memorial Building, 420 Delaware Street, SE, Minneapolis, MN 55455

Investigator: Robert L. Kane, M.D.

The Health Care Financing Administration is planning to implement a second generation Social Health Maintenance Organization (Social HMO) Demonstration. This project will refine targeting and financing methodologies and the benefit design of the current Social HMO demonstration. Under this contract, the University of Minnesota will provide technical assistance in the site selection, development, implementation, and operation of the second generation model.

Pre-award site visits were conducted during September 1994, and site selection is scheduled for January 1995. The second generation Social HMO will have a 1-year developmental phase. Organizations participating in the demonstration will offer Medicare beneficiaries the opportunity to receive a wide range of services including prevention and primary care, acute and post-acute care, and long-term care.

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

Period: November 1983–Indefinite

Grantee: On Lok Senior Health Services, 1333 Bush Street, San Francisco, CA 94109, and California Department of Health Services, 714–744 P Street, P.O. Box 942732, San Francisco, CA 94234–7320.

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

Section 9220 of Public Law 99–272 has extended On Lok's Risk-Based Community Care Organization for Dependent Adults indefinitely, subject to the terms and conditions in effect as of July 1, 1985, with exception of the requirements relating to data collection and evaluation.

Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly

Period: June 1990–March 1996

Grantees: See Below.

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

Elder Service Plan

Period: June 1990–May 1993 (yearly continuation)

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

Period: June 1990–May 1993 (yearly continuation)

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

Providence ElderPlace

Period: June 1990–May 1993 (yearly continuation)

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

Period: June 1990–May 1993

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

Comprehensive Care Management

Period: February 1992–January 1995 (yearly continuation)

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

Period: February 1992–January 1995 (yearly continuation)

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

Palmetto SeniorCare

Period: October 1990–September 1993 (yearly continuation)
Grantee: Richland Memorial Hospital, Fifteen Richland Medical Park, Columbia, SC 29203
Period: October 1990–September 1993 (yearly continuation)
Grantee: South Carolina State Health and Human Services Finance Commission, P.O. Box 8206, Columbia, SC 29202

Community Care for the Elderly

Period: November 1990–October 1993 (yearly continuation)
Grantee: Community Care Organization, 5228 W. Fond du Lac Avenue, Milwaukee, WI 53216
Period: November 1990–October 1993 (yearly continuation)
Grantee: Wisconsin State Department of Health and Social Services, P.O. Box 7850, Madison, WI 53707

Total Longterm Care, Inc.

Period: October 1991–September 1994 (yearly continuation)
Grantee: Total Longterm Care, Inc., 3202 West Colfax, Denver, CO 80204
Period: October 1991–September 1994 (yearly continuation)
Grantee: Colorado Department of Social Services, 1575 Sherman St., Denver, CO 80203

Bienvivir Senior Health Services

Period: June 1994–May 1995 (yearly continuation)
Grantee: Bienvivir Senior Health Services, 6000 Welch, Suite A–2, El Paso, TX 79905–1753
Period: June 1994–May 1995 (yearly continuation)
Grantee: Texas Department of Human Services, P.O. Box 149030, Austin, TX 78714–9030

Independent Living for Seniors

Period: April 1992–March 1995 (yearly continuation)
Grantee: Rochester General Hospital, 311 Alexander Street, Rochester, NY 14604
Period: April 1992–March 1995 (yearly continuation)
Grantee: New York Department of Social Services, 40 North Pearl St., Albany, NY 12243

Up to six additional sites will be phased in over the next 2 years. A contract to evaluate the PACE demonstration was awarded in June 1991. Presentations of the demonstration implementation and evaluation issues were given at the following national meetings: American Public Health Association and Gerontological Society of America annual meetings.

Evaluation of the Program for All-Inclusive Care for the Elderly Demonstration

Period: June 1991–February 1996
Funding: $4,486,514
Contractor: Abt Associates, Inc., 55 Wheeler St., Cambridge, MA 02138–1168
Investigator: Laurence Branch, Ph.D.

The Program for All-Inclusive Care for the Elderly (PACE) demonstration replicates a unique model of managed-care service delivery for 300 very frail community-dwelling elderly, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day health care and multidisciplinary team case management through which access to and allocation of all health and long-term care services are arranged. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. The purpose of the evaluation is to examine PACE sites before and after assumption of full financial risk, with the purpose of determining whether the PACE model of care, as a replication of the On Lok Senior Health Services model of care, is cost effective relative to the existing Medicare and Medicaid systems. Specific evaluation questions relate to the model of care and the effects of the model on participant utilization, expenditures, and outcomes.

Reports based on site visits have been received by the contractor, and primary data collection should begin in January 1995.

Managing Medical Care for Nursing Home Residents

Period: December 1992–December 1998
Funding: Waiver Only

Awardee: United HealthCare Corporation, Inc., P.O. Box 1459, Minneapolis, MN 55440–8001

Investigator: Jeannine Bayard

The objective of this demonstration is to study the effectiveness of managing acute care needs of nursing home residents by pairing physicians and geriatric nurse practitioners (GNPs) who will function as primary medical caregivers and case managers. The major goals of the demonstration are to reduce medical complications and dislocation trauma resulting from hospitalization and to save the expense of hospital care when patients could be managed safely in nursing homes with expanded services. The operating principal of this demonstration is EverCare, a subsidiary of United Health Care Corporation, Inc. EverCare will receive a fixed capitated payment (based on a percentage of the adjusted average per capita cost) for all nursing home residents enrolled and will be at full financial risk for the cost of acute care services for the enrollees. Nine demonstration sites are expected to participate, with each site enrolling approximately 300 persons. GNPs will provide initial assessments of enrollees; make monthly visits; authorize clinic, outpatient, and hospital visits; and communicate with the patients' physicians, nursing facility staffs, and families. Physician incentive plans will be structured to offer a higher reimbursement rate for a nursing home visit and a lower reimbursement rate for services furnished in physicians' offices or in other settings. By increasing the intensity and availability of medical services, Ever Care believes that the model will reduce total care costs; improve the quality of care received by participants through better coordination of appropriate acute care services; and improve the quality of life for and the level of satisfaction of enrollees, and their families.

Waivers were awarded in the summer of 1994, and EverCare is in the process of securing the appropriate State approvals for operating the nine targeted States. Work has entered on identifying payment methodologies for primary care physicians, identifying barriers to marketing approaches through the use of customer focus groups, and in interviewing staff for several target sites. Site operations are expected to begin early in 1995.

A Randomized Controlled Trial of Expanded Medical Care In Nursing Homes for Acute Care Episodes

Period: March 1992–August 1996

Funding: $1,054,007

Awardee: Monroe County Long Term Care Program, Inc., 349 West Commercial Street, Suite 2250, East Rochester, NY 14445

Investigator: Gerald Eggert, Ph.D.

The objective of this demonstration is develop, implement, and evaluate the effectiveness of expended medical services to nursing home residents who are undergoing acute illnesses, or deterioration in chronic ones, which would ordinarily require acute hospitalization. The intervention will include many services which are available in acute hospitals and which are feasible and safe in nursing homes. These include an initial physician visit, all necessary follow-up visits, diagnostic and therapeutic services, and additional nursing care including private duty if necessary. The major goals of the demonstration are to reduce medical complications and dislocation trauma resulting from hospitalization, and to save the expense of hospital care when a patient could be managed safely in the nursing home with expanded services.

Basic preparation for the implementation of the demonstration has been completed. The awardee is in the process of developing provider contracts and in negotiating necessary payments with nursing facilities. Implementation of the demonstration is expected in June 1995.

Nurse Practitioner/Physician Assistant Aggregate Visa Demonstration

Period: September 1990–September 1993

Funding: $130,538

Awardee: The Urban Medical Group, 545 D Centre St., Jamaica Plain, MA 02130

Investigator: Rita Change, Ph.D.

Under section 6114(e) of Public Law 101–239, the Medicare program provides Part B coverage to nursing home residents for medical visits rendered by nurse practitioners who are members of a physician/physician assistant/nurse practitioner team. Under this legislation, the number of visits supplied to any nursing home patient is limited to an average of 1.5 visits per month. Section 6114(e) mandates a demonstration project under which the visit limitation would be applied on an average basis over the aggregate total of residents receiving services from members of the provider team. A preliminary Massachusetts demonstration project, Case Managed Medical Care for Nursing Home Patients, used nurse practitioners and physi-

cian assistants to provide visits to nursing home patients. This demonstration ended on September 30, 1990. Many of the original Massachusetts demonstration sites are also participating in this section project.

The project was conducted in two phases. The first phase (primarily involving planning and development activities) was completed in March 1992. The second phase, which included the actual implementation and operation of the demonstration, was completed in March 1993. Although negotiations with the Medicare carrier, Massachusetts Blue Cross and Blue Shield, were concluded during the first phase, the grantee has experienced a great deal of difficulty in securing usable/clean data. A 6–month no-cost extension of the grant was provided (until September 29, 1993). However, as Massachusetts Blue Cross and Blue Shield was unable to provide corrected data until spring 1994, the project's final report was received in fall 1994.

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

Period: September 1989–September 1994

Funding: $4,444,674

Contractor: Institute for Health and Aging, University of California, San Francisco, Box 0646, Laurel Heights, San Francisco, CA 94134–0646

Investigator: Robert J. Newcomer, Ph.D.

The Medicare Alzheimer's Disease Demonstration was authorized by Congress under Section 9342 of Public Law 99–509 to determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive services to beneficiaries who have dementia. Two models of care are being studied under this project. Both provide case management and a wide range of in-home and community-based services, including homemaker and personal care services, adult day care, and education and counseling for family caregivers. The two models vary by the intensity of the case management beneficiaries and their families receive and the level of Medicare reimbursement that is available each month to pay for demonstration services. Clients are responsible for a 20-percent coinsurance just as they are under the regular Medicare program. There are four Model A and four Model B sites participating in this demonstration. Under Model A, each site has a case manager to client ratio of 1:100. Monthly client expenditure caps which have been adjusted for geographical cost variations range from $336 to $407. Model A sites are located in Memphis, Tennessee; Portland, Oregon; Rochester, New York; and Urbana, Illinois. The case management ratio in the Model B sites is 1:30 and their monthly expenditure caps are between $549 and $662. Model B sites are located in Cincinnati, Ohio; Miami, Florida; Minneapolis, Minnesota; and Parkersburg, West Virginia. Major questions to be addressed by the evaluation include:

What factors are associated with the cost effectiveness of providing an expanded package of home care and community-based services to Medicare beneficiaries with Alzheimer's disease or related disorders?

How do various services impact on the health status and functioning of dementia patients and their caregivers?

What are the effects of providing community-based services on caregiver burden and stress?

Do additional home care services delay or prevent institutionalization of beneficiaries with dementia?

A provision in the Omnibus Budget Reconciliation Act of 1990 extended the demonstration from 3 to 4 years. It also increased the funding for the project's administrative and service costs from $40 million to $55 million and for the evaluation from $2 million to $3 million. OBRA 93 extended the demonstration an additional year and increased funding for administrative and service costs to $58 million and funding for the evaluation to $5 million. During the first 2 years of the demonstration, the sites enrolled approximately 6,000 Medicare beneficiaries, including both treatment and control group members. However, there has been an unexpectedly high client attrition rate. Most of the individuals who have left the project have been disenrolled because of death or nursing home placement. The demonstration ended in November 1994. An interim report describing the initial project implementation phase has been send forward for submission to Congress. A final report indicating the project's findings and recommendations for possible legislative changes will be available in late 1995.

Special Care Managed-Care Initiative

Period: February 1992–February 1995

Funding: $652,270

Awardee: Wisconsin Department of Health and Social Services, 1 West Wilson Street, P.O. Box 309, Madison, WI 53701–0309

The purpose of the Special Care Initiative project is to gain improved understanding of the need, utilization, and cost of delivery of health services to high risk, severely disabled persons. The severely disabled population is a significant user of medical services. Moreover, costs since 1988 have increased at a rate double the rate of population increase. Therefore, an important objective is to contain the cost and utilization of Medicaid services of the severely disabled while maintaining or improving the level of client satisfaction. Special Care, Inc. (SCI), is an independent, nonprofit organization and represents a joint venture between a Milwaukee rehabilitation facility (the Milwaukee Center for Independence) and the Wisconsin Health Organization, an established HMO. SCI will create specialized services, including a dedicated physician's panel, case management services and clinical services as strategies to assess medical need and to better coordinate service resources available in the community. The State of Wisconsin will use a capitation methodology for reimbursement of SCI. Enrollment in SCI will be voluntary.

Service provision for this program began in June 1994. Enrollment will be phased in during the first year of operations beginning with approximately 100 recipients. In April 1994, a contract for the evaluation of the I Care Project was signed between the Department of Health and Social Services and Human Services Research Institute (HSRI). A site visit was conducted in June 1994, and a draft work plan is being developed.

MAINE–NET: Medicaid and Medicare Managed Care for the Elderly and Physically Disabled in Maine

Period: October 1994–September 1997

Funding: $944,940

Grantee: State of Maine Department of Human Services, State House Station #11, Augustus, ME 04333

Investigator: Carreen Wright, M.B.A.

This project is designed to demonstrate integrated models for the financing and delivery of managed health care and social services for Medicare and Medicaid elderly and physically disabled persons in Maine. The project seeks to promote the development of regional service delivery networks or health plans, particularly in rural areas of the State that would be responsible for the management, coordination and integration of services, including multi-disciplinary approaches to care planning and service delivery. The demonstration will provide a comprehensive package of primary, acute, and long term care (institutional and noninstitutional) services as part of a prepaid capitated health plan for the target populations. The demonstration will use and expand nursing home quality indicators developed in the HCFA-sponsored multiState Nursing Home Case Mix and Quality (NHCMQ) demonstration, and will incorporate HCFA's quality assurance guidelines for managed care plans. In addition, the project will develop and use an ADL-based case mix adjustment for long term care services in the construction of capitation payment rates, using the RUGs–III classification system also developed in the NHCMQ demonstration. For services provided in boarding homes and in the community, two new case mix methodologies will be developed for use in the demonstration. The project is in the early developmental stage.

Managed-Care System for Disabled Children and Youth with Special Needs

Period: August 1994–August 1995

Funding: $150,000

Grantee: Government of the District of Columbia, Commission on Health Care Finance, 2100 Martin Luther King Jr. Avenue, S.E., Suite 302, Washington, D.C. 20020

Investigator: A. Sue Brown

The District of Columbia submitted a request for section 1115 waivers, which will permit the District to implement a Medicaid managed-care initiative to serve approximately 3,600 children with disabilities and complex medical needs. A number of key issues within the waiver application required further development. For example, it was felt that the District needed to clearly identify: the service delivery network and clinical management systems, payment methodology and cost projections. As a result, the District was awarded a 12-month development grant for the project, during which the District will complete project development, followed by an application for section 1115 waivers required to implement the demonstration.

Community-Supported Living Arrangements Program: Process Evaluation

Period: September 1993–August 1996

Funding: $411,941

Contractor: SysteMetrics/MedStat, 104 West Anapamu Street, Santa Barbara, CA 93101

Investigator: Brian Burwell

The Community-Supported Living Arrangements (CSLA) program is designed to test the effectiveness of developing, under section 1930 of the Social Security Act, a continuum of care concept as an alternative to the Medicaid-funded residential services provided to individuals with mental retardation and related conditions (MR/RC) as an optional State plan service. The CSLA program services individuals with MR/RC who are living in the community either independently, with their families, or in homes with three or fewer other individuals receiving CSLA services. This model of care includes: personal assistance; training and habilitation services necessary to assist individuals in achieving increased integration, independence, and productivity; 24-hour emergency assistance; assistive technology; adaptive technology; support services necessary to aid these individuals in participating in community activities; and other services as approved by the Secretary of Health and Human Services. Costs related to room and board and to prevocational, vocational, and supported employment services are excluded from coverage. In accordance with the legislatively set maximum, eight States, California, Colorado, Florida, Illinois, Maryland, Michigan, Rhode Island, and Wisconsin, have implemented CSLA programs. The purpose of this contract is to provide an evaluation of the CSLA program to the Health Care Financing Administration's Medicaid Bureau and Congress for their consideration of policy options regarding the continuation and/or expansion of the Medicaid State Plan optional service. The evaluation will address five areas:

Philosophy or goals guiding States' CSLA programs.

A description of CSLA programs with respect to recipients, types of services received, and the cost of such services.

A description and discussion of quality assurance mechanisms being implemented.

An exploration of the question of compatibility of the supported living concept with current goals and the structure of the Medicaid program.

An exploration of the relationship between the supported living concept and the Americans with Disabilities Act.

The contract was awarded on September 30, 1993. As of September 1994, five of the eight site visits to the participating States have been conducted. The final evaluation report is due in February 1995.

Project Demonstrating and Evaluating Alternative Methods to Assure and Enhance the Quality of Long Term Care Services for Persons with Developmental Disabilities through Performance-Based Contracts with Service Providers

Period: September 1994–September 1997

Funding: $350,000

Grantee: Minnesota Department of Human Services, Health Care Administration, 44 Lafayette Road, St. Paul, MN 55155–3853

Investigator: Helen M. Yates

The purpose of this project is to determine whether and how well the implementation of new approaches to quality assurance, with outcome-based definitions and measures of quality, will replace the input and process measures of quality and in the process contribute to improving quality of life for persons with developmental disabilities. The Minnesota Department of Human Services will seek Federal authority to waive necessary provisions of intermediate care facilities for the mentally retarded (ICFs/MR) regulations to permit alternative quality assurance mechanisms in selected demonstration, residential, and support service programs. The Department will enter into performance-based contracts with counties, and participating ICF/MR providers. These contracts will specify the amount and conditions of reimbursement, requirements for monitoring and evaluation, and expected client-based outcomes. These will be determined by the client and by the legal representative, if any, and with the assistance of the county case manager and provider. Desirable outcomes include (among others) the enhancement of consumer choice and automony, employment, and integration into the community. Criteria for measuring participating agency achievement will be drawn from, but not limited to, outcome standards developed by the National Accreditation Council for Services for Persons with Developmental Disabilities; the "values experiences" of Frameworks for Accomplishments; and the goals established in Personal Futures Plans, Essential Lifestyle, and person-centered planning. According to the proposed quality assurance framework, monitoring and the individual outcomes will be done jointly among family members, case managers and other members of the local review team on a quarterly basis. This project is in the development stage.

Development of Outcome-Based Quality Assurance Measures for Small, Integrated Services Settings.

Period: July 1994–July 1995

Funding: $22,750

Contractor: The Accreditation Council, 8100 Professional Place, Suite 204, Landover, MD 20785

Investigator: James Gardner, Ph.D.

The purpose of this contract is to determine the cost of applying outcome measures in small, integrated service settings. This study will provide a data base to maintain information on quality reviews of organizations that serve people with disabilities, an analysis of individual and organizational variables that relate to desirable outcomes, and a final report which analyzes quality reviews conducted in accordance with the Outcome-Based Performance Measures developed by the Accreditation Council on Services for People with Disabilities. The results of this study will be used to assess the quality of services in facilities serving people with chronic mental illness, physical challenges, and mental retardation in diverse settings such as supported independent living or intermediate care facilities for the mentally retarded. Of particular importance is the assessment of the extent to which Outcome Based Performance Measures can coexist with the traditional quality assurance variables such as abuse, neglect, safety, health and physical and psychological welfare.

A workplan was developed in August 1994. The data collection forms and instructions for data collection were developed, refined, and field tested in September 1994.

Texas Nursing Home Case-Mix Demonstration

Period: September 1987–April 1994

Funding: $532,830

Awardee: State of Texas Department of Human Services, P.O. Box 149030 (MC–E–601), Austin, TX 78714–9030

Investigator: Ken C. Stedman

This Texas Department of Human Services project has two parts. The first part was to develop, implement, and evaluate a Medicaid prospective case-mix payment system. The payment system is based on feasibility studies sponsored by the Health Care Financing Administration (HCFA). The major Medicaid objectives of this part of the project are to:

Match payment rates to resident need.

Promote the admission of heavy-care patients to nursing homes.

Provide incentives to improve quality of care.

Improve management practices.

Demonstrate administrative feasibility of the new system.

The second phase of the project is to develop and pilot test a case-mix adjusted prospective payment system for Medicare patients in skilled nursing facilities. The objective for the Medicare pilot test is to develop and implement the administrative processes for a Medicare prospective payment system in four facilities based on a resource utilization group (RUG) classification. The index that will be used for the classification of Medicare patients is the RUG–T18, which uses the same clinical groups and the activities of daily living (ADL) scale used in the New York RUGs II system. The difference occurs in the expanded rehabilitation groups for Medicare patients. Texas will use a quasi-experimental design for the Medicare pilot test to compare the effect of introducing case-mix payment in an experimental catchment area versus continuing the flat-rate, cost-based system in a control catchment area. The State is using a pre-post design for the Medicaid system.

The case-mix classifications are based on a review of six different systems in which the New York RUGs II explained the greatest variance of staff time. The case-mix indexes borrow major elements of the RUGs II system and some of the rationale from the Minnesota system. The Texas index of level of effort (TILE) uses four clinical groups to form clusters and develop subgroups using an ADL scale. Two third-party evaluations will be conducted—one of data reliability and a second of the validity of the data analysis methods.

During the first year, the TILE and RUG–T18 indexes were reviewed for compatibility. The Medicaid payment system became operational statewide under the Texas Medicaid State plan in April 1989. As of the end of the Medicaid part of the project in fall 1992, over 102,000 Medicaid recipients had been a part of the demonstration. An evaluation data base consisting of the Medicaid Client Assessment, Review, and Evaluation (CARE) claims documents for the 102,000 recipients with at least 3 assessments is being used for the evaluation of the demonstration. Medicare waivers were approved, and the Medicare pilot test was implemented in three Austin area nursing homes in November 1992 for a period of 18 months.

At the time of their 1991 Federal certification survey, the pilot test facilities had 59 Medicare Part A covered residents. Cost analyses of both national and State samples of Medicare providers were performed to arrive at baseline costs for calculating the rates for the RUG–T18 groups. The modified patient assessment instrument, the MDS plus, that was developed for the multistate Nursing Home Case-Mix and Quality (NHCMQ) demonstration will be used for Medicare classification. In the Medicare pilot, a nurse has reviewed new admissions weekly onsite to classify residents into the RUG–T18 groups and to give prior authorization of the Medicare stays for specific time intervals. The interrater reliability of the project nurse and the facility nurses has been excellent. A paper entitled "Texas Medicare Case-Mix pilot Study," which describes the pilot test and data reliability processes, has been prepared. The lessons learned from this pilot will be used in the implementation of the NHCMQ demonstration.

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

Period: June 1988–August 1993

Funding: $925,389

Awardee: Center for Health Systems Research and Analysis, University of Wisconsin-Madison, Room 1163, WARF Office Bldg., 610 Walnut Street, Madison, WI 53705

Investigator: David Zimmerman, Ph.D.

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

Convert reimbursement data into specific QCIs.

Identify the Federal regulations for which the use of QCIs has the greatest potential benefit.

Develop and demonstrate in one State (Wisconsin) procedures for providing QCIs to survey staffs.

Assess the potential for implementing the system in other States.

Develop a set of quality indicators (QIs), using resident assessment information, sometimes in combination with claims data, that can be used in the survey process as part of The Multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration.

A program was implemented on December 1, 1990, in which a randomly assigned group of survey teams in two Wisconsin regions were provided information on 33 QCIs for each nursing facility prior to the survey. Surveyors used the QCI information in selecting residents for indepth review and in determining whether care deficiencies should be cited. The surveyors completed and returned a feedback report that documented the results of QCI residents' investigations. Through November 1991, QCIs were used in approximately 120 surveys, in addition to the 17 surveys in which they were used in a pilot study. The quality monitoring information system has been pilot tested, and quality indicators for 12 quality of care domains have been revised. Wisconsin produced a training manual for the four States in the pilot test, as well as an overview of the proposed QIs and the process for using these QIs in the Federal nursing home survey process. These are available for distribution. The final report covering the QCIs which use Medicaid claims data and the QIs which use minimum data set information has been submitted.

Multistate Case-Mix Payment and Quality Demonstration

Period: May 1990–June 1996

Funding: $98,718

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

Investigator: David Wilcox

New York State will participate in the multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration presently in its development phase. The objective of the demonstration is to test the feasibility and cost effectiveness of a case-mix payment system for nursing facility services under Medicare and Medicaid that are based on a common patient classification system.The addition of New York to the demonstration enhances the Health Care Financing Administration's ability to project the results of the demonstration on a national basis. New York represents

a heavily regulated, northern industrialized area with larger, high-cost nursing facilities that are medically sophisticated and highly skilled Sixteen percent of the national Medicare skilled nursing facility days are incurred in New York State. New York is uniquely suited for inclusion in this demonstration because it has already implemented a complementary system for its Medicaid nursing facility payment program.

In early 1991, project staff completed the minimum data set field tests in 25 facilities on 993 residents. These data have been added to the data base analyzed to develop the new NHCMQ Medicare Medicaid classification system. The inclusion of the New York data has resulted in the addition of a very high rehabilitation group to the upper end of the classification. The State has implemented the minimum data set plus (MDS+) statewide as their resident assessment instrument. In November 1992, the State began receiving the information monthly from all facilities; by October 1, 1993, they had received a total of 397,040 assessments. The State has conducted analyses of 1990 Medicare Cost Report data and Medicare provider analysis and review Part A skilled nursing facility stay data. The New York patient review instrument data also were used in estimating the average facility case-mix for the design of the Medicare case-mix payment system. The Medicare portion of the demonstration is expected to become operational in 1995.

The Multistate Nursing Home Case-Mix and Quality Demonstration

Project Nos.:
Kansas, 11–C–99366/7
Maine, 11–C–99363/1
Mississippi, 11–C–99362/4
South Dakota, 11–C–99367/8
Period: June 1989–June 1995
Funding: $5,322,941
Awardees: State Medicaid Agencies

This project builds on past and current initiatives with case-mix payment and quality assurance. The 6-year demonstration will design, implement, and evaluate combined Medicare and Medicaid system in four States—Kansas, Maine, Mississippi, and South Dakota. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The new minimum data set plus (MDS+) for resident assessment will be used for resident care planning, payment classification, and quality monitoring systems. The project consists of three phases: systems development and design, systems implementation and monitoring, and evaluation.

The project has conducted a field test of the minimum data set on 6,660 nursing home residents. The average direct-care staff time across the States is 115 minutes per day per resident. A new patient classification system and a Medicare/Medicaid Payment Index (M^3PI) containing 44 groups has been created. The States implemented the MDS+ in fall 1990 with the approval of the Health Standards and Quality Bureau. A 35-group variation was approved in January for the Medicaid portion of the demonstration in Mississippi and South Dakota. The variation collapse the 12 rehabilitation groups into three groups split only on the project's activities of daily living (ADL) index. The States have collected and reviewed over 600,000 MDS+ documents on over 200,000 different residents assessed between September 1990 and July 1993.

In preparation for developing the payment systems for the demonstration, the resident characteristic data and facility cost reports are being analyzed to determine the case-mix of residents and patterns of service utilization. All of the participating states have implemented their Medicaid payment systems, and the Medicare case-mix-adjusted payment system will be implemented in early 1995. The quality monitoring information system has been pilot tested, and 30 quality indicators have been developed for facility-level and resident-level quality monitoring.

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

Period: September 1989–September 1993
Funding: $3,097,982
Contractor: The Circle, Inc., 8201 Greensboro Drive, Suite 600, McLean, VA 22102
Investigator: Robert Burke, Ph.D.

This 4-year contract has supported the design phase of The Multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration. The demonstration combines the Medicare and Medicaid nursing home payment and quality monitoring system across several States—Kansas, Maine, Mississippi, New York, South Dakota and Texas. This project builds on past and current initiatives with nursing home case-

mix payment and quality assurance in nursing homes. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of process and outcomes adjusted for case mix. The project will have three phases:

Systems design and development.
Systems implementation and monitoring.
Evaluation.

The classification system to be used across the demonstration States for Medicare and Medicaid was completed in June 1991 by researchers from The University of Michigan and Rensselaer Polytechnic Institute. The resource utilization groups, version III (RUG–III) uses 44 groups to explain approximately 45 percent of the variance in nursing staff time and 52 percent of the costs across nursing, occupational therapy, physical therapy, speech pathology, transportation, and social work services. The RUG–III groups are split on clinical conditions, including signs and symptoms of distress, type and intensity of service, and activities of daily living. The 27 groups at the top of the classification match the Medicare coverage criteria. A working paper entitled "Description of the Resource Utilization Group, Version III (RUG–III)," which describes the classification, is available from the Division of Long Term Care Experimentation. The common assessment tool, the minimum data set plus (MDS+), has been developed and implemented as the State resident assessment instrument in the demonstration States: Feldman, J., and Boulter, C., eds.: *Minimum Data Set Plus (MDS+). Multistate Nursing Home Case Mix and Quality Demonstration Training Manual.* Natick, MA. Eliot Press, 1991.

A coordinated effort has been undertaken to develop the State-specific Medicaid payment systems. Four Medicaid systems have been completed and are being implemented at the present time. The analysis of 1990 Medicare cost reports and 1990 case-mix data to develop the Medicare payment design is completed. A working paper entitled "Issue Paper on Development of Medicare SNF Payment Rates" has been developed and distributed to persons working on the payment system design. The Medicare payment system portion of the demonstration is expected to be approved for implementation in early 1995.

Under a subcontract with Allied Technology, the University of Wisconsin's researchers have completed the development of a preliminary list of 30 facility-level quality indicators (QIs) that were used in a 4-State pilot test. They were reviewed by expert surveyors from the 6 States, a research-oriented quality panel, and a clinical workgroup of 60 health professionals representing about 15 disciplines working in long term care. A working paper entitled "Description of the Quality Indicators and System for Using Them in the Nursing Home Survey Process" has been developed and distributed to persons interested in the demonstration. The QIs will serve to enhance the quality assurance process to be used for the operational phase of the demonstration. The final set of QIs will be implemented demonstration wide in 1995. The final report of the technical design of the Multistate NHCMQ Demonstration was received in January 1994. The products of the design phase of the demonstration include several software programs.

Implementation of the Multistate Nursing Home Case Mix and Quality Demonstration

Period: February 1994–July 1996

Funding: $3,209,538

Contractor: Allied Technology, Group, Inc., 1803 Research Boulevard, Suite 601, Rockville, MD 20850

Investigator: Robert E. Burke, Ph.D.

This contract will support the implementation of the multistate Nursing Home Case Mix and Quality (NHCMQ) demonstration. The demonstration combines the Medicare and Medicaid nursing home payment and quality monitoring systems across several States: Kansas, Maine, Mississippi, New York, South Dakota, and Texas. This project builds on past and current initiatives with case mix payment and quality assurance in nursing homes. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of process and outcomes adjusted for case mix. Implementation of the Medicare prospective case mix adjusted system and quality monitoring system is projected to begin January 1994. Implementation of the Medicaid payment system was phased in across States beginning in July 1993.

Evalution of the Nursing Home Case Mix and Quality Demonstration

Period: September 1994–September 1999

Funding: $2,980,219

Contractor: Abt Associates Inc., 55 Wheeler Street, Cambridge, MA 02138–1168

Investigator: Robert J. Schmitz, Ph.D.

Through the Nursing Home Case Mix and Quality (NHCMQ) demonstration, the Health Care Financing Administration is investigating the feasibility of paying skilled nursing facilities (SNFs) on a prospective basis. Currently, SNFs are retrospectively reimbursed for their reasonable costs. The facility's prospective payment is intended to approximate the actual costs of residents' care. Though some costs will continue to be paid on a retrospective basis, the prospective rate will include inpatient routine nursing costs and therapy costs. In addition, quality indicators (QIs) will be derived from resident assessment data and will be used to assess the relative performance of participating facilities. The evaluation will analyze facility responses to the demonstration intervention and will assess the usefulness of the QIs in the State survey and certification process. This project is in the early developmental stage.

Validation of Nursing Home Quality Indicators

Period: July 1992–July 1995

Funding: $788,808

Awardee: SysteMetrics/McGraw Hill, 104 West Anapamu Street, Santa Barbara, CA 93101

Investigator: Tamra Lair, Ph.D

This project is a continuation of a cooperative agreement to investigate the usefulness of claims data from Medicaid and Medicare administrative record systems as sources of nursing home quality of care measures. The previous study involved retrospective analysis of 1987 Medicare and Medicaid claims data and facility deficiency data from two States. The goal of this project is to further the development of an automated quality assurance system using Medicare and Medicaid claims data to provide continuous monitoring of the quality of care rendered to Medicaid recipients in long term care facilities. The objective of this study is to validate the resident level claims-based quality of care indicators (QCIs) by: recomputation of the claims-based indicators for two States using data from 1990; physician and nurse examination of medical records for a sample of residents in a sample of nursing homes from the above States; and establishment of the relationship of the QCIs to deficiencies cited and adverse outcomes.

The project has developed preliminary QCIs and is refining these indicators for continuing analysis.

Use of Long Term Care Services by Mentally Ill Persons

Period: September 1994–September 1996

Funding: $201,938

Grantee: Center for Health Policy Research and Evaluation, Institute for Policy Research and Evaluation, Pennsylvania State University, Office of Sponsored Programs, 110 Technology Center, University Park, PA 16802

Investigator: Dennis Shea, Ph.D.

Recent regulatory policies addressing mental health care in nursing homes and current debate on the role of long term care and mental health care reform have ignored the connections between the two. The significant physical and mental comorbidity among younger and older mentally ill persons links the two however. To understand the impact of policy and regulations on nursing homes, nursing home residents, and mentally ill persons, the long term care service use by mentally ill persons will be examined. The first project objective is to describe the patterns of nursing facility use by persons with a mental illness, including admission and discharge, use of services while in a nursing facility, length of stay, and expenditures. The second objective is to analyze individual, facility and systemic determinants of the use of nursing facilities and other services—especially psychiatric and psychological services—by persons with mental illness. The ultimate goal of the research is to provide a complete description and analysis of the long term care service use patterns of persons with mental illness, adding to our understanding of the likely impact of current policy and future policy changes on the service use of this special population. This project is in the developmental stage.

Changing Roles of Nursing Homes

Period: September 1994–September 1997

Funding: $199,478

Grantee: Institute of Gerontology, University of Michigan, 300 North Ingalls Building, Room 900, Ann Arbor, MI 48109–2007

Investigator: Brant Fries, Ph.D.

Over the past two decades, the role of nursing homes in caring for the elderly and disabled has changed. While considered primarily custodial in the mid-1970's, nursing homes are increasingly caring for populations requiring more special and rehabilitative care, and this role is likely to increase in the future. This study will examine two special populations in nursing homes: the chronically mentally ill (beyond those with dementia) and hospice terminal care residents. A large sample of resident assessments collected on nursing home residents in several States is to be assembled and linked to Federal data sets such as the Online Survey and Certification Reports, the Area Resource File, and Medicare Part A and Part B claims to answer the research questions. The assessment tool, the Minimum Data Set for Nursing Home Resident Assessment and Care Screening, is currently used to collect health status data on all nursing home residents in Medicaid and Medicare certified nursing facilities. Several quality, utilization, and cost issues will be examined. It is hypothesized, for example, that residents with chronic mental illness are more likely than are other similarly impaired residents to be chemically restrained, to experience increasing functional impairment, and to have increased behavior problems. Consequently, it is also hypothesized that the chronically mentally impaired have greater overall utilization of Medicare services than do non-mentally impaired residents with similar levels of function impairment. With regard to the population of hospice users, it is hypothesized that these residents would have a lower rate of rehospitalization than do nonhospice nursing home residents with similar medical conditions. The secondary data analysis will permit an analysis of these special populations and will provide policy-relevant information to HCFA on future directions for nursing homes. This project is in the development phase.

Study of Post-Acute Care

Period: December 1986–May 1994

Total Funding: $3,702,330

Awardee: University of Minnesota, School of Public Health, Post-Acute Care Project, 704 Washington Ave., SE, Suite 203, Minneapolis, MN 55414

Investigator: Robert Kane, M.D.

This is a study of the course and outcomes of post-acute care. It has two major components—an analysis of Medicare data to assess differences in patterns of care across the country and to determine the extent of substitution where various forms of post-acute care services are more or less available and a detailed examination of clinical cases from the most common diagnostic-related groupings receiving post-acute care in a few selected locations. Measures of the complexity of the clinical cases will be developed using a modification of the medical illness severity grouping system. This project is jointly funded by the Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation. The conditions specifically being examined in the clinical analyses are stroke, chronic obstructive pulmonary disease, congestive heart failure, hip fracture, and hip replacement. The three locations from which patients were obtained for the case studies are Houston, Minneapolis/St. Paul, and Pittsburgh. Patients and caregivers were followed with interviews 6 weeks, 6 months, and 1 year after hospital discharge, whether the patients were discharged to nursing homes, rehabilitation hospitals, or home. The results of direct observation of selected aspects of patients' functional ability over time were also recorded. The study will provide extensive clinical and functional information about the kinds of patients who receive post-acute care and what happens to them.

The final report was reviewed and accepted in May 1994. This study produced a number of important findings. Home health care is usually the least expensive PAC choice and often is associated with good patient outcomes. Inpatient rehabilitative care is significantly more expensive than other forms of care and fails to reduce subsequent medical costs. However, in certain cases, it produces better patient outcomes. Nursing home care generally does not produce good patient outcomes. In many cases, patients who go home without formal home health services tend to have good patient outcomes. This underlines the critical role of informal caregivers and the need to find ways to provide them with support without creating uncontrolled demands for payment of their services. Discharge planning choices often fail to maximize patient outcomes. However, it may be possible to begin developing an empirical data base that relates patient outcomes to post-acute care modalities by further refining the methodology used in this study.

The findings from this study are being prepared in the following article: Kane, R.L., Finch, M., et. al: 1994. The Use of Home Health Care in Post-Hospital Care for Medicare Patients. *Health Care Financing Review,* 15(5), forthcoming.

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

Period: May 1990–January 1995

Funding: $1,427,400

Awardee: University of Colorado, Health Sciences Center, 1355 South Colorado Blvd., Denver, CO 80222

Investigator: Andrew Kramer, M.D.

The University of Colorado will assess which subacute institutional settings and combinations of services are most cost effective and provide more positive outcomes for various types of patients. Researchers will identify potential Health Care Financing Administration (HCFA) policy changes that might encourage use of the most appropriate settings and services. This project will use primary and secondary data from three previous HCFA-sponsored studies to compare quality, cost effectiveness, case mix, service mix, and utilization among institutional subacute care alternatives (e.g., skilled nursing facilities and rehabilitation hospitals) within and between two time periods—1984–87 and 1990–92. This methodology is designed to determine the most cost-effective combinations of services and provider settings for various types of patients requiring subacute care; i.e., stroke and hip fracture. Functional related groups (FRGs) and alternative groupings will be tested to explain variation in resource consumption. Several prospective and per-case payment methods for selected types of subacute care will be modeled.

Cross-sectional and longitudinal data collection started in October 1991. By May 1993, 160 facilities had been recruited and visited. Of these facilities, 117 are participating in the longitudinal component. The sample from these 160 facilities includes 1,410 Medicare patients and 1,040 non-Medicare patients. A report on cross-sectional analysis is expected in October 1994 and the report on longitudinal analyses is expected in January 1995.

Acute and Long Term Care: Use, Costs and Consequences

Period: September 1994–August 1997

Funding: $595,787

Grantee: The Urban Institute, 2100 M Street, NW, Washington, D.C. 20037

Investigator: Korbin Liu, Ph.D.

This study will provide current information that will aid policymakers in developing options to better integrate acute, subacute and long term care services. Data from the Medicare Current Beneficiary Survey will be used to address three issues: transitions among acute, subacute and long term care; "catastrophic" costs resulting from the use of those services; and the interactions between Medicare and Medicaid home health care. The tranistions analysis is designed to measure differences in the patterns of acute, subacute and long term care by the characteristics of Medicare beneficiaries, and to determine potential areas of access or quality of care problems. The costs analysis is designed to assess the cumulative risks over 3 years of incurring "catastrophic" health care costs or experiencing Medicaid spend-down. The effects of the Qualified Medicare beneficiaries program will be evaluated. The home health care analysis is designed to estimate the interactions, and possible overlaps between two rapidly expanding public programs that finance similar services. The relationship between home health care use and costs, and the personal characteristics of Medicare beneficiaries and the characteristics of geographic areas, including Medicaid policies, will be estimated. The project is in the developmental phase.

Predictors of Access and Effects of Medicare Post-Hospital Care for Beneficiaries 65 Years of Age and Over

Period: September 1994–September 1996

Funding: $502,614

Grantee: Georgetown University, Division of Community Health Studies and Family Medicine, Office of Sponsored Programs, 37th & O Street, NW, Washington, D.C. 20057

Investigator: David L. Rabin, Ph.D.

As a consequence of regulatory and legislative changes in the late 1980's, Medicare post-hospital care (PHC) has become the most rapidly growing Medicare expenditure. PHC consists of home health care, inpatient skilled nursing facility care, and rehabilitation hospitalization care. The growth in use, changes in eligibility requirements, and the increase in Medicare costs have raised questions about equal access and the effects of PHC use. The literature on PHC suggest two important trends. A few diagnosis-related groups (DRGs) account for most PHC, but within these DRGs large variations exist in use. Personal health, economic, socio-demographic and household factors as well as area and health system characteristics are predictive of use of PHC despite equal access under the Medicare program. This

study uses the Medicare Current Beneficiary Survey to investigate the following three major research objectives:

To describe the personal, area, and health system characteristics of users and those of similar persons with unmet needs for PHC in order to assess differences by gender, race, and income class and potential for substitution of care modes will be examined.

To study the longitudinal effects of PHC on Medicare program costs and rehospitalization.

To study the personal health effects associated with PHC.

This project is in the developmental phase.

Rehabilitating Medicare Beneficiaries at Home

Period: April 1993–April 1994

Total Funding: $80,000

Awardee: Wellmark Healthcare Services, Inc., 60 William Street, Wellesley, MA 02181

Investigator: Samuel Scialabba

Wellmark intends to conduct a 2-year Medicare demonstration that will provide beneficiaries with acute rehabilitation services at home as an alternative to more expensive inpatient rehabilitation hospital services The Health Care Financing Administration has awarded a cooperative agreement to Wellmark to further refine its project design to develop information on: specific eligibility and screening criteria for patient enrollment, detailed cost data on the proposed service package, and informed consent policies to adequately inform patients and caregivers of the risks and responsibilities of rehabilitative home care. Medicare waivers will be required to allow Wellmark reimbursement as a prospective payment system-exempt rehabilitation hospital. Funding for the evaluation of this demonstration will be provided by the Robert Wood Johnson Foundation as part of a national study entitled Evaluation of Innovative Rehabilitation Alternatives and Critical Dimensions of Rehabilitative Care.

A final report has been submitted. A request for Medicare waivers to implement the project is under review. The projected implementation date for this demonstration is March 1995.

Implementation of the Home Health Agency Prospective Payment Demonstration

Period: June 1990–June 1995

Total Funding: $1,629,606

Awardee: Abt Associates Inc., 55 Wheeler St., Cambridge, MA 02138–1168

Investigator: Henry Goldberg

This contract implements and monitors the demonstration design developed by an earlier contract with Abt Associates Inc., The Home Health Agency Prospective Payment Demonstration. The project will implement a demonstration testing two alternative methods of paying home health agencies (HHAs) on a prospective basis for services furnished under the Medicare program. The prospective payment approaches to be tested are Phase I, payments per visit by type of discipline, and Phase II, payments per episode of Medicare-covered home health care. Home health agency participation in the demonstration is voluntary.

Following the initial home health agency recruitment, operations of the first phase of the demonstration began October 1, 1990. Forty-nine HHAs are participating in Phase I. All agencies under Phase I will have completed their three year participation in the demonstration as of October 1994. Implementation of the second phase testing the per episode payment method is scheduled to begin in spring 1995. Recruitment for Phase II agencies will begin in Fall 1994. In each phase, HHAs that agree to participate are randomly assigned to either the prospective payment method or to a control group that continues to be reimbursed in accordance with the Medicare current retrospective cost system. Each HHA will participate in the demonstration for 3 years.

Evaluation of the Home Health Prospective Payment Demonstration

Period: September 1990–June 1995

Total Funding: $2,858,676 (Phase I)

Contractor: Mathematica Policy Research, Inc., P.O. Box 2393, Princeton, NJ 08543–2393

Investigator: Randall Brown, Ph.D.

The purpose of this contract is to evaluate the first phase of a demonstration designed to test the effectiveness of using prospective payment methods to reimburse Medicare-certified home health agencies (HHAs) for services provided under the Medicare program. In Phase I, a per visit payment method which sets a separate payment rate for each of six types of home health visits (i.e., skilled nursing, home

health aide, physical therapy, occupational therapy, speech therapy, and medical social services) will be tested. Mathematica Policy Research will evaluate the effects of this payment method on HHAs' operations, quality of services HHAs deliver to Medicare beneficiaries, and Medicare expenditures. The contractor will also analyze the relationship between patient characteristics and the cost and use of HHA services in order to develop improved methodologies for adjusting prospective payment rates for case-mix variations.

By October 1994, all demonstration agencies will have exited the demonstration. Mathematica has submitted a preliminary impact report based on the findings from the first year of the demonstration. These preliminary findings suggest that treatment agencies have not decreased their cost per visit, increased their total revenues and net revenues, or altered their behavior in ways that affect the quality of home health care. The following article discusses preliminary results from Phase I of the demonstration: Phillips, B.R., Brown, R.S., et al. 1994 Do Preset Payment Rates Affect Home Health Agency Behavior? *Health Care Financing Administration,* 15(5), forthcoming.

Quality Review for the Home Health Agency Prospective Payment Demonstration

Period: September 1991–December 1994

Total Funding: $1,499,085

Contractor: New England Research Institute, Inc., 9 Galen St., Watertown, MA 02172

This contract involves quality review of the care received by Medicare beneficiaries who are clients of the home health agencies that are participating in the Home Health Agency Prospective Payment System demonstration (HHA/PPS). The HHA/PPS demonstration is testing the costs and benefits of prospective payment for Medicare home health services compared to the current retrospective cost reimbursement system. In order to assure that the incentives created under the HHA/PPS demonstration do not result in the provision of inadequate home health care to Medicare beneficiaries, the New England Research Institute, Inc. (NERI), the quality review contractor, implemented the quality assurance plan that calls for a review of patient records for a sample of Medicare beneficiaries receiving care under the HHA/PPS demonstration. If potential or actual problems are discovered, the contractor implements a defined protocol to address the situation.

During the initial year of the contract, NERI staff completed all of the activities related to the start-up of the quality assurance plan, including baseline training for nurse reviewers. Throughout the demonstration period, NERI assessed patterns of problems within home health agencies, which require educational follow-up or additional medical reviews. As the Phase I demonstration period was completed September 30, 1994, NERI has completed analysis of its final sample of records.

Evaluation of Phase II of the Home Health Agency Prospective Payment Demonstration

Period: September 1994–September 1999

Funding: $3,528,408

Contractor: Mathematica Policy Research, Inc., P.O. Box 2393, Princeton, N.J. 08543–2393

Investigator: Barbara Phillips, Ph.D.

This contract will evaluate Phase II of the Home Health Agency Prospective Payment demonstration. This demonstration is testing two alternative methods of paying home health agencies (HHAs) on a prospective basis for services furnished under the Medicare program. The prospective payment approaches that are being tested include payments per visit per types of discipline (Phase I), and payment per episode of Medicare-covered home health care (Phase II). Implementation of Phase II, which will test the per episode payment approach, is scheduled to begin in Spring 1995. HHAs that agree to participate in the demonstration are randomly assigned to either the prospective payment method or to a control group that continues to be reimbursed in accordance with the current Medicare retrospective cost system. HHAs will participate in the demonstration for 3 years.

The evaluation will combine estimates of program impacts on costs, service use, access and quality with detailed information on how agencies actually change their behavior to produce a full understanding of what would happen if prospective payment replaced the current payment methodology nationally. The findings will indicate not only the overall effects of the change in payment methodology, but also how the effects are likely to vary with the characteristics of agencies and patients. This information will be of great value for estimating the potential savings from a shift to prospective payment for home health care, for identifying types of patients who might be at risk of restricted access to care as a result of their need for an unusu-

ally large amount of care. Because of the relatively small number of HHAs participating in the demonstration, the use of qualitative information obtained in discussion with agencies concerning their characteristics and behavior will be essential for avoiding erroneous inferences. This project is in the developmental phase.

Determinants of Home Health Use

Funding: Intramural

Investigator: Elizabeth Mauser, Ph.D.

Modifications in the eligibility requirements for home health services, implementation of the prospective payment system in hospitals, and beneficiary preferences to remain in the community have resulted in significant increases in home health care expenditures. Although home health expenditures continue to rise, relatively little is known about home health users and market characteristics that affect home health use. Consequently, we have implemented several intramural studies to support future efforts of policy reform in the area of post acute care. Using the Medicare Current Beneficiary Survey (MCBS), we are exploring:

Whether home health users can be classified into distinct subgroups in order to understand the special care needs of home health users, determine how specific policies affect different groups of users, and develop case mix adjustments for payment reform.

How home health use has changed over time using 1991, 1992, and 1993 MCBS.

The effect of supply factors on home health use by linking the MCBS with the Area Resource File.

The extent of substitution among different post acute care settings such as skilled nursing, home health and rehabilitation facilities. To identify beneficiaries using rehabilitation services, we are linking the MCBS with the provider of service files.

Using the 1992 MCBS, we have examined the characteristics of beneficiaries using home health as well as estimating multivariate models of the factors that affect utilization and expenditures. Based on this work, the following article is being prepared: Mauser, E., and Miller, N.A. 1994. A Profile of Home Health Users in 1992. *Health Care Financing Review*, 15(5), forthcoming.

Maximizing the Cost Effectiveness of Home Health Care: The Influence of Service Volume and Integration with Other Care Settings on Patient Outcomes

Period: September 1994–December 1997

Funding: $1,231,466

Grantee: Center for Health Policy Research, 1355 South Colorado Boulevard, #706, Denver, CO 80222

Investigator: Peter W. Shaughnessy, Ph.D.

Home health care (HHC) is the most rapidly growing component of the Medicare program in recent years. The rapid growth in home health utilization has occurred despite limited evidence about the necessary volume of HHC to achieve optimal patient outcomes and whether it substitutes for more costly institutional care. Little is known about integrating HHC with care in other settings to reduce overall health care costs. The central hypotheses of this study are: volume-outcome relationships are present for HHC for common patient conditions; upper and lower volume thresholds exist that define the range of services most beneficial to patients; and a strengthened physician role and better integration of HHC with other services during an episode of care can optimize patient outcomes while controlling costs. To test these hypotheses, a total of 3,600 patients will be enrolled from a nationally representative sample of home health agencies. Trained data collectors at each agency will record patient health status and service information between HHC admission and discharge to assess patient outcomes and costs within the HHC episode. Long term, self-reported outcomes will be assessed from telephone interview data at HHC admission and at 6-month followups. These primary data concerning patient status and outcomes will be combined with Medicare claims data over the episode of care to assess the relationship between service volume in HHC and both patient outcomes and costs. Analyses of data relating to physician involvement and the sequence of use of other providers will address issues of integration with other services. This project is in the development phase.

Development of Outcome-Based Quality Measures for Home Health Services

Period: September 1988–June 1994

Funding: $1,965,389

Contractor: University of Colorado, Center for Health Policy Research, 1355 South Colorado Boulevard, Denver, CO 80222

Investigator: Peter Shaughnessy, Ph.D.

The purpose of this study is to develop and test outcome-based measures or indicators of qualify for Medicare home health services. The measures are designed for use in monitoring and comparing quality of home health care across agencies. The study was designed to have three phases. During the first phase, a number of approaches to home health care quality assurance and quality measurement were examined. In the second phase, data sets, data collection approaches, and measurement methods were assessed and a manageable set of outcome measures was developed. The measures include both end-result outcomes (i.e., measures of patient status and utilization) and intermediate-result outcomes (i.e., measures of nonphysiological or nonfunctional status intrinsic to the patient or caregiver). During the third phase, data will be collected from a nationally representative sample of 49 home health agencies.

The third and final phase of the study was designed to systematically collect data for assessing the reliability, validity, and utility of each outcome measure. In this phase, longitudinal data were collected to measure outcomes for approximately 3,000 patients from 49 home health agencies. Further, preliminary analysis from this final phase of the study resulted in an initial design for a Medicare home health quality assurance demonstration.

The final report was submitted in July 1994. The report outlines the findings and conclusion from the final empirical phase of the study and presents the proposed home and health outcomes measures system.

A summary of the findings are being prepared in the following article: Shaughnessy, P., Crisler, K.S., et al. 1994. Measuring and Assuring the Quality of Home Health Care. *Health Care Financing Review,* 15(5), forthcoming.

Design and Implementation of Medicare Home Health Quality Assurance Demonstration

Period: September 1994–May 1999

Funding: $3,234,881

Grantee: Center for Health Policy Research, 1355 South Colorado Boulevard, Denver, CO 80222

Investigator: Peter W. Shaughnessy, Ph.D.

Currently, Medicare's home health survey and certification process is primarily focused on structural measures of quality. Although this process provides important information about home health care, an approach based on patient outcome measures would substantially increase the Medicare program's capacity to assess and improve patient well being. To address this need, the Medicare home health quality demonstration will test an approach to developing outcome-oriented quality assurance and promoting continuous quality improvement in home health agencies. The demonstration is designed to serve two purposes: (1) increase HCFA's capacity to assess the quality of Medicare home health care services; and (2) increase health agencies' ability to systematically evaluate and improve patient outcomes. The proposed quality assurance approach would complement existing home health certification and review programs and could be used with current survey and certification, and PRO intervening care screen approaches. The study's conceptual framework for home health quality assessment is based on home health outcome measures developed under a HCFA-funded study by the University of Colorado, entitled "Development of Outcome-Based Quality Measures in Home Health Services" (contract No. 500–88–0054). This project is in the developmental stage.

Home Care Quality Studies

Period: October 1989–September 1995

Total Funding: $2,848,782

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

Investigator: Robert Kane, M.D.

For this study, the contractor will carry out research on the following topics:

Quality of long-term care services in community-based and custodial settings.

Effectiveness of (and need for) State and Federal protections for Medicare beneficiaries that ensure adequate access to nonresidential long-term care services and protection of consumer rights.

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

Development of a taxonomy clarifying the various objectives and goals ascribed to home and community-based care from the various perspectives of consumers, payers, and care providers.

Development and feasibility-testing of a survey design that would measure the extent of, need for, and adequacy of home care services for the elderly.

A study of variations in labor supply and related effect(s) on home care quality, as well as factors that contribute to these variations.

Recommendations to improve the quality of home and community-based services by identifying best practices and promising quality assurance approaches.

The first project task (development of a taxonomy of goals and objectives) has been completed, and a report on this component has been received. The University of Minnesota is continuing work on each of the remaining primary tasks. The final report for this contract is expected in September 1995.

Findings from this project will be presented in the following article: Kane, R.L., et al., 1994. Multiple Perspectives on Quality of Home Care, *Health Care Financing Review,* 15(5), forthcoming.

Study of Home Health Care Quality and Cost under Capitated and Fee-for-Service Payment Systems

Period: June 1987–February 1994

Total Funding: $1,683,773

Awardee: Center for Health Policy Research, 1355 South Colorado Blvd., Denver, CO 80222

Investigator: Peter Shaughnessy, Ph.D.

This project is designed to evaluate service utilization, quality, and cost of Medicare home health care provided under capitated and noncapitated (fee-for-service) payment systems. The Center for Health Policy Research will collect patient-level, case-mix, and service use data on a sample of approximately 4,000 patients from 44 agencies nationwide. A random and stratified patient sample will be drawn from both fee-for-service and capitated payment environments to assess and compare cost effectiveness of care, quality of care, and incentives to admit and provide care in the two payment environments. Secondary data analysis will also be completed on a sample of 10,000 Medicare beneficiaries using Medicare claims data to compare service use patterns among post-hospital Medicare patients discharged to skilled nursing facilities, home health care facilities, and the community, as well as Medicare home health patients admitted from the community.

The Final Report was submitted in February 1994. The data indicate that fee-for-service patients had better home health outcomes and higher costs than managed care patients. Further, managed care patients in health maintenance organization (HMO)-owned home health agencies had poorer outcomes than patients who received care from HMO-contractual agencies. Typically, the fee-for-service patients received more home health visits than HMO patients and within the managed care environment, HMO-owned home health agency patients received fewer visits than HMO-contractual agency patients. The findings suggest that HMOs and particularly HMO-owned home health agencies are overly restrictive in providing home health services.

The findings from this study are being prepared in the following article: Shaughnessy, P.W., Schenkler, R.E., et al. 1994. Home Health Outcomes Under Capitated and Fee-for-Service Payment. *Health Care Financing Review,* 15(5), forthcoming.

Sources of Medicare Home Health Expenditure Growth: Implications for Control Options

Period: February 1992–February 1995

Funding: $210,706

Awardee: Brandeis University, Heller School, Bigel Institute for Health Policy, P.O. Box 9110, Waltham, MA 02254

Investigator: Christine Bishop, Ph.D.

The overall objective of the project is to develop and consider options for restraining home health expenditure growth. The project has two phases. The first is to use secondary data to examine Medicare home health expenditure growth from 1985 through 1989, and from 1989 through 1991 to attribute total growth to the growth in the number of persons served, visits per person, mix of visits, and visit charges; and to attribute growth to types of agencies by auspice and scale. The second is to examine data from the Regional Home Health Intermediary data base to measure variations in types of patients served at intake, and characteristics of high use patients, by auspice and region, and to consider difference in mix and intensity of services provided.

The first phase of the project was completed, resulting in an overview, entitled "Recent Growth in Medicare Home Health: Sources and Implications." An edited

version of this analysis was published in *Health Affairs* (Fall 1993). The second phase will be completed in February 1995.

Study of Medicare Home Health Agency Use of the Home Health Care Management Benefit

Period: September 1991–January 1993
Total Funding: $81,848
Awardee: Project HOPE Research Center, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814–6133
Investigator: Robyn Stone, Ph.D.

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

Construction of data/analytical files is complete. These files were used to conduct episode analyses and to link plan-of-treatment information with Medicare claims data. The final report for this project has been submitted and is under review.

Determinants of Home Care Costs

Period: August 1990–January 1993
Funding: $125,140
Awardee: Brandeis University Research Center, 415 South S., Waltham, MA 02254
Investigator: Christine Bishop, Ph.D.

The original purpose of this project was to investigate the determinants of formal and informal home care and the mix of the two types of care. However, two shortcomings in the data from Connecticut Community Care, Inc. (CCCI) for the study period preclude this: (1) prior to January 1991, only the services paid for by CCCI and not other sources (eg., Medicaid) were included; and (2) detailed information was not available for informal care. Instead, the study will investigate the patterns and determinants of nursing home use in this community-based population. In addition, Medicaid spend-down among a community-based population will be analyzed.

The final report, entitled "Converting to Medicaid in the Community: The Forgotten Stepchild", has been completed. In the study sample, about eight percent of the persons were found to enroll in the Medicaid program while still living in the community over a 53-month observation period. As expected, community conversion to Medicaid is driven largely by financial status. What was not expected was that Medicaid conversion did not appear to be influenced by the use of medical services. This study did not find any significant relationship between use of drugs or use of hospitals and Medicaid conversion. However, the study did find a marginally significant relationship between temporary nursing home use and conversion. The results also indicate that functional and cognitive status was not significantly related to Medicaid conversion. The final report will be sent to the National Technical Information Service.

Improving the Discharge Planning Process

Period: March 1994–March 1995
Funding: $130,471
Contractor: University of Minnesota, School of Public Health, Box 197,420 Delaware St., SE., Minneapolis, MN 55455
Investigator: Robert Kane, M.D.

Enactment of the Medicare prospective payment system has focused attention on discharge planning. The increased pressure to eliminate medically unnecessary hospital days and the shorter amount of time available for discharge planning has underscored the need to develop a discharge planning process that better relates post acute care services to patient outcomes. The purpose of this project is to examine approaches to improving discharge planning at both the micro and policy level and recommend innovative research or demonstration projects. Currently, a concept paper is bearing developed and a Technical Expert Panel will meet in winter 1995.

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

Period: September 1991–September 1991
Total Funding: $200,000

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

Investigator: Catherine Hawes, Ph.D.

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

The following 10 states have been selected to participate in the study: New Jersey, Texas, Oklahoma, Georgia, Kentucky, Arkansas, Florida, Illinois, California, and Oregon. Survey instruments are currently under revision and pre-test activities are underway in facilities in North Carolina and the District of Columbia.

A 1994/1995 National Health Interview Survey Disability Supplement

Period: June 1993–June 1994

Award: Interagency Agreement

Agency: Centers for Disease Control, National Center for Health Statistics, 6325 Belcrest Road, Room 850, Hyattsville, MD 20782

Investigator: Owen Thornberry

The Health Care Financing Administration's (HCFA) transfer of funds to the National Center for Health Statistics is in support of the implementation of the 1994/1995 disability survey as a supplement to the National Health Interview Survey. Although HCFA provides extensive support for the disabled through Medicare and Medicaid, very little is known about this population. The National Health Interview Survey Disability Supplement (NHISDS) will be the first comprehensive survey on the disabled in 15 years. The NHISDS will be conducted during 1994 and 1995 calendar years, with approximately 250,000 people of the 96,000 sampled households. The survey will consist of two phases:

Phase I will screen the relevant populations and will collect basic descriptive information.

Phase II will obtain information on all household members who experience limitations caused by a health condition.

Data from Phase I will be used to make estimates of the prevalence of disability and to determine eligibility for Phase II questionnaires. In Phase II, separate questionnaires will be given to adult and child respondents. This survey will be the first source of information to determine the size, characteristics, service use, and out-of-pocket costs for individuals with mental retardation and related conditions. The survey of children will provide information on the number, characteristics, severity, and effects on families of children with disabilities. This survey will collect information on income and assets, along with basic disability information, to better understand the characteristics of actual and potential Supplemental Security Income recipients. The information gathered from the NHISDS will be crucial for addressing a broad number of HCFA policy concerns affecting persons with disabilities.

The questionnaires for the disability supplement have been revised. Phase I interviews began in January 1994 and Phase II adult and children interviews began during summer 1994.

Long-Term Care Survey

Period: September 1990–February 1993

Award: Interagency Agreement

Agency: National Institute on Aging, 9000 Rockville Pike, Bethesda, MD 20892

Investigator: Richard Sussman

The Office of the Assistant Secretary for Planning and Evaluation and the Health Care Financing Administration agree to transfer funds to the National Institute on Aging (NIA) to support an existing NIA grant to Duke University, Center for Demographic Studies. This grant, number 1R37AG07198, is entitled Functional and Health Changes of the Elderly, 1982–89. The National Long-Term Care Survey (NLTCS) is a detailed household survey of persons 65 years of age or over who have some chronic (90 days or more) functional impairment. The survey has been administered three times. The first, conducted in 1982, was devised as a cross-sectional survey. The second conducted in 1984, added a longitudinal component to the sample design. The third, administered in 1989, used the cohorts from the previous sur-

veys in addition to persons becoming 65 years of age to form a nationally representative sample of impaired elderly persons. To facilitate the use of the data base, the following tasks related to the 1982, 1984, and 1989 NLTCSs will be carried out under this agreement:

File linkage over the entire period 1982–89.
Derivation of new longitudinal sample weights.
Linkage of Medicare administrative records.
Improvement of coding by checking consistency of survey items.
Improvement in survey documentation.
Seminars and education.

A second version of the public use data file, containing Medicare Part A and B files, was sent to the Michigan Archives in fall 1993. This public use version can be obtained from Michigan Archives by calling (313) 763–5011. However, this second version has recently been found to have incomplete Medicare data for certain years; another version with complete Medicare data will be sent once Medicare files have been received from HCFA.

Long-Term Care Program and Market Characteristics

Period: February 1992–September 1995
Funding: $808,047
Awardee: University of California, San Francisco, Office of Research Affairs, 3333 California Street, Suite 11, San Francisco, California 94143–0962
Investigator: Charlene Harrington, Ph.D.

This project will collect data on and study the effects of nursing home and home health care characteristics and markets for Medicare and Medicaid services in 50 States. Primary and secondary data for the 1990–93 period will be collected to update earlier data collected in previous studies for the 1978–89 period. A comprehensive survey will collect data on licensed nursing home bed supply and occupancy rates, State certificate-of-need programs, State preadmission screening programs, and Medicaid nursing home and home health reimbursement. A special analysis will provide detail on each States' current methodology for determining nursing home capital costs, the impact of proposed case-mix reimbursement on operating income, reimbursement methodology for free-standing sub-acute services/units, and Medicaid methodology used to reimburse for care in board and care homes, geriatric day care centers, and ICF–MR facilities. A public use database will be prepared to provide a complete set of data for the period 1978–93.

The first 2 years of the project have been completed, with a continuation of the studies for the third year under way. An additional study is planned for the third year to collect information on State loan programs to identify those agencies making loans to health care facilities. The following State data book that presents data on long-term care program and market characteristics across the 50 States and the District of Columbia has been published: *State Data Book on Long-Term Care Program and Market Characteristics,* Health Care Financing Extramural Report, HCFA Pub. No. 03354.

Long-Term Care Studies (Section 207)

Period: September 1989–July 1995
Funding: $3,790,000
Contractor: Health and Sciences Research Incorporated, 9302 Lee Highway, Suite 500 Fairfax, VA 22031
Investigator: David Kennell

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

The financial characteristics of Medicare beneficiaries who receive or need LTC services.

How the Medicare beneficiaries' characteristics affect their utilization of institutional and noninstitutional LTC services.

How relatives of Medicare beneficiaries are affected financially and in other ways when beneficiaries require or receive LTC services.

How the provision of LTC services may reduce expenditures for acute care health services.

Analyses will use existing LTC and other survey data bases (e.g., the National Long-Term Care Surveys, the Longitudinal Study of Aging, the National Nursing Home Survey, the Survey of Income and Program Participation, and the National Medical Care Expenditure Survey). Medicare administrative records and other ex-

tant information will also be utilized. A number of focused analytic studies, policy reports, syntheses, and special studies are required under the contract.

With the repeal of the Medicare Catastrophic Coverage Act of 1988, this project is no longer congressionally mandated. A large number of studies have been initiated, and several draft reports have been received. Current studies include:

Health Care Service Use and Expenditures of the Non-Institutionalized Population
An Examination of the Relation of Part A and Part B Medicare Expenditures
The Catastrophic Costs of Long Term Care
Issues in Long Term Care Policy for the Disabled Elderly with Cognitive Impairment
Synthesis of Literature on Targeting to Reduce Hospital Use
Synthesis on Reimbursement Options for Medicaid and Medicare Nursing Home Stays
Elderly Wealth and Savings; Implications for Long Term Care
Synthesis of the Literature on Effectiveness of Special Assistive Devices in Managing Functional Impairment
Nursing Home Bed Supply: Synthesis of the Literature and State Initiatives
Synthesis of the Literature on Unmet Need for Long Term Care Services
Synthesis of the Literature on Financing and Delivery of Long Term Care for the Disabled Non-Elderly
Analysis of Nursing Home Payment with Current Beneficiary Survey (CBS) Data
Analysis of Informal and Formal Care
The Potential of Coordinated Care Targeted to Medicare Beneficiaries with Medicaid Coverage
Analysis of Non-Participation in the 2176 Program
Regional Variations in Medicare Home Health
Case Studies of Medicaid Estate Planning
Effect of Geographic Variations on Medicare Capitation Rates
Consumer Protection and Private LTC Insurance
Key Issues for Private LTC insurance
Simulations of SNF Payment Options
Longitudinal Health Care Use and Expenditures of Disabled Persons
Interrelationship of Medical Conditions in the Nursing Home Population
Analysis of Post-Acute Care and Therapy Services Using the HCFA Episode Database
Analysis of Choice Processes in Capitated Plan Enrollment: Statistical Models for Evaluation of Voluntary Demonstration Projects
Analysis of Transitions in the Characteristics of the LTC Populations
Costs of Medicare Skilled Nursing Facility Therapy
Catastrophic Costs and Medicaid Spenddown
State Responses to Medicaid Estate Planning

A conference to present selected findings of the contract was convened November 1994 and conference proceedings will be published by July 1995.

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

Period: August 1991–July 1993

Total Funding: $139,898

Awardee: Brandeis University Research Center, P.O. Box 9110, Waltham, MA 02254–9110

Investigator: Christine Bishop, Ph.D.

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

A preliminary study design has been completed. However, the development of an analytic research file has been delayed. The final report for this project is anticipated in late 1994.

Interaction of Medicaid and Private Long-Term Care Insurance

Period: August 1991–July 1993

Funding: $80,000

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

Investigator: Christine Bishop, Ph.D.

For this study, researchers will examine the characteristics of purchasers and nonpurchasers of private long-term care insurance, the types of insurance purchased, and the role of State Medicaid program characteristics and personal characteristics in influencing the purchase decision.

The study found, that after accounting for available control variables, purchase of private long-term care insurance is less likely where Medicaid supports a relatively high level of input intensity in nursing homes; where nursing home beds are more available; and where higher-income persons may be eligible for Medicaid as "medically needy" due to nursing home spending. These results suggest that the Medicaid "safety-net" deters long-term care insurance purchase, and that improvements, in Medicaid coverage of long-term care may further suppress demand for private long-term care insurance. The final report will be sent to the National Technical Information Service.

FUTURE DIRECTIONS FOR LONG-TERM CARE

During 1994, HCFA devoted substantial resources to the further development and implementation of demonstrations to test the cost-effectiveness of prospective payment systems for nursing homes and home health agencies, to implement and monitor new coordinated care systems for the frail elderly, and develop outcome-oriented quality measures to improve the quality of care in these settings.

We will continue to test alternative financing schemes for long term care services, including implementation of the Multi-State Nursing Home Case Mix and Quality Demonstration. The Home Health Agency Prospective Payment Demonstration will continue during 1995.

We will continue our efforts to develop, operate, and evaluate coordinate care systems for the frail elderly, including the Medicare Alzheimer's Disease Demonstration, the Program for the All-inclusive Care of the Elderly Demonstration, the Social/Health Maintenance Organization Demonstration, the Community Nursing Organization Demonstration, and the EverCare Demonstration.

We also will continue the development and testing of outcome-oriented measures of quality for nursing home and home health services and assessment of the applicability of using payment generated data to monitor quality. In this light, we will implement a multi-State demonstration integrating resident assessment and case-mix payment data with the quality assurance process for nursing home providers.

Another very important area that will continue to be explored is alternative financing mechanisms for long-term care. Although the majority of the elderly are covered by both Medicare and supplemental insurance, a large portion of long-term care services remain uncovered. Medicaid covers long-term nursing care, but only after the elderly individuals have depleted their resources. Research is continuing that will identify the sources of financing for long-term care at various points throughout institutionalization. This research will further examine characteristics of individuals who come to rely upon Medicaid for payment for their care. By identifying the risks associated with nursing home use, we hope to be able to propose improved methods of paying for this care. Alternatives being studied as a solution for some of the elderly's problems in financing long-term care are life care centers and private long-term care insurance. Other ORD financing research continues to examine various States' reimbursement of long-term care in order to assess the feasibility of recommending policy changes, e.g., prospective payment for SNF care.

We will continue to support data collection and data analyses from projects that gather detailed information from representative national samples or other large segments of the elderly population. Research is continuing on the estimated future acute and long term care utilization based on information from available surveys on the morbidity, disability and mortality of different birth cohorts. We will continue initiatives to make additional data bases available for research and analysis, such as the 1989 Long Term Care Survey, State Medicaid data, and the Medicare Current Beneficiary Survey.

In 1995, we also will continue an evaluation of the Community Supported Living Arrangements (CSLA) program, mandated by section 4712 of OBRA 90. Eight States are receiving funding through this optional Medicaid State plan service to develop CSLA programs, in which service individuals with mental retardation and relate conditions living in the community independently, with their family or in a home of three or fewer individuals. HCFA will also expand its research activities related to the nonelderly disabled. In particular, we will be working with State Med-

icaid agencies to develop integrated systems for providing acute and long-term care services to various subgroups of the disabled, including those dually eligible for Medicare and Medicaid, SSI recipients, and others.

OFFICE OF INSPECTOR GENERAL

INTRODUCTION

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95–452, as amended, is to protect the integrity of HHS programs, as well as the health and welfare of beneficiaries served by those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. The OIG's statutory mission is carried out through a nationwide network of audits, investigations, and inspections.

The OIG's Office of Audit Service (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

The OIG's Office of Investigations (OI) conducts criminal, civil and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries. The investigative efforts of OI lead to criminal convictions or civil judgments, program exclusions or civil monetary penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Over the years, OIG findings and recommendations have been the basis for extensive oversight hearings and legislation improving the management of the department's programs. The OIG acts as an independent fact finder, with no vested interest in particular programs or operations. The OIG performs a variety of self-initiated reviews as well as reviews requested by the Secretary, departmental senior staff, and congressional committees. The OIG works with departmental and congressional officials, so long as such relationships do not compromise our independence or integrity.

ACCOMPLISHMENTS

Our continuing resource constraints demand that we direct our activities with great care while streamlining our work force and expenditures. This is a challenge all Government agencies are facing, and we take it very seriously. At the same time, FY 1994 was a year of noteworthy successes. Our total savings surpassed $8 billion, which represents $80 in savings for each dollar invested in OIG and $6.4 million in savings per OIG employee. Our accomplishments included a record $379 million settlement of criminal fines, civil damages, and penalties for fraud and kickbacks by a health care corporation.

HEALTH CARE

To leverage our limited resources, we continue to coordinate our activities with a number of outside entities, especially in the health care area. Working with the Department of Justice, the Federal Bureau of Investigation and the HHS Office of General Counsel, we are developing a voluntary disclosure program to offer certain federally funded health care providers incentives to disclose any fraud and abuse they discover within their companies. We are also embarking on a Federal/State partnership with State auditors to provide broader audit coverage of significant Medicaid issues.

Over the years, OIG findings and recommendations have contributed to many significant reforms in the Medicare program. Such reforms include implementation of the prospective payment system (PPS) for inpatient hospital services and fee schedule for physician services; the Clinical Laboratory Improvement Amendments of 1988; regional consolidation of claims processing for durable medical equipment (DME); establishment of fraud units at Medicare contractors; prohibition on Medi-

care payment for physician self-referrals; and new payment methodologies for graduate medical education (GME).

The OIG has documented excessive payments for hospital services, indirect medical education, DME and laboratory services, leading to statutory changes to reduce payments in those areas. To ensure quality of patient care, OIG has assessed clinical and physiological laboratories; evaluated the medical necessity of certain services and medical equipment; analyzed various State licensure and discipline issues; reviewed several aspects of medical necessity and quality of care under PPS, including the risk of early discharge; and evaluated the care rendered by itinerant surgeons and the treatment provided by physicians performing in-office surgery.

Electonic Data Interchange and Paperless Processing.—This OIG report identifies emerging issues in the expansion of HCFA's use of electronic data interchange and related technology to achieve paperless processing. Some significant issues affecting implementation of this initiative are: the development of systems to process electronically submitted claims and manage data more efficiently; the establishment of standards to facilitate the electronic flow of data among providers, payers and quality of care reviewers; the identification of incentives and barriers, to encourage providers to submit claims and patient data electronically; and the use of companion technologies. The report also discusses concerns involving the trustworthiness and reliability of data as it moves from one partner in electronic commerce to another and from one process to another.

Medicare Secondary Payer.—The OIG has estimated that the Medicare program may be paying out as much as $1 billion a year unnecessarily because Medicare fiscal intermediaries and carriers do not always identify the primary payers, and because insurers, underwriters and the third party administrators often do not pay as primary payers when they are required to do so. This problem, which was first identified as a high risk area in 1989, has been addressed through several initiatives, including proposals for legislative remedies and legal actions against noncomplying insurers.

Use of Nursing Home and Medigap Guides.—The Assistant Secretary for Public Affairs (ASPA) requested that OIG examine departmental strategies for distributing various publications to ensure that they are received by intended users. As part of its 1993 Medicare beneficiary satisfaction survey, OIC questioned beneficiaries about their awareness of two HCFA booklets that provide guidance to Medicare beneficiaries and their families: Guide to Choosing a Nursing Home and Guide to Health Insurance for People with Medicare. The OIG determined that less than 15 percent of the beneficiaries surveyed know about the booklets, and only 2 percent or fewer had ever used either of them. The OIG found that beneficiaries who used the booklets found them useful, and most beneficiaries stated that they would use the guides if they needed nursing home care or Medigap insurance. The OIG recommended that HCFA work with SSA and ASPA to develop a more effective strategy to make the guides available to beneficiaries. All three agencies agreed with the recommendation and have begun to explore ways to make the booklets more accessible to beneficiaries.

SOCIAL SECURITY

The Office of Inspector General reviews all aspects of SSA's programs and operations, including: disability insurance benefits, information resources management, program integrity and efficiency, quality of service, representative payees and SSI benefits. The OIG is also providing oversight to SSA's financial management by auditing SSA's financial statements, examining internal controls and reporting on the status of debt management activities.

Social Security Client Satisfaction.—The OIG has conducted annual client satisfaction surveys of Social Security beneficiaries since 1987. In the overview report of this year's survey, OIG noted that overall satisfaction had leveled off after a few years of decline. Over 77 percent of respondents rated service as good or very good. However, disabled clients gave markedly lower satisfaction ratings than nondisabled clients in this and prior years. This is significant because the proportion of disabled clients in OIG's sample has increased over the last 3 years, consistent with an increase in SSA's disability workloads. Moreover, these lower ratings account for the decline in overall satisfaction since 1990. Factors that continued to foster high satisfaction ratings were staff job performance and staff courtesy, while service delays appeared to lower satisfaction. A separate report on client subgroups noted that non-English speaking clients and clients with frequent contact with SSA were less satisfied than other clients, but key indicators of service delivery in urban offices had significantly improved.

Satisfaction with 800 Number.—We compared local and 800 number telephone service based on client responses to the last three Social Security client satisfaction surveys. A review of over 30 questions showed no real difference in satisfaction between clients who called the 800 number and callers to local offices. For example, both groups gave similar ratings on staff job performance, staff courtesy and the clarity of explanations given by staff. Differences were identified in only three areas; local callers' overall satisfaction ratings remained essentially unchanged for 3 years, while 800-number callers' ratings declined; SSI clients were more likely to call a local number than the 800 number; and access, measured by the number of call attempts required to reach SSA, appeared to have improved for urban local callers and declined for rural local callers.

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

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

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

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

During 1994, staff of the Office of the Assistant Secretary for Planning and Evaluation undertook or participated in the following analytic and research activities which had a major focus on the elderly:

1. Policy Development—Aging

TASK FORCE ON ALZHEIMER'S DISEASE

As a member of the DHHS Council on Alzheimer's Disease, each year ASPE helps prepare the annual report to the Congress on selected aspects of caring for persons with Alzheimer's disease. The report focuses on the Department's current and planned services research initiatives on Alzheimer's disease.

FEDERAL INTERAGENCY FORUM ON AGING-RELATED STATISTICS

ASPE is a member of the Federal Interagency Forum on Aging-Related Statistics (The Forum). The Forum was established to encourage the development, collection, analysis, and dissemination of data on the older population. The Forum seeks to extend the use of limited resources among agencies through joint problem solving, identification of data gaps and improvement of the statistical information bases on the older population that is used to set the priorities of the work of individual agencies.

DEPARTMENTAL DATA PLANNING AND ANALYSIS WORKING GROUP

The Data Planning and Analysis Working Group chaired by ASPE analyzes Departmental data requirements and develops plans minimizing barriers to full utilization of such data. The Group identifies needs for data within HHS, evaluates the capacity of current systems to meet these needs and prepares recommendations for ensuring effective and efficient performance of HHS data systems.

LONG-TERM CARE MICROSIMULATION MODEL

During 1994 ASPE continued to use extensively the Long-Term Care Financing Model developed by ICF, Inc. and the Brookings Institute. The model simulates the utilization and financing of nursing home and home care services by a nationally representative sample of elderly persons for the period 1986 to 2020. It gives the

Department the capacity to simulate the effects of various financing and organizational reform options on future public and private expenditures for nursing home and home care services.

2. Research and Demonstration Projects

Institute for Research on Poverty, University of Wisconsin

Robert M. Hauser, Principal Investigator.

A research agenda of diverse but interrelated two-year studies concerned with the relationships between poverty and family structure, education and social welfare, child support and paternity, labor force behavior, and welfare dependence. In the 1991–93 biennium there are no projects dealing exclusively with the elderly. However, the Institute does do a number of activities and publishes a number of materials on poverty which include the elderly as an important subgroup.

Funding: Fiscal Years 1993–95—$3,300,000

End Date: June 1996

PANEL STUDY OF INCOME DYNAMICS

University of Michigan, Institute for Social Research

James N. Morgan, Greg J. Duncan, and Martha S. Hill, Principal Investigators

Through an interagency consortium coordinated by the National Science Foundation (NSF contributes approximately $1.5 million per year), ASPE assists in the funding of the Panel Study of Income Dynamics (PSID). This is an ongoing nationally representative longitudinal survey that began in 1968 under the auspices of the Office of Economic Opportunity. The PSID has gathered information on family composition, attitudes, employment, sources of income, housing, mobility, and a host of other subjects every year since then on a sample of approximately 5,000 families and has followed all original sample members that have left home. The current sample size is over 7,000 families. The data files have been disseminated widely and are used by hundreds of researchers both within this country and in numerous foreign countries to get an accurate picture of changes in the well-being of different demographic groups including the elderly.

Funding: ASPE (and HHS precursors)—FY67 through FY79—$10,559,498; FY80—$698,952; FY81—$600,000; $200,000; FY93—$250,999; FY84—$550,000; FY85—$300,000; FY86—$225,000; FY87—$250,000; FY88—$250,000; FY89—$250,000; FY90—$300,000; FY93—$300,000; FY94—$800,000

HEALTH AND RETIREMENT STUDY

University of Michigan, Survey Research Center

Principal Investigator: Tom Juster

The Survey of Health and Retirement is a new nationally representative longitudinal survey that will gather data on health and retirement issues from U.S. households. In addition, financial and background histories will be gathered. Data from the survey are expected to be used for investigating how changes in the Social Security system and private pension systems have affected retirement plans. These data will support research on health care needs and costs. The survey was jointly sponsored by the Department of Health and Human Services and the National Institute on Aging (NIA).

Funding: NIA—FY91—$2,500,000; FY92—$2,500,000; FY93—$2,500,000; FY94—$100,000

ANALYSIS AND COMPARISON OF STATE BOARD AND CARE REGULATIONS AND THEIR EFFECTS ON THE QUALITY OF CARE IN BOARD AND CARE HOMES

Research Triangle Institute

Catherine Hawes, Principal Investigator

As the Nation's long-term care system evolves, more emphasis is being placed on home and community-based care as an alternative to institutional care. Community-based living arrangements for dependent populations (disabled elderly, mentally ill, persons with mental retardation/developmental disabilities) play a major role in the continuum of long-term care and disability-related services. Prominent among these arrangements are board and care homes.

There is a widespread perception in the Congress and elsewhere that too often board and care home residents are the victims of unsafe and unsanitary living conditions, abuse and neglect by operators, and fraud. There is also the perception that an increasing number of board and care residents are so disabled that they require a level of care greater than board and care operators are able to provide.

This project will analyze the impact of State regulations on the quality of care in board and care homes and document characteristics of board and care facilities, their owners and operators, and collect information on the health status, level of dependency, program participation and service needs of residents.

Funding: FY 1989—$350,000; FY 1990—$300,000; FY 1991—$400,000

End Date: September 1995

EVALUATION OF THE ELDERLY NUTRITION PROGRAM

Mathematica Policy Research

Michael Ponza

At the request of Congress (Section 206 of the 1992 Older Americans Act Amendments), the Department of Health and Human Services is conducting an evaluation of the Elderly Nutrition Program. The evaluation, which is co-sponsored by ASPE and the Administration on Aging, will provide reliable estimates of the impact of the program's nutritional components on the nutrition, health, functioning, and social well being of participants. It will also describe how the program is administered, operated and funded, and the effectiveness of those components. The study will also describe and compare the characteristics of congregate and home-delivered meal participants, and assess how well the program is reaching special populations, such as low-income and minority elderly.

Funding: FY 1993—$1,200,000; FY 1994—$1,245,000

End Date: September 1995

POST-ACUTE CARE FOR MEDICARE PATIENTS

University of Minnesota

Robert Kane, Principal Investigator

The primary objective of this study is to describe the "natural history" of care received by patients with five different impairments (identified by DRG) in three post-acute care modalities. These modalities include home health care, skilled nursing care, and rehabilitation. This study will not only provide a history of what care was delivered in which settings, but will also assess and compare outcomes and costs of care across settings and impairments. In addition, the study will determine the factors that influence hospital discharge decisionmaking. This study's findings may then be used to construct a revised payment method for post-acute care in the Medicare program.

Two sets of data will be collected. The first set will contain information from hospital discharge records and pre and post discharge client interviews in three U.S. cities. The second set will include a 20 percent national sample of Medicare acute care discharges to be linked with the utilization files of Medicare covered services provided in post-acute care settings. Data collection has been completed, and the analysis phase is currently underway.

Funding: FY 1987 $500,000; FY 1988 $727,000; FY 1989 $695,335

End Date: October 1994

A NATIONAL STUDY OF ASSISTED LIVING

Research Triangle Institute—Catherine Hawes, Principal Investigator

Assisted living refers to residential settings that combine housing, personal assistance and other supportive service arrangements for persons with disabilities. These settings are thought to offer greater autonomy and control to consumers over their living and service arrangements than is typically provided by more traditional residential settings, such as nursing homes or board and care homes.

Where assisted living fits in the long-term care system and its potential for addressing the needs of the elderly and persons with disabilities is the focus of this ASPE study. The study will examine the role of assisted living from the perspective of consumers, owners, workers, regulators, developers and investors, and others who have a stake in the Nation's long-term care system.

The study will focus on such issues as (a) trends the supply of assisted living facilities, (b) barriers to development, (c) the existing regulatory structure, (d) the extent to which assisted living embodies in reality the principles of consumer automony and choice in a supportive residential setting, and (e) the effect of such features (or their absence) on persons who live and work in assisted living facilities. The contractor will interview legislators, regulators, housing finance agency experts at the State and national levels; speak with investors and developers; and survey over 900 assisted living operators, plus their staffs and residents across the country.

PUBLIC HEALTH SERVICE—CENTERS FOR DISEASE CONTROL AND PREVENTION

1994 UPDATE OF SENATE SPECIAL COMMITTEE ON AGING'S ANNUAL REPORT, DEVELOPMENTS IN AGING

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

The Health Promotion and Education Database and Cancer Prevention and Control Database contain health information that pertains to aging. The databases include disease prevention, health promotion, and health education information on nutrition, smoking cessation, cholesterol, high blood pressure, injury prevention, exercise, weight management, stress management, diabetes mellitus, and breast and cervical cancer screening. The databases are a valuable resource for health providers working with the elderly. They are available through CDC's CDP (Chronic Disease Prevention) File CD–ROM, the Public Health Service's Combined Health Information Database (CHID) and CDC's WONDER/PC system. CDP File is available from the Superintendent of Documents, Government Printing Office, Washington, DC 20402, 202–512–1800 (Stock No. 717–145–00000–3). CHID can be accessed through most library and information services. Persons who wish to access CHID directly can contact CDP Online, 333 Seventh Avenue, New York, NY 10001, 1–800–950–2035. For more information about WONDER/PC, contact CDC WONDER/PC Customer Support at 404–332–4569.

In 1990, the Aging Studies Branch in the Division of Chronic Disease Control and Community Intervention was established to: (1) conduct epidemiological research, investigations, and surveillance of selected chronic diseases and conditions in older adults; (2) develop and evaluate prevention strategies and demonstration projects; and (3) provide consultation and technical assistance to States and other agencies. Research and programmatic efforts are focused on musculoskeletal diseases (osteoarthritis, osteoporosis), chronic and neurological disease (Alzheimer's disease), urinary incontinence, depression, developing measures of health status and quality of life, assessing long-term care needs among minorities and promoting/supporting State efforts in these areas.

Musculoskeletal diseases are prevalent and disabling chronic diseases, affecting approximately 38 million persons in the United States. Data indicate that 49.4 percent of persons 65 years and older have symptomatic musculoskeletal diseases and 11.6 percent of persons in this age group have arthritis as a major or contributing cause of activity limitation. Data are needed to describe the natural history of disease as well as to direct development of effective intervention efforts. CDC has several projects underway addressing these issues related to osteoporosis and arthritis. Chronic neurological diseases, conditions common among elderly, rank high in measures of morbidity, disability, family stress, and economic burden. For example, the costs due to dementias alone were estimated at $24–$48 billion in 1985, and will increase as the population ages. However, the epidemiology of these conditions is poorly understood. CDC is collaborating in a research study to better understand the epidemiology of Alzheimer's disease.

Urinary incontinence (UI), the involuntary loss of urine so severe as to have social or hygienic consequences, affects 15–30 percent of community-dwelling older people and at least half of all nursing home residents. UI costs are conservatively estimated at $10.3 billion annually. UI goes largely untreated in millions of people, although a third of cases can be cured and another third helped significantly. CDC is investigating incidence and prevalence rates for different types of UI in those 65 and older using National Health and Nutrition Examination Survey-Epidemiologic Follow-up Study. CDC has funded intervention demonstration projects in two States and one university to develop and evaluate strategies to decrease disability due to this cause among older individuals. Results from these efforts should be forthcoming in the next year.

Quality of life is often thought to be more valuable than quantity of life. Several of the measures have been included in the Behavioral Risk Factor Surveillance System (BRFSS) to assess quality of life in the States. Findings from the 1993 BRFSS indicate population subgroup differences in health-related quality of life that can be used to target intervention efforts.

Other projects are examining: co-morbidities among older adults hospitalized with depression, unusual kidney disease among the Zuni Indians, long-term care needs among Southwest Americans Indians, and surveillance of neurological problems resulting from folate supplementation in Vitamin B12 deficient individuals.

The CDC-funded Center for Health Promotion in Older Adults (CHPOA) at the University of Washington School of Public Health is focused on "Keeping Older

People Healthy and Independent." Compared with those receiving standard HMO care, seniors at the HMO Group Health Cooperative of Pugent Sound who had a nurse-educator assessment and up to six interventions had fewer injurous falls, fewer restricted activity days, and better physical function. The Center has identified muscle weakness, lack of physical activity, psychoactive drugs, and home hazards as preventable risk factors for falls and hip fractures which are devastating and costly problems of older adults. The Center also found that a low-cost, low-risk program emphasizing group exercise at a community senior center produced significant improvements in physical function, pain, and indicators of depression. In addition, the Center demonstrated a model of social activation necessary for health promotion among elderly residents of low-income housing facilities.

Diabetes is a major contributor to morbidity and mortality among persons 65 and older. An estimated 2,810,000, or 9 percent of all Americans 65 years of age and older have diagnosed diabetes, compared with less than 2 percent of all Americans below age 65. Each year about 181,000 new cases of diabetes are identified among those who are 65 and older. In 1990, diabetes contributed to over 128,000 deaths and an estimated 1,650,000 hospitalizations among Americans 65 and older. About $5.2 billion in direct medical costs can be attributed annually in the United States to diabetes among persons 65 and older. Across all population groups, diabetes accounts for about $91 billion in direct costs and lost productivity each year in the United States.

During 1994, CDC's effort continued to focus on the prevention of eye disease and cardiovascular disease associated with diabetes. All diabetes control programs funded through cooperative agreements with 46 State and territorial health departments currently address visual impairment associated with diabetes and at least one of the following complications: lower extremity disease or cardiovascular disorders associated with diabetes. In 1990, among Americans with diabetes age 65 and older, there were 31,000 hospital discharges for non-traumatic amputations, In 1989, 62,135 diabetic persons over age 65 died of cardiovascular disease (CVD); CVD is the cause of death for 80 percent of all diabetic persons over 65. In 1989, 4,791 persons over 65 years of age began treatment for end-stage renal disease. Decisions about diabetes control program directions reflect State judgments about disease burden, past program direction and interests, and existing resources within the Department of Health. In FY 1995, as a new 5-year project period began, diabetes control programs will evolve from highly localized demonstration projects to central coordinative mechanisms of fully developed programs, involving the entire State health system, to reduce the burden of diabetes. As such, their activities will be organized around, (1) defining the diabetes burden, (2) developing new approaches to reducing the diabetes burden, (3) implementing specific measures to reduce the burden of diabetes, and (4) coordinating overall program efforts of the health care system to reduce the burden of diabetes.

Breast cancer is the most commonly diagnosed cancer and the second leading cause of death from cancer among American women. Breast and cervical cancer tend to be diagnosed in advanced stages relative to advancing age. Breast cancer mortality could be reduced by up to 30 percent, among women over age 50, if currently recommended screening guidelines, including mammography and clinical breast examinations were followed (PHS 1991). Cervical cancer mortality rates continue to decrease from 14.8/100,000 in 1973/74 to 3.0/100,000 in 1990. However, in those women 50 and older, the rates are still significantly higher than those of women under the age of 50, 2 and 1.3 respectively. Recent data indicate that older women have not been receiving routine screening for cervical cancer. Currently, CDC is funding 50 States, 3 territories, and the District of Columbia through the National Breast and Cervical Cancer Early Detection Program.

NATIONAL CENTER FOR ENVIRONMENTAL HEALTH

The National Center for Environmental Health (NCEH) has finalized Phrase III of the 5-year observation study of women experiencing the climacteric, and a manuscript is in the process. Risk factors for osteoporosis were studied. The study has shown that women have hormone-dependent bone loss before menopause and that androgens as well as estrogens may be important to maintaining bone density in women.

CDC also maintains the national accuracy base for the standardization of lipid and lipoprotein measurements by maintaining reference methods for cholesterol, triglyceride, and high-density lipoprotein cholesterol. In collaboration with the National Heart, Lung, and Blood Institute, CDC provides standardization service to 150 domestic and international lipid laboratories participating in longitudinal studies and clinical trials involving lipid metabolism and the assessment of risk factors

associated with coronary heart disease. CDC has also established a national reference method laboratory network for cholesterol. This network standardizes clinical laboratories and manufacturers of diagnostic products to assist in meeting the Healthy People 2000 objective that at least 90 percent of clinical laboratories measure cholesterol within the recommended national standard for accuracy.

NATIONAL CENTER FOR HEALTH STATISTICS

Background

The National Center for Health Statistics (NCHS) is the Federal Government's principal health statistics agency. The NCHS data systems address the full spectrum of concerns in the health field from birth to death, including overall health status, life style, and onset and diagnosis of illness and disability, and the use of health care.

The Center maintains over a dozen surveys and vital statistics data files that collect health information through personal interviews; physical examination and laboratory testing; review of hospitals, nursing home, and physician records; administrative records; and other means. These data systems, and the analysis and reports that follow, are designed to provide information useful to a variety of policy makers and researchers. NCHS frequently responds to requests for special analyses of data that have already been collected and solicits broad input from the health community in the design and development of its surveys.

Since most of the data systems maintained by NCHS encompass all age groups in the population, a broad range of data on the aging of the population and the resulting impact on health status and the use of health care are produced. For example, NCHS data have documented the continuing rise in life expectancy and trends in mortality that are essential to making population projections. Data are collected on the extent and nature of disability and impairment, limitations on functional ability, and the use of special aids. Surveys currently examine the use of hospitals, nursing homes, physicians' offices, home health care and hospice, and are being expanded to cover hospital emergency rooms and surgi-centers.

In addition to NCHS surveys of the overall population that produce information about the health of older Americans, a number of activities provide special emphasis on the aging. They are described below.

A Focal Point for Data on Aging

NCHS has established a focal point for data on aging by creating a position of Coordinator of Data on Aging. Dr. Joan F. Van Nostrand is the Coordinator. This focal point cuts across the Center's data systems to coordinate:

The collection, analysis and dissemination of health data on older Americans,

International research in data on aging, and

Measurement research in aging in such areas as development of questions on cognitive impairment for population-based surveys and assessment of disability.

The Coordinator provides information to the general public about NCHS activities and data on aging Americans.

International Collaborative Effort on Measuring the Health and Health Care of the Aging

NCHS launched the International Collaborative Effort on Measuring the Health and Health Care of the Aging (abbreviated as the ICE on Aging) in 1988. The purpose of the ICE on Aging is to join with international experts in conducting research to improve the measurement of health and health care of the aging. Research results will be applied to the Center's programs to strengthen the collection, analyses, and dissemination of data on older persons. Results also will be disseminated widely to encourage their international application. The international emphasis of the research permits the exchange of perspectives, approaches, and insights among nations facing similar situations and challenges. The first International Symposium on Data on Aging was held in late 1988 to develop proposals for research in selected areas. Proceedings from the 1988 Symposium were published in 1991 in the Center's *Vital and Health Statistics Series*. The following research projects began in 1989:

Comparative Analysis of Health Statistics for Selected Diseases Common in Older Persons—Hip Fracture: USA and Hong Kong;

Measuring Outcomes of Nursing Home Care: USA, Australia, Canada, The Netherlands, Norway;'

The Measurement of Vitality in Older Persons: USA, Italy and Israel;

Health Promotion and Disease Prevention Among the Aged: USA and the Netherlands; and

Functional Disability: USA, Canada, and Hungary.

A second International Symposium presenting interim results of these research projects was held in 1991. Proceedings were published in 1993. A third and final international symposium is planned for 1995–96 to present final research results. Articles presenting data from the hip fracture research and the nursing home outcomes research have been published:

Van Nostrand, J.F., R. Clark, and T. Romoren. Nursing home care in five nations. *Ageing International: XX,* 2.1–6. 1993.

Ho, S., et al. Hip fracture rates in Hong Kong and U.S., 1988–89. *American Journal of Public Health.* 93(5) 694–97.

NCHS has issued several *Information Updates for the ICE on Aging.* They described each research project in depth and detail progress. To be placed on the mailing list for past and future Information Updates, contact the NCHS Coordinator of Data on Aging, Joan F. Van Nostrand, DPA, Room 1120, National Center for Health Statistics, 6525 Belcrest Road, Hyattsville, MD 2782, phone (301) 436–7104.

Federal Interagency Forum on Aging-Related Statistics

The NCHS, in conjunction with the National Institute on Aging and the Bureau on the Census, co-chairs the Federal Interagency Forum on Aging-Related Statistics. The Forum encourages communication and cooperation among Federal agencies in the collection, analysis, and dissemination of data on the older population. The Forum membership consists of over 20 Federal agencies that produce or analyze data on the aging population.

In 1994, the Forum has produced the following publications. Copies are available from the NCHS Coordinator of Data on Aging:

Cohen, R.A., and J.F. Van Nostrand. Highlights from Trends in the Health of Older Americans: United States, 1994. National Center for Health Statistics, 1994.

Forum activities for 1995 include:

Publication of a report titled Trends in the Health of Older Americans: United States, 1994 *Vital Health Statistics* 3 (30), 1995.

Publication of a bibliography. *Health of an Aging America: 1994 Bibliography, Guide to Reports About Older Americans* from the National Center for Health Statistics.

Development of a report on the relationship between health promotion activities and mortality.

Development of a report on projections of the health and use of care of older Americans in the 21st century.

Measuring Cognitive Impairment in Population-Based Surveys

A Work Group has been established by the Federal Interagency Forum on Aging-Related Statistics with the task of measuring cognitive impairment in national, population-based surveys. The Work Group is to produce field-tested questions on cognitive impairment and its impact on functional disability. These questions will be suitable for national, population-based surveys which focus on the elderly. This activity builds on the previous work of the Forum in developing research recommendations for strengthening assessment of cognitive impairment. Activities in 1994 included a presentation at the Third Practical Aspects of Memory Conference at the University of Maryland entitled Issues in Measuring Impairment in National Sample Surveys. Specific activities for 1994–95 are to: (1) Identify the state-of-the-art in measuring cognitive impairment of the elderly in national surveys, (2) implement a research agenda for strengthening its measurement in national surveys, (3) conduct field-tests of questions. The final product will be several sets of tested questions on cognitive impairment and functional disability which could be used in national, population-based surveys of the elderly.

Vital Statistics on Aging

Mortality statistics from the national vital statistics system continue to play an important role in describing and monitoring the health of the elderly population. The data include measures of life expectancy, causes of death, and age-specific trends in death rates. The basis of the data is information from death certificates, completed by physicians, medical examiners, coroners, and funeral directors, used in combination with population information produced by the U.S. Bureau of the Census.

At NCHS two efforts are currently underway to both assess and improve mortality data for the elderly. NCHS is looking into the possibility of increasing the level of age detail shown in tabulations of mortality for the elderly, focussing on the age group 85 years and over, which is often treated in tabulations as an aggregated category. As life expectancy has increased, the need for detailed mortality data for the "extreme aged" has increased accordingly. Current efforts involve assessing both the availability and quality of mortality and population data for more detailed age groups among the elderly.

Also under study is the process by which medical information on the death certificate is collected, including issues related to the format of the cause-of-death section. The format presently in use, prescribed by the World Health Organization, requests that the certifying physician report a single causal chain of medical events that led to death, initiated by an "underlying" cause of death. The single sequence concept presents difficulties in certification for some elderly deaths which may reflect the consequences of several concurrent disease processes. These and other issues related to certification are now under study.

National Mortality Followback Survey: 1986 and 1993

The 1986 National Mortality Followback Survey (NMFS) was the first such survey in 18 years. Over 100 papers and publications have used the data. The followback survey broadens the information available on the characteristics of mortality among the population of the United States from the routine vital statistics systems by making inquiry of the next of kin of a sample of decedents. Because two-thirds of all deaths in the Nation in a year occur at age 65 or older, the 1986 survey focussed on the study of health and social care provided to older decedents in the last year of life. This is a period of great concern for the individual, the family and community agencies. It is also a period of heavy care use. Agency program planning and national policy development on such issues as hospice care and home care can be informed by the data from the survey. A public use data tape from the next-of-kin questionnaire was released in 1988. A second tape, combining data from the next-of-kin and hospitals and other health care facilities, was available in 1990. Several survey reports focused on the aging. They were about persons dying of diseases of the heart, cerebrovascular disease, utilization of home health care and nursing homes, and risk factors associated with the elderly.

A pretest of the 1993 National Mortality Followback Survey was completed in June, 1992 and field operations for the main survey began in July 1994. The 1993 NMFS design parallels the design of the 1986 survey, with an additional emphasis on deaths due to external causes (homicide, suicide, and accidents) and disability in the last year of life. Hospital records are not included in the 1993 survey; however, medical examiner/coroner records are included for deaths referred to medical examiners/coroners. To investigate death among the elderly, a specific sub-sample of 1,000 centenarians will be included in the survey. Release of a public use data tape is anticipated for mid-1996.

National Health Interview (NHIS): Special Topics

The NHIS continues to collect data on a wide range of special health topics for the civilian, non-institutionalized population, including the aging population. Data collection has begun for 1994–95 for the special health topics on disabilities. The disability topic has two phases. The first phase questionnaire identifies persons with disabilities. The second phase collects detailed information about persons identified as having a disability.

Disability Phase 1 includes section on.—Sensory, communication and mobility problems; selected chronic conditions; activities and instrumental activities of daily living (ADL/IADL); functional limitations (including work disability); mental health; services and benefits; self-perceived disability; condition pages; (the following is asked only of persons under 18 years of age) special health needs of children; early child development; education; and relationships to respondent.

Disability Phase 2 includes section on.—Housing and long-term care services; transportation; social activity; work history/employment; vocational rehabilitation; assistance with key activities; other services; self direction; communication (the following is asked only of persons 70 years and over) family structure, relationships and living arrangements; conditions and impairments; help with care; health opinions and behaviors; community services and social support; and interviewer observations.

Data collection for an NHIS data year begins in January of that year and ends in December. Public-use data tapes are usually available about one year after the end of data collection.

Second Supplement on Aging (SOA II)

In 1994 the National Center for Health Statistics will conduct a second Supplement on Aging (SOA II) as part of the National Health Interview Survey. Interviews will be conducted with a nationally representative sample of approximately 10,000 civilian non-institutionalized Americans age 70 years and older. The study will provide important data on the elderly that can be compared with similar data from the 1984 SOA. In addition SOA II may serve as a baseline for a second Longitudinal Study on Aging (LSOA–II), which would follow the baseline cohort through one or more followback waves.

Information for SOA II will be obtained from the 1994 NHIS core questionnaire and Phase 1 of the 1994 Disability Supplement (both of which are administered to household respondents), from functional limitation questions asked of all healthy and disabled elderly age 70 years and older as part of Phase 2 of the Disability Supplement, and from questions on a separate Supplement on Aging asked of all individuals age 70 years and older. Both the Phase 2 Disability Supplement and the Supplement on Aging will be administered during a separate contact, 6 to 9 months after the core questionnaire. Survey questions and methodology will be similar to the first Longitudinal Study on Aging (LSOA–I), but improvements will reflect a number of methodological and conceptual developments that have occurred in the past decade, as well as suggestions made by users of LSOA–I and others in the research community.

A primary objective of SOA II is to examine changes which may have occurred in physical functioning and health status among the elderly over the past decade. To this end, questions concerning physical functioning and health status and their correlates will be repeated in SOA II. These include questions on Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), and functional limitations (Nagi), as well as medical conditions and impairments, family structure and relationships, and social and community support. In addition to these repeated items, the SOA II questionnaire has been expanded to include information on risk factors (tobacco and alcohol use), additional detail on both informal and formal support services, and questions concerning the use of prescription medications.

The data, when used in conjunction with data from LSOA–I, will enable users to identify changes in functional status, health care need so living arrangements, social support, and other important aspects of life across two cohorts with different life course perspectives. This will provide researchers and policy planners with an opportunity to examine trends and determinants of "healthy aging."

Longitudinal Study on Aging

The Longitudinal Study on Aging (LSOA) has been a collaborative effort of the National Center for Health Statistics and the National Institute of Aging. The baseline information for the LSOA came from the Supplement on Aging (SOA), a supplement to the 1984 National Health Interview Survey (NHIS).

The SOA included 16,148 persons 55 years of age and over living in the community in 1984. The Supplement obtained information on housing, including barriers and ownership; support, including number and proximity of living children and recent contacts in the community; retirement, including reasons for retirement and sources of retirement income; and measures of disability, including activities of daily living, instrumental activities of daily living and ability to perform work-related activities.

The sample for the LSOA came from the 7,541 persons who were 70 years of age and older at the time of the SOA in 1984. The survey was designed to measure changes in functional status and living arrangements, including institutionalization. Reinterviews were conducted in 1986, 1988, and 1990. The recontacts were primarily by telephone using Computer Assisted Telephone Interviewing (CATI); however, when the telephone contact was not feasible, a mail questionnaire was sent to the sample person. In addition, to the three reinterviews, permission was obtained from the sample person or proxy to match their records with other records maintained by the Department of Health and Human Services.

The fourth version of the LSOA public use data tape was released in October 1991. The information for the Version 4 files was obtained from:

1984 NHIS, SOA, and Health Insurance Supplement to the NHIS
1986, 1988, and 1990 telephone interviews with mail follow-up
1984–1989 National Death Index (NDI) match
1984–1990 Medicare records match

The public use data tape includes three files—one for persons, one for Medicare hospitalizations, and one for other Medicare use. Each file includes the information obtained in the previous reinterviews. These data are also available on CD–ROM.

A diskette containing detailed multiple cause of death data for the LSOA sample is available. The diskette complements the Version 4 public use data tape. Future releases of the LSOA public use data tape will include information from additional matches to the NDI and Medicare files.

The LSOA public use data sets are available from three sources: The National Technical Information Service (NTIS), The Division of Health Interview Statistics, NCHS, and the National Archives of Computerized Data on Aging. The diskette on multiple cause of death is available from NTIS.

National Health and Nutrition Examination Survey III

The National Health and Nutrition Examination Survey (NHANES) provides valuable information available through direct physical examinations of a probability sample of the population. The third cycle of this survey, NHANES III, went into the field in 1988. Data collection ended in October 1994. NHANES III will provide a unique data base for older persons, as a number of important methodologic changes have been made in the survey structure. There is no upper age limit (previous surveys had an age limit of 74 years), and the sample has been selected to include approximately 1,300 persons aged 80 or older. The focus of the survey includes many of the major chronic diseases of aging which cause morbidity and mortality including cardiovascular disease, osteoarthritis, osteoporosis, pulmonary disease, dental disease and diabetes. Preliminary Data on Nutrition for the Elderly has been published in McDowell MA, Briefel RR, Alaimo K, et al. Energy and Macronutrient Intakes of Persons Ages Two Months and Over in the United States: Examination Survey, Phase 1, 1988–91. *Advance Data from Vital and Health Statistics;* No. 255. Hyattsville, Maryland: National Center for Health Statistics, 1994.

In addition to the focus on nutrition, information on social, cognitive and physical function is incorporated into the survey. Data from home examinations will be available for those unable or unwilling to come to the central examination site, the Mobile Examination Center.

NHANES I Epidemiologic Followup Study

The first National Health and Nutrition Examination Survey (NHANES I) was conducted during the period 1971–75. The NHANES I Epidemiologic Followup Study (NHEFS) tracks and reinterviews the 14,407 participants who were 25–74 years of age when first examined in NHANES I. NHEFS was designed to investigate the relationships between clinical, nutritional, and behavioral factors assessed at baseline (NHANES I) and subsequent morbidity, mortality, hospital utilization, as well as changes in risk factors, functional limitation and institutionalization. Followups were conducted in 1982–84, 1986 (limited to persons age 55 and over at baseline) and 1987. Data collection for the fourth wave of the followup, the 1992 NHEFS, was completed in June 1993. The preliminary editing phase is underway and is scheduled for completion in February 1994. Detailed editing will begin March 1994 and is scheduled to be completed in February 1995.

While persons examined in NHANES I were all under age 75 at baseline, by 1987 more than 3,600 subjects were over 75, providing a valuable study group to examine the aging process. Public use data tapes are available from the National Technical Information Service for the first three waves of followup. Each set of four tapes contain information on vital and tracing status, subject and proxy interviews, health care facility stays in hospitals and nursing homes, and mortality data from death certificates. All NHEFS Public Use Data Tapes can be linked to the NHANES I (baseline) Public Use Data Tapes.

National Health Care Survey (NHCS)

In order to provide more comprehensive data describing the Nation's use of health care providers into an integrated family of surveys, collectively called the National Health Care Survey (NHCS). The objectives of the NHCS are to provide national data describing the utilization of services in ambulatory, hospital and long-term care settings; to provide these data on an annual basis using an integrated cluster sample design; and to develop the capability of conducting patient follow-up studies.

Currently, the NHCS includes six ongoing national data collection activities:

The National Ambulatory Medical Care Survey—visits to non-Federal, office-based physicians;

the National Home and Hospice Care Survey—patients of hospices and home health agencies;

the National Hospital Discharge Survey—discharges from non-Federal, short-stay hospitals;

the National Hospital Ambulatory Medical Care Survey—visits to emergency and outpatient departments of non-Federal, short-stay hospitals;

the National Health Provider Inventory—a national listing of nursing homes, hospices, home health agencies and licensed residential care facilities; and

the National Survey of Ambulatory Surgery—discharges from hospital-based and free-standing ambulatory survey centers.

Details on specific surveys relevant to the elderly are presented below by specific survey. Plans call for the implementation of the National Nursing Home Survey in 1995 and in 1997.

National Home and Hospice Care Survey

The National Home and Hospice Care Survey (NHHCS) is a national probability sample survey of home health and hospice care agencies, and their patients. The 1992 NHHCS, the first of an annual survey, collected data from a nationally representative sample of 1,500 hospices and home health agencies. The second survey was conducted in 1993. All agencies providing home health and hospice care were included in the survey without regard to licensure or to certification status under Medicare and/or Medicaid. Information about the agency was collected through personal interview with the administrator. Information was collected about a sample of six current patients and six discharged patients through personal interview with designated agency staff. Data from the NHHCS will allow analysis of the relationships that exist between utilization, services offered, and charges for care, as well as provide national baseline data about home health an hospice care agencies, and their patients.

Data from the NHHCS was analyzed and published in 1993 and 1994 in NCHS *Advance Data* reports. Other analyses will be released in Series 13 *Vital and Health Statistics.* In addition, data are released in the form of public use computer tapes and in the form of special tabulations prepared for individual requestors.

National Health Provider Inventory (NHPI)

The National Center for Health Statistics (NCHS) conducted the NHPI, formerly called the National Master Facility Inventory, in the spring of 1991. This mail survey includes the following categories of health care providers: nursing and related care homes, licensed residential care facilities, facilities for the mentally retarded, home health agencies, and hospices. Data from the 1991 NHPI was used to provide national statistics on the number, type, and geographic distribution of these health providers and to serve as sampling frames for future surveys in the Long-Term Care Component of the National Health Care Survey. The 1991 NHPI public-use tapes are available at National Technical Information Service.

National Survey of Ambulatory Surgery (NSAS)

The National Survey of Ambulatory Surgery (NSAS) is currently in the field. Data will be available in late 1995.

National Hospital Discharge Survey

The National Hospital Discharge Survey (NHDS) is the principal source of national information on impatient utilization of non-Federal, short-stay hospitals. The NHDS was redesigned in 1988 as one of the components of the National Health Care Survey. This survey collects data on the demographic characteristics of patients, expected source of payment, diagnoses, procedures, length of stay, and selected hospital characteristics.

Data reports and public-use tapes are available from 1970 through 1992. A multiyear dataset covering the years 1979 through 1992 is available on CTAPE from the National Technical Information Service (NTIS) Fall of 1994. Diskettes containing tabulations published in the Series 13, Detailed Diagnoses and Procedures Report, are available for 1985 through 1992.

National Nursing Home Survey

During 1985, NCHS conducted the National Nursing Home Survey (NNHS) to provide valuable information about older persons in nursing homes. The NNHS was first conducted in 1973–74 and again in 1977. Preliminary data from the 1985 survey were published in 1987–88 and a summary report, which integrated final data from the various components of the survey, was published in 1989. Also published were analytical reports on: diagnostic and related groups, utilization, discharges, current residents and mental health status. Public-use computer tapes are available

through the National Technical Information Service. Plans call for implementation of the next NNHS in 1995.

National Nursing Home Survey Followup

The National Nursing Home Survey Followup (NNHSF) is a longitudinal study which follows the cohort of current residents and discharged residents sampled from the 1985 NNHS described above. The NNHSP builds on the data collected from the 1985 NNHS by extending the period of observation by approximately 5 years. Data collection has been completed. Wave I was conducted from August through December 1978, and Wave II was conducted in the fall of 1988. Wave III began in January of 1990 and continued through April. The study is a collaborative project between NCHS, HHS and the National Institute on Aging (NIA). The followup was funded primarily by NIA and was developed and conducted by NCHS.

The NNHSF interviews were conducted using a computer-assisted telephone interview system. Questions concerning vital status, nursing home and hospital utilization since the last contact, current living arrangements, Medicare number, and source of payment were asked. Respondents included subjects, proxies, and staff of nursing homes.

The NNHSF provides data on the flow of persons in and out of long-term care facilities and hospitals. These utilization profiles will also be examined in relation to information on the resident, the nursing home and the community. Public-use computer tapes for WAVES I, II, and III of the NNHSF are available through the National Technical Information Services (NTIS). In addition, the National Nursing Home Survey Followup Mortality Data Tape, 1984–90 is now available through NTIS.

National Employer Health Insurance Survey (NEHIS)

The National Employer Health Insurance Survey is being jointly conducted by the NCHS, the Health Care Financing Administration, and the Agency for Health Care Policy and Research. The NEHIS will provide data necessary to produce national level estimates of total employer-sponsored private health insurance premiums, the employer and employee premium share, the total amount of benefits provided, and the administrative cost. In addition to the number of workers, retirees, and former workers covered, the survey will provide the breadth of policy benefits and the number and characteristics of plans in each establishment.

The NEHIS is being conducted in all 50 States and the District of Columbia. Interviews will be completed for approximately 43,000 business establishments, sampled from several size categories. The data collection method will be Computer Assisted Telephone Interviewing (CATI). Data will be released to the public in the form of published reports and electronic data products.

The estimates will be used to gain an understanding of geographic variations in spending for health care and the probable differential impacts that proposed health policy initiatives will have by State. As the private sector, State and Federal Governments develop and implement reforms of the health care system, there are likely to be major changes in the extent and form of private health insurance coverage, benefits, and premium sharing. No discussion of the impact of the reform upon business and individuals can be complete without analysis of these changes. Over the past several years, the task of producing national private health insurance premiums and benefit estimates has increased in difficulty as the industry has become more complex. Simultaneously, the importance of accurate health care costs estimates has increased as the pressure or burden of health care costs have mounted on the primary health care payers such as government, business and households and as initiatives to contain cost growth have been discussed and implemented.

Improving Questions on Functional Limitations

The National Laboratory for Collaborative Research in Cognition and Survey Measurement of NCHS conducted several cognitive research projects with old (65–74), very old (75–84), and oldest (85+) respondents. The objectives were to test the adequacy and suggest improvements to existing survey questions for collecting information on functional limitations (e.g., limitations on bathing, dressing, transferring), life history events (education, employment, residence, onset of health conditions) and falls.

Activities include:

Publication of Problems Eliciting Elders' Reports of Functional Status by Keller, Kovar, Jobe, and Branch in *Journal of Aging and Health,* Vol. 5, No. 3.

Presentation of Cognitive Techniques in Interviewing Older People by Jobe, Keller, and Smith at the Conference on Methods of Determining Cognitive Processes Used to Answer Questions, Champaign, IL, November, 1993.

NATIONAL CENTER FOR INFECTIOUS DISEASES

Infectious diseases have a disproportionate impact on older Americans. Pneumonia and influenza remain the sixth leading cause of death in the United States and septicemia has risen dramatically during the past three decades to become the 13th leading cause of death. Pneumonia and septicemia are also contributing and precipitating factors in the deaths of many Americans with other illnesses, especially cardiovascular diseases, cancer, and diabetes. Quality of life declines for millions of older Americans as a result of infectious illnesses. Prevention and control of infectious disease will enhance and lengthen the lives of older Americans.

CDC emphasizes surveillance and training to prevent and control hospital-acquired and other institutionally acquired infections in elderly patients. CDC conducts surveillance of elderly patients in hospitals and trains practitioners in nursing homes. Additionally, CDC staff provides education regarding infection control to care providers at nursing home and patient care conferences. This education focuses on patient care treatment and procedures associated with the highest risk of infection. Through the National Nosocomial Infections Surveillance (NNIS) system, special infection risks of elderly patients have been identified. According to NNIS, over half of the hospital-acquired infections occur in elderly patients, although these patients represent about one-third of all discharges from hospitals. The use of certain devices, such as urinary catheters, central lines, and ventilators, are associated with high risk of infection in all types of patients. In elderly patients, the risk of infection is high even when a device is not used, suggesting that infection control must address other risk factors such as lack of mobility and poor hygiene and nutrition, in addition to device use.

Although delivering the influenza vaccine to persons at risk is a critical step in preventing illness and death from influenza, immunization is only part of the prevention equation. CDC's efforts to combat influenza in the elderly include: (1) conducting prospective surveillance for influenza and other respiratory viruses in nursing homes; (2) conducting studies to better define the immunological response of the elderly to influenza vaccines and to natural infection; (3) conducting immunological studies involving laboratory and clincial evaluation of inactivated and live attenuated influenza vaccines in an effort to identify improved vaccine candidates; (4) increasing surveillance of influenza in the People's Republic of China and other countries in the Pacific Basin to better monitor antigenic changes in the virus; (5) improving methodologies for rapid viral diagnosis; and (6) using recombinant DNA techniques to develop influenza vaccines that may protect against a wider spectrum of antigenic variants.

Pneumococcal pneumonia causes an estimated 40,000 deaths each year; 80–90 percent of these are in persons ≥ 65 years old. Prevention of pneumococcal disease in the elderly requires widespread application of effective immunization. CDC is currently evaluating the emergence of drug-resistant pneumococcal strains through laboratory-based surveillance and is actively promoting increased vaccine use in the elderly and other groups at risk. This is critical to decrease illness and death from pneumococcal infections in the elderly. Cost-benefit analyses are favorable for the current vaccine; however, the benefits to the population, and to society in general, would significantly increase with a more effective vaccine.

Recent studies have suggested that noninfluenza viruses such as respiratory syncytial virus and the parainfluenza viruses may be responsible for as much as 20 percent of serious lower respiratory tract infections in the elderly. These infections can cause outbreaks that may be controlled by infection control measures and be treated with antiviral drugs. Consequently, it is important to define the role of these viruses and risk factors for these infections among the elderly population. CDC is completing a collaborative investigation of respiratory syncytial virus, the parainfluenza viruses, and adenovirus infections associated lower respiratory tract infections among hospitalized adults to determine the proportion caused by these viruses and associated risk factors.

Group B streptococcus (GBS) is a major cause of invasive bacterial disease in elderly persons in the United States. To document the magnitude of GBS disease in the elderly and develop preventive measures, CDC established population-based surveillance for GBS disease and case control studies to identify risk factors for GBS disease in the elderly. An article published in June 1993 in The New England Journal of Medicine documents some of the findings. The incidence of GBS disease in nonpregnant adults increased with age and was particularly high in older blacks.

For example, the incidence of black adults who are 70 years and older was 47 per 100,000 compared to 5 per 100,000 in black adults ages 20–29. The in-hospital mortality rate for this particular study was 21 percent among the nonpregnant adults. This data will be utilized to develop and evaluate vaccines and to promote the prevention and treatment of GBS disease in the elderly population.

Foodborne disease is of particular concern in the elderly, who typically can have higher illnesses and death from foodborne pathogens than younger persons. Of particular concern are Salmonella enteritidis infections, often caused by undercooked eggs, and Escherichia coli 0157:H7 infections, often caused by undercooked hamburger. CDC is working with USDA and FDA to encourage use of pasteurized eggs in nursing homes and thorough cooking of hamburger meat.

Studies using information from national data bases show that of all age groups, the elderly (≥70 years) have the greatest number of hospitalizations and deaths associated with diarrhea in the United States. Efforts to control this important cause of illness requires further study of the agents involved and their transmission. The recent identification of rotavirus as a cause of epidemic diarrhea in the elderly suggests that one approach to control may involve use of vaccines currently being developed for young children.

NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

Several CDC funded Extramural Injury Research Grants have focused on injury prevention in the elderly. The following Extramural Research Grants to study problems affecting the elderly include:

Hip Fracture Prevention from Falls in the Elderly Research Program Project Grant

The theme of the Research Program Project grant in "Hip Fracture Prevention from Falls in the Elderly" and as such addresses falls as a leading cause of unintentional injury, the elderly as a target population at greatest risk, prevention as a major phase of injury control, and biomechanics as one of its major disciplines. The proposed RPPG is an outgrowth of a CDC Injury Prevention and Control Research Project entitled "Biomechanics of Hip Fracture Risk" which provided new evidence that fall severity is a dominant factor in the etiology of hip fractures in the elderly. Based on the findings of the RO1 grant, this project will attempt to extend these concepts to a prevention program which represents a cluster of three interdisciplinary research projects focusing on injury prevention through the integrated application of biomechanics, engineering and geriatric medicine. Three projects will accomplish this goal: (1) Hip Fracture Prevention by Trochanteric Padding; (2) Bisphosphonate Therapy for Prevention of Femoral Osteoporosis, and (3) Biomechanics of Hip Fracture Risk.

Dually Stiff Floors for Injury Prevention of the Elderly

The aim of this project is to develop an intervention to reduce injuries from falls based on "Dually Stiff Flooring." The investigator proposes a floor designed to offer both a non-compliant configuration during normal motions and a significant advance in protection from injuries due to falls. The proposed intervention could have wide application in living areas for the elderly.

Biomechanics of Slips on Ramps and Level Surfaces

The long-term goal of this study is to improve the design of ramps and walkways to reduce slip and fall injuries. This will be accomplished by gaining an improved understanding of the biomechanics of slips and falls on level walkways and ramps under varying conditions. Body kinematics and foot forces of subjects walking on ramps of differing angles under slippery conditions will be performed. This biomechanical analysis will then be compared to slip resistance measurements of the floor surface acquired by six different testing devices currently used in the evaluation of the shoe/floor interface.

Elderly Driver Referral Project

The proposed study will attempt to ascertain relationships between the capabilities of drivers and their safety of operation in order to enable license administrators to initiate licensing actions that minimize the threat from those who cannot operate safely while preserving the mobility of those who can. The psychophysical capabilities of the entire sample will be assessed through a battery of test measures designed specifically to tap capabilities shown to relate separately to age and highway accidents. The relationships obtained in this manner will be applied to (1) improve

the methods of detecting drivers whose abilities may be diminished by age, (2) develop tests to validly assess drivers' ability to drive safely, and (3) formulate licensing actions capable of achieving an optimum balance between safety and mobility.

Spectral Signature as a Predictor of Falls in the Elderly

This proposal will develop a method to identify elderly individuals that may be at risk of falling. This method will involve the use of the spectral signature of force plate data obtained from postural sway to predict the potential of falls among elderly patients. Data from this study will augment existing knowledge in the area of biomechanical prevention of falls.

Preventing Falls in the Nursing Home Elderly

This study seeks to evaluate an intervention to reduce falls among nursing home residents by comparing rates of falls between intervention and control nursing homes. The intervention targets environmental safety, caregiving practices, medications, resident activity, and resident and staff education.

Antidepressants and the Risk of Falls

This study proposes a retrospective, inception cohort study of an estimated 2,500 new antidepressant users and 2,500 nonusers for the period of 7/1/93 through 6/30/95. The study will be conducted in nursing homes because residents have the highest prevalence of depression and antidepressant use, are particularly vulnerable to tricyclic antidepressants (TCA) adverse effects, and have the highest rates of falls and related injuries. Study findings will further injury control by providing information clinicians need to chose pharmacotherapy that minimizes risk of falls.

Driving Ability and Car Crashes in Old Age and Dementia

The investigators propose to objectively determine which neuropsychological and psychophysical measures best discriminate between safe and unsafe drivers, by comparing the performance of the Alzheimer's Disease (AD) patients on the driving simulator and on a battery of off-road behavioral tests with their actual road-test scores and State driving records. One of the ultimate goals of this line of research is the development of fair and accurate criteria to predict driving ability in cognitively disabled populations.

Longitudinal Studies of Elderly Drivers: Functional and Medical Correlates of Motor Vehicle Crashes

This study extends the current "Longitudinal Study of Elderly Drivers" project which began in 1992 and was scheduled to be completed in 1995. The investigators have assembled a 20 year longitudinal crash history file for 400,000 drivers 65 or older for the period 1971–90. They plan to utilize this file and access to state DOT personnel and beginning this spring to conduct a prospective cohort study of 5,000 elderly drivers who successfully complete application renewal procedures.

The following Intramural Research Grants to study problems affecting the elderly include:

The Study to Assess Falls Among the Elderly (SAFE) was a population-based case-control study of falls among community dwelling elderly in South Miami Beach, Florida from 1987 through 1989. The SAFE data set includes 175 female hip fracture cases and 935 controls age 65 and older. Two projects are planned using these data.

1. CDC, in collaboration with the Miami Veterans Administration Center, will develop a self-administered home hazards assessment instrument using female VA patients over age 65. CDC will distribute this validated instrument to state health departments where it will be used as the basis for fall intervention and prevention strategies.
2. SAFE also contains the names of both prescription and non-prescription medications that study participants took in the month before their injury occurred. These data will be used to describe medication use and to determine whether certain classes of medications increase hip fracture risk among elderly women.

NATIONAL IMMUNIZATION PROGRAM

CDC is continuing its efforts to increase the awareness of adults to be immunized against the vaccine-preventable diseases of influenza, pneumococcal disease, hepa-

titis B, measles, mumps, rubella, tetanus, and diphtheria. As a liaison with outside organizations that promote adult immunization activities, such as the Administration on Aging, the American College of Physicians, and the American Hospital Association, CDC provides speakers for conferences and technical review of documents. CDC responds to public inquiries and has available a booklet for the lay public, "Immunization of Adults: A Call to Action," which promotes immunization of adults in the community. CDC is also continuing assistance to State and local health systems in expanding immunization program coverage of adult populations through promotion of the recommendations of the Advisory Committee on Immunization Practices (ACIP). These recommendations were revised and published in November 1991.

CDC continues to include adult immunization issues in its annual National Immunization Conference. In the 26th and 27th Conferences held in St. Louis, MO in June 1992 and in Washington, D.C. in June 1993, respectively, at least one poster and eight oral presentations addressed various adult immunization issues. In the 28th Conference held in Charlotte, NC in June 1994, three poster and four oral presentations focused on adult immunization.

The National Vaccine Advisory Committee (NVAC) Report on Adult Immunization was adopted January 1994 and establishes five major goals for adult immunization in the United States, 18 recommendations for achieving these goals, and 72 strategies recommended for implementation. The goals include:

improving provider and public awareness,
assuring adequate delivery of vaccines to adults,
assuring adequate financing mechanisms for adult vaccination,
improving disease surveillance and monitoring of vaccination levels, and
assuring adequate support for research in five key areas.

Assistant Secretary for Health, Dr. Philip R. Lee, has also asked the National Vaccine Program Office (NVPO) to consult with CDC, the National Institutes of Health (NIH), the Food and Drug Administration (FDA), Health Care Financing Administration (HCFA), and other relevant agencies to identify steps to implement the report's recommendations. Dr. Lee also asked the NVPO to encourage States and private sector organizations to address the recommendations in the report.

CDC continues to participate in the National Coalition for Adult Immunization (NCAI), a network of 73 private, professional, volunteer organizations, and public health agencies with the common goal of improving the immunization status of adults. Each year during the last week of October, the NCAI promotes National Adult Immunization Awareness Week to emphasize the importance of vaccinating all adults. To unify the diverse interests of the member organizations and offer a foundation of common goals, the NCAI has developed and adopted the Standards for Adult Immunization Practice. The Standards outline basic strategies that, if fully implemented, would improve delivery of vaccines to adults and help achieve the Year 2000 National Health Objectives. The objectives of the NCAI are accomplished by three working Action Groups—Influenza/Pneumonia, Measles-Mumps-Rubella, and Hepatitis B—that conduct disease-specific informational and educational activities for health care providers and the public.

The Healthy People 2000 goal for influenza vaccination coverage of noninstitutionalized persons at risk of complications is 60 percent. Influenza vaccination levels in such persons ≥65 years of age have steadily improved from 23 percent in 1985 to 41 percent in 1991. The 1993 vaccination level in this age group was 51.2 percent, based on preliminary data from the NCHS' 1993 National Health Interview Survey. The increases in older persons may be attributable to better acceptance by practitioners and the public of preventive medical services, increasing delivery of vaccine by nonphysicians such as visiting nurse and home health agencies, and lack of perceived risk associated with vaccination.

CDC and the Health Care Financing Administration are also participating in an interagency agreement, begun in 1989, to study the effectiveness of pneumococcal vaccine in preventing morbidity and mortality among the Medical Part B beneficiaries in Hawaii. Medicare records are being used to: (1) evaluate the clinical effectiveness of pneumococcal vaccination in preventing hospitalization and death of Medicare beneficiaries; (2) describe medical care utilization patterns of vaccinated and unvaccinated persons; (3) evaluate hospital care patterns of vaccinated and unvaccinated persons; and (4) evaluate long-term outcomes of individuals in relationship to vaccination status. The final reports of the project will be completed in 1994.

NATIONAL CENTER FOR PREVENTION SERVICES

Tuberculosis

During 1993, 5,847 TB cases were reported among persons 65 and older—the case rate for persons of all ages was 9.8 per 100,000 population while the rate for persons age 65 and older was 17.8.

Elderly residents of nursing homes are at even higher risk for developing TB than elderly persons living in the community. According to a CDC-sponsored 1978–85 survey of 15,379 reported TB cases in 29 States the incidence of TB among elderly nursing home residents was 39.2 per 100,000 person-years while the incidence of TB among elderly persons living in the community was 21.5 per 100,000 person-years. Investigators have also documented transmission of tuberculosis infection to residents and staff in nursing homes during TB outbreaks.

During 1990, the CDC and the HHS Advisory Council for Elimination of Tuberculosis published recommendations for controlling TB among nursing home residents and employees. The recommendations called for TB screening of nursing home residents upon admission and employees at entry, annual rescreening for employees, attention to timely case-finding among symptomatic elderly persons, and the use of appropriate precautions to prevent the spread of TB in facilities providing residential care for elderly persons.

Oral Health and Dental Disease Prevention

CDC and the National Institute of Dental Research, NIH, have developed a plan to achieve functional and healthy oral conditions for all Americans. The U.S. Public Health Service (PHS), through its Oral Health Coordinating Committee, is taking steps to implement the PHS Oral Health 2000 Adult Initiative. This initiative, viewed as a decade-long commitment, represents the collective effort of PHS agencies to accelerate improvement in oral health for adult Americans particularly those at increased risk of oral diseases including older adults. The private and voluntary sector will also be involved to facilitate comprehensive approaches to reduce the occurrence and severity of oral diseases; prevent the unnecessary loss of teeth in the U.S. population; and alleviate physical, cultural, racial/ethnic, social educational, economic, health care delivery, and environmental barriers that prevent adults from achieving good oral health.

Persons are at higher risk for oral cavity and pharyngeal cancer as their age increase. Approximately 95 percent of oral cavity and pharyngeal cancer occurs in persons aged 40 and over, with 60 years as the average age at diagnosis. Individuals aged 65 and over experience poorer survival rates from these cancers.

CDC has developed liaisons with Federal and State agencies to (1) assess the magnitude of the disease burden from cancers of the oral cavity and pharynx; (2) determine the extent of programs currently in place that address the problem; and (3) begin development of a comprehensive public health strategy to reduce incidence and morality rates in the United States. CDC and NIH have developed a monograph on oral cavity and pharyngeal cancers to provide public health, research, education, and health care provider communities with detailed information on the incidence, mortality, and 5-year relative survival rates for oral and pharyngeal cancer in the United States. This publication was published in November 1991.

A work group composed of representatives from Federal agencies, academic institutions, private dentistry, and State health departments was convened by CDC in early December to begin developing a national strategy.

FOOD AND DRUG ADMINISTRATION

As the percentage of elderly in the Nation's population continues to increase, the Food and Drug Administration (FDA) has been giving increasing attention to the elderly in the programs developed and implemented by the agency. To enhance this effort, the FDA Working Group on Aging-Related Issues was established in 1992. FDA has been focusing on several areas for the elderly that fall under its responsibility in the regulation of foods, drugs, and medical devices. Efforts in education, labeling, drug testing, drug utilization, and adverse reactions are of primary interest. Working relationships exist with the National Institute on Aging, the Centers for Disease Control, and the Administration on Aging of the Department of Health and Human Services to further strengthen programs that will assist the elderly now and in the future. Some of the major initiatives that are underway are described below.

CONSUMER EDUCATION

To further the goals established by the joint Public Health Service/Administration on Aging Committee on Health Promotion for the Elderly, during the last 8 years FDA has coordinated the development and implementation of significant consumer education programs with the National Council on Patient Information and Education (NCPIE) and many private sector organizations. NCPIE is a nongovernmental group consisting of professional (e.g., medical, pharmacy, nursing), consumer, and pharmaceutical industry organizations whose goal is to stimulate consumer education and program development. Special emphasis has been placed on the elderly, who use more prescription drugs per capita than the rest of the population.

The "Get the Answers" campaign is a program urging consumers to ask their health professionals questions about their prescriptions. The major component of the campaign is a medical data wallet card that lists the five questions consumers should ask when they get a prescription. These questions are:

What is the name of the drug and what is it supposed to do?

How and when do I take it—and for how long?

What foods, drinks, and other medicines, or activities should I avoid while taking this drug?

Are there any side effects, and what do I do if they occur?

Is there any written information available about the drug?

The "Get the Answers" message has been widely disseminated to consumers through news releases, advice columns, and other media. Wallet cards with the "Get the Answers" message are available through FDA's Office of Consumer Affairs and around the country in FDA's local offices from Public Affairs Specialists (PAS).

The Women and Medicines Campaign was initiated during "Talk About Prescriptions" month, October 1991. The purpose of the campaign is to ensure safer and more effective use of medicines through improved communication between women and health care providers (e.g., doctors, pharmacists, dentists, nurses). The campaign focuses on concerns related to all women, but especially targets vulnerable populations such as the elderly and minorities. It is important because women use more medicines than men and serve as the medicine managers for other family members. A brochure and planning guide were produced by NCPIE with the support of FDA. These materials can be used in many settings, including classrooms, waiting rooms, workplace seminars, and health fairs.

The brochure, "Medicines: What Every Woman Should Know," shares information that will assist women to improve communication with health care providers. The planning guide, "Women Have Special Medicine Information Needs," shares information that will assist health care providers to improve communication with Women.

Concurrent with the activities aimed at consumers, FDA, NCPIE, and many private sector organizations are conducting a major campaign to encourage health professionals to provide drug information to their patients. Urging consumers to "Get the Answers" and health professionals to "Give the Answers" is vital to bridge the communications gap—to get both sides to talk to each other about medications.

Currently, NCPIE is advocating the use of "Brown Bag Mediation Review." This is a procedure to permit health professionals to review all medication being taken by elderly patients. Patients are asked to bring in all their current medication (in a brown bag) to an appointment with a physician, nurse, pharmacist, or other health professional. NCPIE is using funds from a grant from the Administration on Aging to disseminate materials and promote the program to health professionals. FDA's Field Public Affairs Specialists (PAS) promote and coordinate these brown bag review in their local areas.

In additional to consumer education initiatives, FDA and NCPIE are continuing to evaluate the effectiveness of consumer education programs and are monitoring the attitudes and behavior of consumers and health professionals about consumer drug information. FDA is encourage by the number and quality of consumer education activities undertaken by the various sectors. FDA will continue to provide leadership to foster the consumer education initiative.

FDA's continuing consumer education initiatives include the publication of the reprints "Testing Drugs in Older People" and "Unproven Medical Treatments Lure the Elderly" from the *FDA Consumer* magazine. The first article discusses the physiological changes that occur in aging bodies and the need for medication adjustment. The second article illustrates the impact unproven remedies pose to the elderly population.

FDA's Office of Consumer Affairs continues to provide the elderly with consumer education about FDA-regulated products through consumer briefings, meetings,

consumer advisory committee participation, information campaigns, "Dear Consumer" letters, information through the Consumer Inquiry Line, and the *Consumer Quarterly*. One example of a "Dear Consumer" letter included a *Hearing Aid Outreach* targeted to over 200 key consumer organizations alerting them to FDA's public hearing on this issue and to urge them to submit comments during the open period.

CLINICAL STUDY GUIDELINES

In 1989, FDA published the "Guidelines for the Study of Drugs Likely to be Used in the Elderly." The guideline provides detailed advice on the study of new drugs in older patients. It is intended to encourage routine and thorough evaluation of the effects of drugs in elderly populations so that physicians will have sufficient information to use drugs properly in their older patients. The guideline serves as a stimulus to the development of this information and suggests additional steps to sponsors who are already assessing the effects of their drugs in the elderly.

On August 2, 1994, FDA published a final guideline in the Federal Register entitled "Studies in Support of Special Populations: Geriatrics." The guideline was prepared by the Efficacy Working Group of the International Conference on Harmonization of Technical Requirements for Registration of pharmaceuticals for Human Use. The guideline is intended to reflect sound scientific principles for testing drugs in geriatric populations. It provides useful information for sponsors submitting applications to the Food and Drug Administration.

FDA's efforts to ensure that premarket testing adequately considers the needs of older people also include regulation and education of institutional review boards (IRBs). An IRB must review all research in humans involving FDA-regulated products to ensure adequate protection of the study subjects, and must assure FDA that adequate additional safeguards are in place during research involving vulnerable populations, such as the elderly. Through the bioresearch monitoring program, FDA inspects IRBs to ensure compliance with FDA requirements. The program also informs and educates IRBs by means of national and regional conferences and through the dissemination of information sheets on a variety of topics of interest to IRBs.

POSTMARKETING SURVEILLANCE EPIDEMIOLOGY

The Office of Epidemiology and Biostatistics prepares an annual report, "Annual Adverse Drug Experience (ADE) Report," which analyzes the ADE reports FDA receives each year through direct reporting by health professionals or through manufacturers' reports. The annual report includes an analysis of ADE reports by age and sex, identifying the number of reports involving males and females 60 years or older. Of 77,274 ADE reports received and computerized in 1993, 49,919 (65 percent) reported the age and sex of the patient. Of these reports, 16,962 (34 percent) were for individuals 60 years or older.

GERIATRIC LABELING

On November 1, 1990, FDA published a proposed rule to amend its regulations pertaining to the content and formation of prescription drug product labeling (55 FR 46134). The proposed rule would require a person marketing a prescription drug to collect and disclose available information about the drug's use by the elderly (persons aged 65 years and over). "Available information" would encompass all information in the applicant's possession relevant to an evaluation of the appropriate geriatric use of the drug, including the results from controlled studies, other pertinent premarketing or postmarketing studies or experience, or literature entitled "Geriatric use" with reference, as appropriate, to more detailed discussions in other parts of the labeling, such as the "Warnings" or "Dosage and Administration" sections.

The proposed rule is not intended to alter the type or amount of evidence necessary to support drug approval but rather to ensure that special information about the use of drugs by the elderly is well organized, comprehensive, and accessible. Public comments on the proposed rule have been evaluated, and FDA is preparing a final rule.

MEDICATION INFORMATION LEAFLETS (MILS) FOR SENIORS

The American Association of Retired Persons (AARP) Pharmacy Services Division, in conjunction with FDA's Drug Marketing Practices and Communications Branch (MPCB) publish MILS—educational leaflets about drugs written for use through the AARP prescription drug mail order program. The leaflets provide the patient with:

A description of the contents
A list of the diseases for which the drug is used as a treatment
Information the patient should tell the physician before taking the medication
Dosage information—how the medication should be taken
Instructions on what to do if a dose is missed
Possible interactions with other medications
Possible serious and non-serious side effects

"Marketing Research" Study

The FDA designed and supervised the data collection of a survey to assess information needs and motivations of subgroups of older individuals with hypertension who subscribe to the AARP Pharmacy Service. Analyses identified four distinct subaudiences who are expected to respond differently to varying health promotion message strategies.

An article entitled "A Segmentation Analysis of Prescription Drug Information-Seeking Motives Among the Elderly" was published in the *Journal of Public Policy and Marketing* (fall 1992) and was presented at the 1992 Marketing and Public Policy Conference in Washington, D.C. Additional studies with AARP on patient education messages for older Americans are being conducted.

Year 2000 Health Objectives

A consortium of over 300 government and private agencies developed a set of health objectives for the Nation which is serving as a national framework for health agendas in the decade leading up to the year 2000. The overall program is called "Healthy People 2000." In the food and drug safety area, FDA has responsibility for objective 12.6, which sets as a target to:

> Increase to at least 75 percent the percentage of health care providers who routinely review all prescribed and over-the-counter medicines taken by their patients 65 years and older each time medication is prescribed or dispensed.

FDA's Marketing Practices and Communications Branch conducted a number of studies that track patients' receipt of medication information from doctors and pharmacists from 1982 to 1992, documenting that 58% of Americans over 65 received at least some information about prescriptions. The survey is being conducted again in 1994 to track progress toward meeting this objective.

During the coming year, FDA will work with private sector organizations to advance medication counseling activities.

Pharmacy Initiative

During the past few years, Dr. David Kessler, FDA Commissioner, has personally sought to encourage greater pharmacy-based counseling. Through speeches, articles, and editorials in major medical (*New England Journal of Medicine*) and pharmacy (*American Pharmacy*) journals, Dr. Kessler has encouraged the increased role of pharmacists, using computers to generate targeted information informing patients about the uses, directions, risks and benefits of medication. The pharmacy profession has responded positively, bringing many examples of their initiatives to FDA's attention. In particular, several organizations have informed FDA of the expanded use of new technology to provide patient instructional materials to their customers. FDA will continue to work closely with these organizations in an effort to disseminate more information to patients about their medications.

Health Fraud

Health fraud—the promotion of false or unproven products or therapies for profit—is big business. These fraudulent practices can be serious and often expensive problems for the elderly. In addition to economic loss, health fraud can also pose direct and indirect health hazards to those who are misled by the promise of quick and easy cures and unrealistic physical transformations.

The elderly, more often than the general population, are the victims of fraudulent schemes. Almost half of the people over 65 years of age have at least one chronic condition such as arthritis, hypertension, or a heart condition. Because of these chronic health problems, senior citizens provide promoters with a large, vulnerable market.

To combat health fraud, FDA uses a combination of enforcement and education. In each case, the Agency's decision on appropriate enforcement action is based on considerations such as the health hazard potential of the violative product, the ex-

tent of the product's distribution, the nature of any mislabeling that has occurred, and the jurisdiction of other agencies.

FDA has developed a priority system of regulatory action based on three general categories of health fraud: direct health hazards, indirect hazards, and economic frauds. The Agency regards a direct health hazard to be extremely serious, and it receives the Agency's highest priority. FDA takes immediate action to remove such a product from the market. When the fraud does not pose a direct health hazard, the FDA may choose from a number of regulatory options to correct the violation, such as a warning letter, a seizure, or an injunction.

The Agency also uses education and information to alert the public to health fraud practices. Both education and enforcement are enhanced by coalition-building and cooperative efforts between government and private agencies at the national, State, and local levels. Also, evaluation efforts help ensure that our enforcement and education initiatives are correctly focused.

The health fraud problem is too big and complex for any one organization to effectively combat by itself. Therefore, FDA is working closely with many other groups to build national and local coalitions against health fraud. By sharing and coordinating resources, the overall impact of our efforts to minimize health fraud will be significantly greater.

FDA and other organizations have worked together to provide consumers with information to help avoid health fraud. Since 1986, FDA has worked with the National Association of Consumer Agency Administration (NACAA) to establish the ongoing project called the NACAA Health Products and Promotions Information Exchange Network. Information from FDA, the Federal Trade Commission (FTC), the U.S. Postal Service (USPS), and State and local offices is provided to NACAA periodically for inclusion in the Information Exchange Network. This system provides information on health products and promotions, consumer education materials for use in print and broadcast programs, and the names of individuals in each contributing agency to contact for additional information.

In 1994, FDA's Public Affairs Specialists (PASs) continued to alert diverse and culturally specific elderly populations throughout the United States by sponsoring community workshops. These exchanges provided an opportunity for seniors to convey their concerns about suspected health fraud products. Dietary supplements, herbal remedies, and unproven medical treatments, such as shark cartilage, were key issues. Health Fraud Workshops during 1994 included the Districts of San Juan, Miami, Orlando, Atlanta, New York, Nashville, and Phoenix. PASs also convey this important information via additional mechanisms such as radio and television shows as well as public service announcements.

Regional Hispanic Health Fraud Conference

FDA has made special efforts to target health fraud information to Hispanics, particularly the elderly. As a special population, they are particularly at risk because of language and cultural considerations that may limit their access to health care and information about health fraud.

The Hispanic Health Fraud Initiative was kicked off at the model 1989 National Health Fraud Conference in San Juan, Puerto Rico. The primary conference goal was to provide practical guidance to individuals and organizations in the Commonwealth that would enable them to recognize and defend themselves against health fraud, quackery, and misinformation.

FDA has conducted a series of followup regional conferences throughout Puerto Rico and the continental United States. The series began in Puerto Rico in September 1990 in the Carolina Region. In 1991, the series was continued in Caguas, Fajardo, Ceiba, and Humacoa. These conferences were cosponsored by the Congress of Workers and Consumers of Puerto Rico (COTACO) and the Puerto Rico Department of Consumer Affairs. The first in the statewide series of conferences was held in FDA's Pacific Region (Culver City, CA), in September 1990. In 1993, FDA conducted two regional Health Fraud conferences to target health fraud information to Hispanics. The conferences were held in May in Miami, Florida, and Albuquerque, New Mexico. In 1994, FDA PASs conducted Hispanic health fraud workshops targeting the elderly in San Juan, Puerto Rico, and Miami, Florida. One concern expressed was about the practice of medication-sharing by seniors.

"Health Is Life" Consumer Education Campaign

FDA, the Food Marketing Institute (FMI), and the National Urban League (NUL) launched a cooperative consumer health education campaign which is culturally specific (language and graphics) and focused to promote healthy lifestyles among African Americans. The campaign components include seven nutritional and health pro-

motion posters. The posters promote good health behaviors and are targeted to the following African American audiences: elderly and young males; pregnant women; children 6 to 12 years of age; adolescents 12 to 17 years of age; and the general population.

The campaign was unveiled at the July 1991 annual convention of the National Urban League and has been promoted through over 150 other national African American multiplier organizations, such as the Auxiliary to the National Medical Association; National Council of Negro Women; LINKS, Inc.; Delta Sigma Theta Sorority; and the Congressional Black Caucus. The NUL's affiliate network of 114 local organizations are displaying the posters and promoting the relationship between diet and health to their constituencies. An additional 3,000 copies of the posters were provided to the FMI membership for display in member food store chains.

FOOD LABELING

Food labeling is very important to the elderly. Elderly people have a greater need for more information about their food to facilitate preparation of special diets, maintain adequate balance of nutrients in the face of reduced caloric intake, and ensure adequate levels of specific nutrients which are known to be less well absorbed as a result of the aging process (e.g., vitamin B12).

The new food label, which is now required on most foods, offers more complete, useful, and accurate nutrition information to help the elderly meet their nutritional needs. Significant labeling changes include: nutrition labeling for almost all foods; information on the amount per serving of saturated fat, cholesterol, dietary fiber, and other nutrients of major concern to today's consumers; nutrient reference values to help consumers see how a food fits into an overall daily diet; uniform definitions for terms that describe a food's nutrition content (e.g., *light, low fat,* and *high-fiber*), claims about the relationship between specific nutrients and disease, such as sodium and hypertension; standardized serving sizes; and voluntary quantitative nutrition information for raw fruit, vegetables, and fish.

Manufacturers were required to comply with most of the new labeling requirements as of May 1994—although a 3-month extension was granted to firms who were unable to meet the May deadline, Regulations pertaining to health claims became effective a year earlier, in may 1993. A recent survey indicates that the vast majority of food in the stores now carries the new food label and that more than 87 percent of the nutritional information accurately measures what is in the package. This is an important indication to consumers that they can trust what it says on the food label.

To help consumers get the most from the new food label, educational materials are being widely disseminated. Among materials now available is a large-print brochure, "Using the New Food Label to Choose Healthier Foods," which is easier to read for senior citizens who may have vision problems.

FDA, in coordination with USDA, has established a national database and information hotline at the National Agricultural Library to record and disseminate information about educational activities, seminars, packages of materials, and lesson plans. They have sponsored four national seminars on aspects of food label education, particularly on ways to reach underserved populations. AARP member Dorothy Campbell represented senior citizens at the May 1994 seminar. She stressed the benefits of the increased legibility of the new label to older Americans, and urged meeting attendees to educate older Americans on the positive aspects of using the new label; i.e., help them focus on what to eat, not what to avoid.

Material on the new food label is available from FDA's Office of Consumer Affairs.

DIETARY SUPPLEMENTS

The Dietary Supplement Health and Education Act of 1994 was signed by the President in October 1994. This Act required FDA to withdraw its Advanced Notice of Proposed Rulemaking requesting comment on approaches to assuring the safety of dietary supplements. The Act also defines supplements, defines new dietary ingredients as dietary ingredients that were not marketed in the U.S. before October 15, 1994, places the burden of proof for safety on FDA, and sets standards for the distribution of third party literature (e.g., books, publications, and articles).

The law also allows statements of nutritional support under certain conditions. Such statements may describe the role of a nutrient or ingredient intended to affect the structure or function in humans or describe general well-being from consumption of a nutrient or dietary supplement ingredient. The manufacturer must be able to substantiate that such a statement is truthful and not misleading, and the statement must contain the following disclaimer, "This statement has not been evaluated

by the FDA. This product is not intended to diagnose, treat, cure, or prevent disease."

The law authorizes the FDA to issue regulations for Good Manufacturing Practices for dietary supplements, including expiration date labeling. It also establishes a 7-member Commission on Dietary Supplement Labels to conduct a study and issue a report making recommendations on the regulation of label claims for dietary supplements by October 25, 1996. The law further requires the Secretary of HHS to establish an "Office of Dietary Supplements" at the National Institutes of Health.

TOTAL DIET STUDIES

The Total Diet Study, as part of FDA's ongoing food surveillance system, provides a means of identifying potential public health problems related to the diets of the elderly and other age groups. Through the Total Diet Study, FDA is able to measure the levels of pesticide residues, toxic elements, chemicals, and nutritional elements in selected foods of the U.S. food supply. In addition, the study allows FDA to estimate the levels of these substances in the diets of 12 age groups: infants 6 to 11 months old; children 2, 6, and 10 years old; 14- to 16-year-old boys; 14- to 16-year-old girls; 25- to 30-year-old men; 25- to 30-year-old women; 40- to 45-year-old men; 40- to 45-year-old men; 60- to 65-year-old men; 60- to 65-year-old women; men 70 years and older; and women 70 years and older. Because the Total Diet Study is conducted yearly, it also allows for the determination of trends and changes in the levels of substances in the food supply and in daily diets.

POSTMARKET SURVEILLANCE OF FOOD ADDITIVES

FDA's Center for Food Safety and Applied Nutrition (CFSAN) monitors complaints from consumers and health professionals regarding food and color additives, dietary supplements, and dietary practices as part of its Adverse Reaction Monitoring System. Currently, the database contains approximately 9,900 records. Of the complainants who reported their age, approximately 17 percent were individuals over age 60.

PROJECT ON CALORIC RESTRICTION

FDA is participating in research which could lead to significant insight into the relationship between dietary habits and life span. The Project on Caloric Restriction (PCR) is a collaborative effort of FDA's National Center for Toxicological Research (NCTR) and the National Institute on Aging (NIA). It is designed to study whether a diet that is calorically restricted will add to the longevity and health of laboratory rats and mice. An increasing interest in the role of caloric restriction in aging coupled with the potential economic impact associated with health care was the impetus of the creation of the PCR.

The extraordinary interest displayed by research groups across the country and the NCTR's commitment to the PCR project has produced a scientific environment conducive to the interchange of ideas and the formulation of new approaches to the diverse scientific disciplines. NCTR developed a matrix which identifies areas of ongoing research, identifies additional research areas that need to be addressed and helps to avoid duplication of research effort.

Current studies into the mechanisms of aging and cancer inhibition by caloric restriction (CR) have been exploring the effects of glucocorticoids and sex steroids on aging and cancer. Other studies have demonstrated CR-induced increase of apoptosis, a process also seen in aging animals, providing support for hypotheses of action of this process that include selective cell-killing. CR increases the ability of the heart to resist anoxia manyfold in aging hearts, and the mechanism of that process is being investigated. CR has been found to significantly slow the progress of retroviral-induced disease. The inhibitory effect on spontaneous disease seems to occur through the inhibition of recombination "rescuing" defective virus, a process that increases in aging. The inhibitory effect of CR on induced retroviral disease has yet to be understood, but appears to be related to the inhibition of viral function. CR has also been shown to significantly improve immune function. Modulation of basic aspects of chronic disease by CR provides both a mechanistic tool to understand the diseases and suggests intervention to inhibit them. The results of extensive epidemiologic analyses of the National Health and Nutrition Survey have resulted in characterizing a series of markers for the impact of dietary parameters for man, and have demonstrated the relationship of risk of breast and colorectal cancer with appropriate CR-related parameters.

Also, based on the recent demonstrations of the salutatory impact of CR in both non-human primates and man, projects are being designed to extend many of the

biomarkers of health developed in rodents to more human-like systems as well as people.

In addition to these efforts, an extensive analysis of animal testing data has shown the impact that dietary modulation has on all long-term animal experiments, and has led to new approaches to the interpretation of aging and toxicity studies.

Many of these results are consistent with the idea that CR induces an adaptation phenomenon within at least some animal species. Not all functions are altered. Rather, those processes that appear to be most affected are those which have been previously referred to as longevity assurance processes. These processes have as their primary role maintenance of the information flow and content of biological systems and work in concert with one another with the end result being the multiple of these interactive changes. By fine tuning these processes, possible via altering gene expression is some very basic way, animals may keep themselves alive until a more advantageous period for reproduction. By studying mechanisms of action, we can hopefully gain the advantages of this adaptation phenomena without its negative consequences and discomforts.

The collaborative project between NCTR and NIA is currently undergoing expansion in order to provide animals to more interested researchers and broaden the information base on biomarkers and mechanisms of aging.

Intraocular Lenses

Data on intraocular lenses (IOLs) continue to demonstrate that a high proportion (85–95 percent) of the patients will be able to achieve 20/40 or better corrected vision with the implanted lenses and that few (3 to 5 percent) will experience poor visual acuity (20/200 or worse). The data also demonstrate that the risks of experiencing a significant postoperative complication are not great. Furthermore many of the complications result during the early postoperative period and are associated with cataract surgery; the incidence of these complications is generally not affected by IOL implantation. Approved lenses have a significant impact on the health of elderly patients having surgery to remove cataracts. The IOLs, because they are safe and effective, have become the treatment of choice, allowing elderly patients to maintain their sight and thus their ability to drive and otherwise lead normal lives. FDA continues to monitor several hundred investigational IOL models and has, to date, approved thousands of models as having demonstrated safety and effectiveness.

FDA scientists have tested the optical quality of the IOLs being marketed. FDA nonclinical studies include measurement of focal length, resolving power, and image quality. This information provides useful data on the optical quality of new IOL designs. In addition clinical study data for the evaluation of the product is obtained on preoperative and postoperative visual acuity, intraocular pressure, and evaluations of the visual field in addition to any patient factors that may affect the performance of the lens. Test results show that the overall optical quality of currently marketed IOLs is excellent.

At the December 1994 Eye Care Technology Forum at NIH, FDA agreed to pursue incorporating the standard operating procedures (SOPs) used by the National Eye Institute in the testing. Those SOPs for the measurement of visual acuity, intraocular pressure, and for automated perimetry for evaluating visual fields will be presented for panel and public comment at the Ophthalmic Devices Panel meeting on January 26, 1995.

Pacemakers

Dysfunction of the electrophysiology of the heart can develop with age, be caused by disease, or result from surgery. People with this condition can suffer from fainting, dizziness, lethargy, heart flutter and a variety of similar discomforts or ills. Even more serious life-threatening conditions such as congestive heart failure or fibrillation can occur.

The modern pacemaker is designed to supply stimulating electrical pulses when needed to the upper or lower chambers of the heart or both. It has corrected many pathological symptoms for a large number of people.

Approximately 750,000 elderly persons have pacemakers. An estimated 125,000 pacemakers are implanted annually, 20 percent being replacements. An estimated 75 percent of these are for persons 65 years of age or older. Without pacemakers, some of these people would not have survived. Others are protected from life-threatening situations and, for most, the quality of life has been improved.

FDA, in carrying out its responsibilities of ensuring the safety and efficacy of cardiac pacemakers, has classified the pacemaker as a Class III medical device. Devices

in Class III must undergo testing requirements and FDA review before commercial release of the device.

Under the Deficit Reduction Act of 1984 (P.L. 98–369, § 23.04), Congress mandated that data be collected on all implants and explants of pacemakers in order to recover costs in the case of defective pacemakers. HCFA has been collecting these data (at a cost of at least $250,000 a year) and sending them to FDA. FDA was to use them for direct patient notification and studies of pacemaker problems. HCFA and FDA have developed an operational registry with a data base of approximately 1.2 million pacemaker and lead entries to date.

Physicians and providers of health care services must submit information to a national cardiac pacemaker registry if they request Medicare payment for implanting, removing, or replacing permanent pacemakers and pacemaker leads. The final rule implementing the registry became effective on September 21, 1987.

In June 1994, OMB informed FDA that, in accordance with the Paperwork Reduction Act, it would *not* reinstate approval of FDA's activity because any need for these data has been eliminated by implementation of requirements for manufacturers to track high-risk devices under the Safe Medical Devices Act of 1990 (final rule, August 1993). FDA and HCFA staff recently decided to approach Congressional staff to argue for amendment of the original law to eliminate the registry provision.

RENAL DIALYSIS

There were a projected 226,000 patients with kidney failure in the United States in 1994. More than 100 individuals are diagnosed with end stage renal disease (ESRD) each day. ESRD patients will need to remain on either hemodialysis or peritoneal dialysis for the rest of their lives unless they are able to receive a successful kidney transplant. Therapy can be delivered at dialysis facilities or in the home, depending on various factors.

In 1992, 42 percent of the ESRD population was over 60 years of age. Through age 50, the average remaining life span is greater than 5 years for ESRD patients. Although the remaining lifetimes are shorter for the elderly ESRD population, the general population also faces higher mortality with aging. The projected expected remaining lifetime for dialyzed patients with ESRD is approximately one-fourth to one-sixth that for the general population through age 50, while the ratio is often closer to one-third for older patients. These figures are based on actuarial calculations and assumed death rates, and are taken from the U.S. Renal Data System 1991 Annual Data Report.

Because of the nature of the underlying disease and necessary supportive therapy, ESRD patients are at risk for a number of potential complications during or as a result of their therapy. Many of the potential complications can occur from a failure to correctly maintain or use dialysis equipment, insufficient attention to safety features of the individual dialysis system components, or insufficient staffing or personnel training. FDA's Center for Devices and Radiological Health (CDRH), in conjunction with major hemodialysis organizations, such as the Health Industry Manufacturers Association (HIMA), the Renal Physicians Association (RPA), and the American Nephrology Nurses Association (ANNA), has been active in helping to develop several educational videotapes (soon to be distributed) which address human factors, water treatment, infection control, reuse, and delivering the prescription (soon to be distributed) as well as manuals on water treatment and quality assurance. Complimentary videos illustrating health and safety concerns and the use of proper techniques have been distributed to every ESRD facility in the United States. These videos have received a favorable acceptance from the nephrology community.

CDRH is currently working on a draft guidance document for the labeling of hemodialyzers for safe and effective reprocessing for reuse manufacturers. A video on the methods for correct reprocessing and reuse of hemodialyzers developed by the FDA, RPA, and other concerned groups is available. The video attempts to follow the standard protocols that have been detailed in the Association for the Advancement of Medical Instrumentation (AAMI) Recommended Practice for the Reuse of Hemodialyzers. These practices also have been adopted by HCFA as a condition of coverage to ESRD providers that practice reuse.

A multistate study conducted for the FDA in 1987 indicated that dialysis facilities appeared to have inconsistent quality assurance (QA) techniques for many areas of dialysis treatment. To address this problem, FDA funded a contract to develop guidelines that could be used by all dialysis facility personnel to establish effective QA programs. The guidelines printed in February 1991 were mailed to every dialysis facility in the United States free of charge.

In the past year, FDA has continued to work cooperatively with the nephrology community and the ESRD patient groups to improve the quality of dialysis delivery.

These efforts appear to be yielding positive results. CDRH has also been cooperating with CDC and HCFA in the exchange of information to try to increase the safety of dialysis delivery.

MAMMOGRAPHY

Since 1975, CDRH (formerly the Bureau of Radiological Health (BRH)) has conducted a great many mammography activities. These have been done with several goals in mind:

Reduce unnecessary radiation exposure of patients during mammography to reduce the risk that the examination itself might induce breast cancer; and

Improve the image quality of mammography so that early tiny carcinoma lesions can be detected at the state when breast cancer is most treatable with less disfiguring and more successful treatments.

THE NATIONAL STRATEGIC PLAN FOR THE EARLY DETECTION AND CONTROL OF BREAST AND CERVICAL CANCER

FDA, NCI and CDC have coordinated a combined effort to cover 75 professional, citizen, and government groups to develop the National Strategic Plan for the Early Detection and Control of Breast and Cervical Cancer. The goal of this plan, approved by the Secretary of Health and Human Services on October 15, 1992, is to mount a unified effort by all interested groups to combat these two serious cancer threats. FDA staff took the lead in writing the Breast Cancer Quality Assurance section, one of six components of the plan, and anticipated in the development of the other components.

MAMMOGRAPHY QUALITY STANDARDS ACT OF 1992

On October 27, 1992, the President signed into law the Mammography Quality Standards Act (MQSA) of 1992. This Act requires the Secretary of Health and Human Services to develop and enforce quality standards for all mammography of the breast, regardless of its purpose of source of reimbursement. By October 1, 1994, any facility wishing to produce, develop, and enforce quality standards for all mammography of the breast, regardless of its purpose of source of reimbursement. By October 1, 1994, any facility wishing to produce, develop, or interpret mammograms will have to meet these standards to remain in operation. The Secretary delegated the responsibility for implementing the requirements to FDA on June 1, 1993, and Congress first appropriated funds for these activities on June 6, 1993. Implementation of MQSA is a key component of Secretary Shalala's National Strategic Action Plan Against Breast Cancer.

FDA's accomplishments since the Agency was delegated authority to implement MQSA in June 1993 include—staffing of a new division; development of interim standards; approval of three accreditation bodies; certification of several thousand facilities by the statutory deadline of October 1, 1994; implementation of a rigorous training program for inspectors; development of a compliance and enforcement strategy (coordinated with HFA); outreach to facility and consumer communities; and planning for program evaluation.

MQSA inspections will supplant the Health Care Financing Administration's Medicare Screening Mammography Inspections. Under MQSA, HCFA has agreed to recognize FDA-certification of a mammography facility as meeting quality standards for reimbursement purposes.

BLOOD GLUCOSE MONITORS

Recent publications estimate the number of diagnosed diabetics in the United States to be 7 million and increasing at a rate of 600,000 per year. Over 65 percent of diabetics are 55 years and, of course, many must monitor their blood glucose.

Since the implementation of Medical Device Reporting (MDR) regulations in December 1984, approximately 3,500 reports were submitted to FDA regarding erroneous test results encountered by users of self-monitoring blood glucose (SMBG) systems. As a result of these findings, a project was conducted to study and provide strategies to reduce the likelihood of problems with use of these devices. The study was conducted in four phases: (1) information/data analysis including labeling, instructional and training materials; (2) identification of problems and contributing factors, including the use of data obtained by survey, contract, scientific literature, laboratory testing and MDR submissions; (3) development of a strategy for corrective action(s); and (4) implementation of corrective actions that could include assistance and collaboration with interested organizations.

Because the limitations of the elderly (e.g., slowed response time and deficient vision) are important considerations in properly using glucose meters, FDA conducted a human factors analysis of blood glucose meters. Completed in May 1990, the goals of the analysis were:

Determine if operation and instructional materials of blood glucose meters are compatible with users' ability;

Determine if the features of blood glucose meters contribute to user error; and

Determine the quality and quantity of instructional material available to meter users for learning proper meter operation.

The study found that instructional materials did not adequately prepare users to obtain accurate results. In addition, the study pointed out the need for proper training of users by health professionals. It also led to suggestions for design changes to enhance the user's ability to obtain accurate readings.

A National Steering Committee for Quality Assurance Glucose monitoring was formed in 1991 to address findings of the human factor study. The Committee developed user education strategies and instructional material designed to reduce problems associated with the use of blood glucose meters. This material was incorporated into several documents.

A consumer brochure containing tips for safe and accurate self-testing of blood glucose was completed in FY 1993. Also, procedural checklists for both the diabetic and the diabetic health care trainer were completed in FY 1993. Camera-ready copies were sent to SMBG system manufacturers who agreed to print and distribute the material.

Patient Restraints

Protective patient restraints are devices used to protect patients from falls and other injuries. Restraints are used mostly on elderly patients. FDA's Manufacturers Medical Device Reporting (MDR) database has documented 79 deaths related to patient restraint use. The scientific literature suggests that the annual deaths related to use of this device may be as high as 200. Moreover, the use of patient restraints is expected to increase as the number of elderly persons increases. FDA believes that the users of these devices, including doctors, nurses, nursing assistants, and nurses aides need better instructional materials and labeling to be able to use these devices properly. Accordingly, FDA initiated an educational campaign aimed at development of graphic messages to be used on the restraints and in the package labeling to effectively convey important safety information to restraint users.

FDA made restraints "prescription use" devices in March 1992, and proposed regulations so that FDA can review the devices for safety, labeling, and design prior to marketing. Final regulations are expected to publish in January 1995.

Hearing Aids

Several events have occurred in 1993 which have caused FDA to reevaluate the regulatory framework governing the sale and distribution of hearing aids. In 1993, FDA reviewed the advertising, promotional material, and labeling of commercially available hearing aids. For numerous products examined, FDA found the manufacturer was making unsubstantiated performance claims. Based on this review, FDA sent letters to eight major hearing aid manufacturers directing them to immediately remove all misleading promotional literature and advertising. FDA also issued letters to all other hearing aid manufacturers indicating that FDA believes this is an industry wide problem and directing them to review and correct their promotional literature and advertising as needed. Manufacturers who want to make claims of user benefit beyond the general claim of improved hearing will be required to substantiate those claims by submitting valid scientific evidence from clinical trials. To assist manufacturers, FDA has developed a guidance document that sets forth the criteria necessary for clinical protocols. The guidance document was developed in August of 1993.

In 1994 FDA developed a proposal which would amend the current 1977 hearing aid regulation. Major considerations in developing the draft proposal included reexamining whether the pre-purchase medical evaluation to determine hearing aid candidacy should be replaced by, or supplemented with, a more comprehensive pre-purchase hearing assessment and whether to eliminate the existing waiver provision for a pre-purchase medical evaluation required by the current 1977 regulation. FDA has come to question whether the Federal waiver provision of the existing 1977 hearing aid regulation is consistent with the Federal policy that each hearing aid purchaser receive a clinically appropriate pre-purchase hearing evaluation.

Data from a 1991 survey of 11 hearing aid dispensers in Vermont demonstrated that 70 percent of hearing aid purchasers did not have a medical examination prior

to purchasing a hearing aid. Results from a field survey of four FDA districts conducted in the fall of 1993 verified that the waiver is still used in a majority of cases.

In the Federal Register of November 3, 1993, FDA published an advance notice of proposed rulemaking (ANPRM) announcing its intentions to review and potentially revise the Federal hearing aid regulations. Over 3,000 comments were received from manufacturers, physicians, audiologists, hearing aid dispensers, professional organizations, consumers, consumer interest groups, educational institutions, State governments, State professional organizations, and State licensing boards. These comments and testimony at a December 6 and 7, 1993 public hearing concerning the ANPRM are addressed in the draft regulation's preamble.

On June 13, 1994, FDA sent a letter to State Attorneys General, Device Program Directors, and Health Officers asking that they respond to questions concerning the effectiveness of state licensure for determining competency to conduct a hearing assessment, current licensing systems in place, and the probable economic impact of instituting or modifying current State licensure systems to conform with the proposal's requirement that professionals who dispense hearing aids be competent to perform a hearing assessment.

VACCINES

The use of pneumococcal vaccine and influenza vaccine in this population has the potential for saving many lives annually. Death attributed to pneumonia and influenza is the only category representing infectious diseases among to top 10 causes of mortality in the United States. One of the objectives of the Healthy People 2000 is to increase the use of vaccines in order to reduce the number of deaths caused by epidemic-related pneumonia and influenza. In addition, another objective of this Public Health Service Goal is to reduce the number of pneumonia-related days of restricted activity.

Elderly persons are at increased risk for complications after influenza virus infection, particularly secondary pneumonia caused by Streptococcus pneumoniae (pneumococcus), Hemophilus influenzae, Staphylococcus aureus, and other bacteria. In addition, pneumococci are the most frequent cause of bacterial pneumonia, and mortality related to pneumococcal pneumonia increases with age. Therefore, the elderly represent a target group for special vaccination programs.

Scientists at the Center for Biologics Evaluation and Research (CBER) perform lot release testing on both the influenza virus vaccines and the pneumococcal vaccine which help achieve the objectives of Healthy People 2000 by ensuring the quality of the vaccines. CBER is active in programs directed at improving pneumococcal, influenza virus and other vaccines that may be useful in the elderly, including diagnostic skin tests for tuberculosis and blood products.

Scientists and other staff at CBER work with others at the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), and national control authorities to ensure that the influenza virus vaccines available contain the proteins of the virus strains that would provide the best match and most effective vaccine for the viruses likely to cause influenza that year. CBER, through its Vaccines and Related Biological Products Advisory Committee, makes the recommendation for strain selections after review of scientific data related to the viruses causing disease in human populations. In addition, the scientists at CBER develop and provide specific reference reagents that are used for production of influenza virus vaccines and for surveillance and identification of currently circulating influenza strains.

IMMUNE SENESCENCE

Elderly individuals are especially vulnerable, as evidenced by increased morbidity and mortality, to a wide spectrum of infectious diseases caused by bacterial and viral etiologic agents. Moreover, the incidence of most malignancies increases and peaks among the elderly. The immune system is responsible for protection against infections, and its proper function is also thought to be instrumental for protection against the outgrowth of malignant cells. It is now well documented that advancing age compromises the ability of the immune system to fulfill its function. The decreased vigor of the immune response with age is believed to be, at least in large part, responsible for the increased vulnerability of the aged to infectious and malignant diseases.

Efforts are underway, by investigators at CBER to understand and dissect mechanisms underlying the immunologic decline with age. Investigators at CBER are trying to understand why the activity of T cells is decreased with age. Proper function of T cells, central players in the immune system, is especially crucial to fending off infection and rejecting tumors. Investigators at CBER have demonstrated that the

expression of certain proteins, and the genes which encode them, is reduced with advanced age. These proteins, known as perforin (or poreforming protein or cytolysin) and granzymes, are found within granules in killer T cell. They are released upon contact with foreign cells (e.g., tumor cells) or virally infected cells, and are believed to be involved in the lysis and death of the target cells. Moreover, the function of another class of T cell, the helper T cell, is also compromised with age, and compromise of its function may further magnify the decremental function of killer T cells. Investigators at CBER, using a rodent model, have shown that these cells exhibit reduced activity within the whole aged animal. Investigators have further shown that a new cytokine can restore the decreased CTL function of the aged individual to more youthful levels in vitro.

DIALOGUE WITH ALZHEIMER'S ORGANIZATIONS

The Office of AIDS and Special Health Issues has initiated efforts to establish communications channels with Alzheimer's organizations. Preliminary interactions have been coordinated efforts between FDA's leaders and scientists and the Alzheimer's organizations, patients, and caregivers. At these meetings, the Commissioner and others explained the agency's Neurological Assessment Team concept to facilitate and coordinate the functions of the drug process. The Office of AIDS and Special Health Issues is creating an information system to support liaison activities with the appropriate Alzheimer's advocacy groups. Future efforts to respond to the concerns of Alzheimer's patients and caregivers on both a short- and long-term basis are underway. Over the past 2 years, several meetings have been held with individuals from a number of organizations representing Alzheimer's patients and their families, to begin a dialogue aimed at better understanding their needs and concerns. At these meetings the Commissioner and others emphasized that there are no distinctions made by FDA in dealing with issues and products related to life-threatening illnesses, and that the Agency is in the process of establishing mechanisms to ensure this. Subsequent to these meetings, the FDA announced the creation of the Office of AIDS and Special Health Issues (OASHI). This Office has been charged both with internal coordination of issues related to serious and life-threatening diseases and with providing a liaison function between the FDA and groups representing individuals with these diseases. The growth of this function in the face of other limitations in growth at FDA reflect the commitment of the Commissioner and other senior FDA staff to improving the relationship between FDA and these groups. OASHI began hiring personnel in late 1993.

WOMEN'S HEALTH

The FDA Office of Women's Health (OWH) was established in July 1994. Its priorities are to serve as the principal advisor to the Commissioner and other key officials on scientific, ethical, and policy issues relating to women's health; provide leadership and policy direction for the Agency regarding women's health; coordinate efforts to establish and advance a women's health agenda; monitor the inclusion of women in clinical trials and completion of gender analysis as specified in the 1993 Guidelines for the Study and Evaluation of Gender Differences in the Clinical Evaluation of Drugs; identify and monitor the progress of crosscutting and multidisciplinary women's health initiatives; and serve as the Agency's liaison with other agencies, industry, and associations.

Since its inception, the Office has collaborated with other FDA entities on a broad range of health issues concerning older women in an effort to expedite the review of products for prevention, diagnosis, and treatment, and to ensure the safety and efficacy of FDA regulated products. The OWH is establishing a special intra-agency working group to focus particularly on cardiovascular disease and osteoporosis.

The Office participated with other Federal agencies and private sector entities in several activities. This included the Federal conference, "A Public Health Agenda for an Aging Society," which examined the implications of the aging of the population in the setting of public health policy; the National Council on Patient Information and Education meeting, "Advancing Prescription Medicine Compliance: New Paradigms, New Practices," which focused on improving out-patient medicine use; and the launching of the Older Women's League and Campaign for Women's Health national public education campaign designed to promote prevention and early treatment of osteoporosis and heart disease.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration (HRSA) has lead responsibility for Federal efforts to promote access to health care services, primarily through programs which increase the availability of community health resources.

HRSA's programs are far-reaching in their support of health services to disadvantaged and underserved groups. In addition to older people, our clients include mothers and children, minorities, the homeless, the poor, drug users, migrant workers, people with AID/HIV, those with Hansen's Disease, and those who need organ transplants. Our challenge is to help assure the best possible care to as many individuals as possible at reasonable cost.

HRSA also provides technical assistance and resources to improve the education, supply, distribution, and quality of the Nation's health professionals, and access to health services and facilities. Our partners in these efforts include State and local health departments, universities, private nonprofit organizations, and many other participants in the Nation's public health care system.

A primary emphasis during the past year has been on strengthening the role of State and local health departments. HRSA, in conjunction with the Centers for Disease Control, has been instrumental in assisting the three organizations representing public health officials, the Association of State and Territorial Health Officials (ASTHO), the National Association of County Health Officials (NACHO), and the U.S. Conference of Local Health Officers (USCLHO), in forming a coordinated approach to public health practice with the creation of the Joint Council of Official Public Health Agencies. They are currently working on the development of a strategic plan.

HRSA is concerned about training our Nation's professionals to provide care for today's older individuals and individuals who will be old in the future. The Agency provides services to underserved older Americans, such as those who live in rural areas and those with low incomes. One-quarter of older Americans live in rural areas. One out of four elderly Americans, or 7.4 million, are poor or near poor.

Several HRSA components significantly influence programs and activities that benefit older Americans.

BUREAU OF PRIMARY HEALTH CARE

The Bureau of Primary Health Care (BPHC) helps assure that primary health care services are provided to persons living in medically underserved areas and to persons with special health care needs. It also assists States and communities in arranging for the placement of health professionals to provide care in health professional shortage areas. The Bureau provides services to older Americans through Community and Migrant Health Centers (C/MHCs), the National Health Service Corps, the Division of Federal Occupational Health, the Home Health Demonstration Program, and the Alzheimer's Demonstration Grant Program.

COMMUNITY AND MIGRANT HEALTH CENTERS

During fiscal year 1994, C/MHCs located in medically underserved areas, provided a range of family-oriented, preventive and managed care primary care services to those individuals who would otherwise lack access to care, particularly the poor and minorities. Approximately 7 million people were served in FY 1994, of which approximately 8 percent (or 525,000) were age 65 or older.

In FY 1994, the Bureau awarded funds to a C/MHC to develop an integrated service network for the provision of comprehensive primary health services to frail elderly population located in Boston, Massachusetts. In addition, the Bureau is currently working with the Health Care Financing Administration to determine the feasibility of C/MHCs serving as service delivery contractors for Medicare managed care patients.

To review the geriatric care provided in C/MHCs, the Bureau assesses the following clinical measures, pertinent to geriatric care in C/MHCs. These measures include: (1) functional measurement, (2) evaluation of multiple medication use, and (3) immunization tracking. The development of clinical protocols and establishment of baseline values are currently in progress.

THE NATIONAL HEALTH SERVICE CORPS

The National Health Service Corps places physicians, nurse practioners, physician assistants, certified nurse midwives, and other health professionals in health personnel designated shortage areas. Older Americans with special health care needs and reduced mortality need primary care providers close at hand. The Corps works closely with C/MHCs, other primary care delivery systems and the Indian Health

Service to provide assistance in recruiting and retaining health personnel for populations in need.

DIVISION OF FEDERAL OCCUPATIONAL HEALTH

The Division of Federal Occupational Health (DFOH) provides a variety of services related to health promotion and disease prevention in the elderly to managers and employees of over 3,000 Federal agencies. Retirement planning, care of aging parents, and prevention of osteoporosis are some examples of geriatric issues that are regularly addressed in educational seminars and counseling sessions provided by the Division's clinical and employee assistance programs.

HEALTH CARE SERVICES IN THE HOME DEMONSTRATION PROGRAM

The Health Care Services in the Home Demonstration Program was developed to identify low-income persons who can avoid unnecessary institutionalization or hospitalization if case-managed skilled home health services are provided in the homes. Through the program, these services are provided to technology-dependent children, disabled adults, the frail elderly, and others who are uninsured or underinsured.

Five State health departments have been awareded demonstration grants—Hawaii, Mississippi, North Carolina, South Carolina, and Utah. There were significant variations in terms of demographics, service needs, health resources available, cultural attitudes, and organizational structure among the grantees.

Each State found people who were uninsured or underinsured for case managed skilled home health services provided by a multidisciplinary team. Many people were inadequately served both in terms of their needs, preferences, and quality of care by current services. Together these States have provided services to approximately 8,700 uninsured or underinsured clients in the first 5 years of the program.

Approximately $15.5 million has been awarded for this 6-year program. The first grants were awarded in fiscal year 1988; the demonstration will continue through June 1995.

ALZHEIMER'S DEMONSTRATION GRANT PROGRAM

The Alzheimer's Demonstration Grant Program was established under Section 398 of the Public Health Service Act as amended by Public Law 101–157, the Home Health Care and Alzheimer's disease amendments of 1990. In fiscal year 1992, $3.9 million in grants were awarded to governmental agencies in nine States, the District of Columbia and to Puerto Rico. In fiscal years 1993 and 1994, $4.9 million was awarded, and four additional States were added, bringing the program to its legislative ceiling of 15 grantees. Funding remains level in fiscal year 1995.

The purpose of this program is to demonstrate how existing public and private nonprofit resources within States may be more effectively identified, utilized, and coordinated to deliver appropriate respite care and supportive services to underserved persons with Alzheimer's disease, their families and their caregivers. In addition, the program seeks to identify service gaps and barriers to access within communities and, where possible, develop innovative and creative approaches to bridge these gaps and overcome barriers. Lastly, the program will result in permanent infrastructure development and yield important information via evaluation about appropriate models and the provisions of respite care and supportive services for diverse underserved populations.

To date, approximately 2,185 clients have been served by the program, 56 percent of whom reside in rural areas. Of this total, 51 percent are Caucasian, 21 percent are African American, 20 percent are Hispanic, 5 percent are Asian and Pacific Island American and 1 percent are Native American.

The primary type and number of respite service delivery sites supported by the program are: 40 stipended and unstipended in-home respite programs; 50 adult day care programs; 28 support groups; 28 case management programs; 12 legal assistance programs; 5 institutional respite programs; 3 telephone helplines; and 3 transportation programs.

Descriptive and outcome-oriented (client satisfaction) evaluation activities are currently in progress. A preliminary descriptive report is expected in early 1995.

OFFICE OF RURAL HEALTH POLICY

The Office of Rural Health Policy was established in 1987 at the urging of the Senate Special Committee on Aging in order to address severe shortages of health services in rural areas, where one-quarter of the Nation's elderly live. Aging-related issues are of particular importance to the Office, since rural counties have, on average, a higher percentage of seniors over 65 years of age than urban counties; and

these residents are often poorer, sicker, and more isolated than their urban counterparts.

To strengthen support for health services in rural areas, the office plays a collaborative role throughout the Department and with the States and the private sector. For example, it apprises interest groups, such as the National Council on Aging and the American Association of Retired Persons about its activities and about the needs of the rural elderly. Within the Department the Office advises the Secretary, in particular, on the effects that Medicare and Medicaid programs have on rural health care, on the shortage of healthcare providers, the viability of rural hospitals, and the availability of primary care and also emergency medical services to elderly and other rural residents.

The Office supports local and State initiatives to build rural health care services through a $27 million grant program to rural communities, themselves, and a $3.9 million program of matching grants to the States to support State offices of rural health which can recruit rural providers and assist their rural communities in developing more local health services.

The Office of Rural Health Policy also promotes informed policymaking by administering a small $2.7 million program of grants for policy-relevant studies at established rural research centers throughout the country. These centers provide data capability on a wide range of rural health concerns, including areas relevant to the elderly.

The Office also participates in the Vice President's multi-departmental initiative to develop the Nation's information highway. In concert with the effort to explore the development of rural healthcare networks, the Office administers $9.5 million in telemedicine grants to rural communities who want to test the ability of telecommunications technologies to bring specialized health care to their citizens.

The Office of rural Health Policy has worked with other Federal offices and agencies, such as the Health Care Financing Administration, the Department of Agriculture, the Department of Transportation, and the National Institute on Aging, to sponsor workshops and seek public advice on a range of rural needs that include emergency medical services, managed care options for Medicaid and Medicare clients, physican recruitment, and rural economic development.

To enhance dissemination of information on strategies for better health services to rural regions, the Office initiated a national rural health information and referral service with USDA that is available to rural residents throughout the Nation with a toll-free line (1–800–633–7701) and through an electronic bulletin board.

The Office also channels public advice on rural issues to the Department by staffing the Secretary's National Advisory Committee on Rural Health, a citizen's advisory panel chartered in 1987 to address health care crises in rural America.

BUREAU OF HEALTH PROFESSIONS

The Bureau of Health Professions (BHPR) monitors and guides the development of health resources by providing leadership to improve the education, training, distribution utilization, supply, and quality of the Nation's health personnel.

The Bureau has established Seven Strategic Directions to achieve the Department's Year 2000 National Health Promotion and Disease Prevention Objectives and to guide the implementation of the Bureau's programs in an era of health care reform.

The Seven Directions are:

1. Health Care Reform: Promotion Primary Health Care Education;
2. Health Care Reform: Increasing the Number of Health Care Providers from Minority/Disadvantaged Backgrounds;
3. Health Care Reform: Establishing Linkages Between Education Programs and Service Settings;
4. Health Care Reform: Assuring Health Care Quality Through Publicly-Responsive Reforms in Health Professions Education Practice and Liability Management;
5. Health Care Reform: Strengthening Public Health Education and Practice;
6. Health Care Reform: Strengthening Health Professions Data, Information Systems and Research; and
7. Health Care Reform: Building the Capacity of Nursing and Allied Health Professions to Meet the Demands for Health Services.

The strategy defined by these seven directions will be implemented through a variety of collaborative public and private efforts and programs supported and operated by the Bureau. Programs include: education and training grant programs for institutions such as health professions schools and health professions education and training centers; loan and scholarship programs for individuals, particularly those

from disadvantaged backgrounds; the National Practitioner Data Bank; and the Vaccine Injury Compensation Program.

The Bureau supports the Council on Graduate Medical Education. The Council reports to the Secretary and the Congress on matters, related to graduate medical education, including the supply and distribution of physicians, shortages, or excesses in medical and surgical specialties and subspecialties, foreign medical graduates, financing medical educational programs, and changes in types of programs. It also supports the National Advisory Council on Nurse Education and Practice which advises the Secretary on PHS title VII nursing authorities. In addition, the Bureau has established the National Commission on Allied Health.

BHPR administers several education-service network multidisciplinary and interdisciplinary programs such as the Area Health Education Centers (AHECs), the Geriatric Education Centers (GECs), and Rural Interdisciplinary Training Programs. In addition, it also administers the AIDS Regional Education and Training Centers Program which provides multidisciplinary training for primary health care providers in the care of HIV-infected individuals and people with AIDS.

The National Vaccine Injury Compensation Program is administered by BHPR. The program, which became effective October 1, 1988, was created by the National Childhood Vaccine Injury Compensation Act of 1986, as a no-fault system through which families of individuals who suffer injury or death as a result of adverse reactions to certain childhood vaccines can be compensated without having to prove negligence on the part of those who made or administered the vaccines.

BHPr maintains a federally sponsored health practitioner data bank on all disciplinary action and malpractice claims. The National Practitioner Data Bank (NPDB) was created by The Health Care Quality Improvement Act of 1986, Title IV of P.L. 99–660, as amended November 1986. The Act authorized the Secretary of Health and Human Services to establish a data bank to ensure that unethical or incompetent medical and dental practitioners do not compromise health care quality. The NPDB is a central repository of information about: malpractice payments made on behalf of physicians, dentists, and other licensed health care practitioners; licensure disciplinary actions taken by State medical boards and State boards of dentistry against physicians and dentists; and adverse professional review actions taken against physicians, dentists, and certain other licensed health care practitioners by hospitals and other health care entities, including health maintenance organizations, group practices, and professional societies. The NPDB opened on September 1, 1990.

Under Section 777, three programs received funding in FY 1994, the Geriatric Education Centers (777a), Faculty Fellowship Program in Medicine and Dentistry (777b), and Optometry Training (777c).

GERIATRIC EDUCATION CENTERS

Of the 47 GECs that make up the membership of the National Association of Geriatric Education Centers, 20 received awards in FY 1994. Fifteen GECs are consortia partnerships of two or more universities with many representing multiple schools of the health professions in their respective States. At the State and national level the GECs comprise a comprehensive educational system, serving as the primary coordinating body for the preparation of faculty, health professions students, and health care personnel to better serve the Nation's elderly in their own homes and in long-term care institutions and community based agencies. A total of 42 fellows are enrolled, 24 physicians and 18 dentists.

Awards were made to the following institutions in FY 1994:

Consortia:

	FY 1994 Award
Univ. of California, LA	$508,958
Univ. of California, Davis	
Univ. of California, San Francisco	
University of Colorado	242,571
Regional Colorado AHEC	
Univ. of Colorado, Colorado Springs	
Univ. of Northern Colorado	
University of Denver	
Columbia University	290,761
New York University	
Beth Abraham Hospital	
University of Pittsburgh	352,239
Pennsylvania State University	
Temple University	
Harvard Medical School	250,209

	FY 1994 Award
Dartmouth College	
Research Fdn. of CUNY	314,594
New York Medical College	
New York School of Podiatric Med.	
SUNY College of Optometry	
Univ. of Illinois, Chicago	308,880
Southern Illinois University System	
Sangamon State University	
University of Miami	492,294
Barry University	
Florida A&M	
Florida International University	
St. Louis University	296,878
U. of Missouri, School of Optometry	
Washington U., Occupational Therapy	
St. Louis College of Pharmacy	
Kirksbille Coll. of Osteopathic Med.	
University of Kentucky	308,264
East Tennessee State Univ.	
U. of Ohio, Cincinnati	
Baylor University	284,769
Univ. of Texas, Houston HSC	
Univ. of Texas Medical Branch	
Univ. of North Texas	
Univ. of Texas-Pan Am	
Texas Southern Univ.	
Univ. of Houston	
Texas A&M University	
University of Florida	247,902
Florida A&M University	
George Washington Univ	270,000
Georgetown University	
Howard University	
Case Western Reserve Univ	297,000
Marquette University	444,552
Univ. of Wisconsin-Madison	
Univ. of Wisconsin-Milwaukee	
Milwaukee Area Technical College	
Medical College of Wisconsin	
Geriatrics Inst. of Sinai Samaritan Medical Center	
Single Institution:	
Univ. of Minnesota	270,000
Univ. of Nevada, Reno	325,350
Univ. of Med. & Dent. of NJ	239,742
University of Hawaii	242,664
Stanford University	345,373

Awards for these 20 GECs totaled $6,333,000 for Fiscal Year 1994. Funding for FY 1995 under Section 777(a) is expected to be approximately $6 million. These Centers are educational resources providing multidisciplinary and interdisciplinary geriatric training for health professions faculty, students, and professionals in allopathic medicine, osteopathic medicine, dentistry, pharmacy, nursing, occupational and physical therapy, podiatric medicine, optometry, social work, and related allied and public or community health disciplines. They provide comprehensive services to the health professions educational community within designated geographic areas. Activities include faculty training and continuing education for practitioners in the disciplines listed above. The Centers also provide technical assistance in the development of geriatric education programs and serve as resources for educational materials and consultation.

In preparation for the *National Forum on Geriatric Education and Training* to be held in FY 1995, 11 study groups were provided minimal funds to develop white papers on the status of geriatric education in medicine, nursing, dentistry, public health, social work, allied and associated health, interdisciplinary education, enthnogeriatrics, case management, managed care and long-term care. Resulting recommendations will be presented to Federal and non-Federal response panels during the Forum and an agenda for action to meet workforce needs will be developed within the context of shared responsibility for projected outcomes.

FACULTY TRAINING PROJECTS IN MEDICINE, DENTISTRY, AND PSYCHIATRY

Nine joint medicine and dentistry projects were funded under the Faculty Fellowship Program in Geriatric Medicine, Dentistry, and Psychiatry. Currently, Section 777b provides the only funding for faculty development in geriatric medicine and dentistry in the country. These interdisciplinary programs have four learning components: longitudinal clinical experience, teaching, research, and administration.

The following institutions received five year awards in FY 1994:

University of California, Los Angeles	$177,571
University of Connecticut	278,727
Boston University	283,009
Harvard University	335,007
University of Michigan	253,282
University of Medicine and Dentistry of New Jersey	295,138
Duke University	309,369
University of North Texas	176,869
Baylor School of Dentistry	
University of Texas, San Antonio	307,690

OPTOMETRY TRAINING

A $24,899 contract was awarded in FY 1994 to the Association of Schools and Colleges of Optometry to examine and document the status of and the need for faculty training in geriatric optometry.

There are 17 Schools of Optometry with total of 186 faculty; 16 schools have geriatric content in their curricula. Of the 27 faculty currently teaching geriatrics, 9 have had some formal geriatric training. A need exists for significant knowledge and skill enhancement of a minimum of 18 faculty with opportunities for advanced training for the remaining 9. Barriers to the development of separate faculty development programs relate to the low numbers of persons to be trained. Opportunities for the basic and interdisciplinary training required by optometric faculty exist through the Geriatric Education Centers programs. Some Schools of Optometry who are affiliated with the GECs are encouraged to develop optometric-specific learning experiences for faculty. Schools of Optometry continue to be eligible applicants for Geriatric Education Centers grants.

Division of Medicine

The Division continues to support through its grant and cooperative agreement programs significant educational and training initiatives in geriatrics.

Fourteen predoctoral grantees and 53 graduate program grantees under section 747, Family Medicine Training, indicated that they are actively involved in the development, implementation, and evaluation of their geriatrics curriculum and training. The predoctoral grantees received funds totaling $573,243, the residency program grantees received funds totaling $353,686 specifically for developing and enhancing geriatrics curriculum and training experiences. In addition, 13 faculty development programs reported that they provided geriatrics training. Seven of the section 747 Family Medicine Departments program grants received awards totaling $483,624 for the purpose of strengthening geriatric training and carrying out research activities in this area.

Under section 748, the General Internal Medicine and General Pediatrics Residency Training Programs reported nine grantees who provided geriatric medicine training a total of $152,634 was awarded.

The Area Health Education Center (AHEC) Program (section 746) awarded $18.7 million to 19 Basic/Core AHEC Programs and $3.2 million to 13 Model State-supported AHEC programs. Approximately 5 percent of these awards support geriatric activities. Trainees include a full range of health professions students (i.e., medicine, nursing, nurse practitioner, physician assistant, pharmacy, dentistry, mental health), primary care residents (family medicine, general internal medicine, general pediatrics) and local health care providers.

Geriatrics training components will be developed by 3 of 10 grantees under the Health Education and Training Centers Program (section 746(f)). Approximately $2.8 million was awarded for this program. Approximately 3 percent of this amount was directed to geriatric activities that impacted physicians, social workers, nurses, community health workers, and public health trainees.

Nine Physician Assistant Training Program (section 750) grantees have instituted training activities in geriatrics. These grantees were awarded $153,422 specifically for their efforts in this area.

Six grantees receiving support for Pediatric Primary Care Residency Training under section 751 authority have included curricular emphasis in geriatric health. These grantees received a total of $299,700.

Geriatrics training components will be developed by 4 to 13 grantees under the Health Education and Training Centers Program (section 746(f)). Approximately $2,800,000 was awarded for this program. Approximately 3 percent of this amount was directed to geriatric activities that impacted physicians, social workers, nurses, community health workers, and public health trainees.

Division of Nursing

The Division of Nursing continues to administer grants awarded through four programs: (1) Advanced Nurse Education, (2) Nurse Practitioner-and-Nurse-Midwifery, (3) Special Projects, and (4) Professional Nurse Traineeships. The fourth program provides funds to schools which allocate these funds to individual full-time master's and post-master's nursing students who are preparing to be nurse practitioners, nurse-midwives, nurse educators, public health nurses, or in other clinical nursing specialties.

Activities relating to the Aging, Advanced Nurse Education and Nurse Practitioner/Nurse Mid-Wifery programs during FY 1993 include.—The Advanced Nurse Education Program (section 821) authority supported 7 grants totaling $1,188,126 for gerontological and geriatric nursing concentrations in programs leading to a master's or doctoral degree in nursing. Graduates of these programs are prepared broadly to meet a wide range of needs relative to the elderly in many settings, but are particularly prepared to deal with the older individual who is acutely ill. In addition, the program prepares nurses who can teach and do research in this important field.

Under the Nurse Practitioner and Nurse-Midwifery Program (section 822(a)) 8 master's or post-master's gerontological nurse practitioner programs received $716,061 in grant support. As nurses with advanced academic preparation and clinical training, they are prepared as primary health care providers to manage the health problems of the elderly in a variety of settings, such as long-term care facilities, ambulatory clinics and the home. They provide nursing care which includes the promotion and maintenance of health, prevention of disease, assessment of health needs, and long-term nursing management of chronic health problems.

Emphasis is placed on teaching and counseling the elderly to actively participate in their own care and to maintain optimum health.

The Nursing Special Projects Grant Program (section 820) supported 11 projects, amounting to $1,337,130 for paraprofessional fellowships for LPN to RN training, and for nursing practice arrangements in communities to demonstrate methods to improve access to primary health care in medically underserved communities. The nursing practice arrangements targeted the elderly as an integral component of services provided. Project activity was based in home settings and in the community in both urban and rural areas.

Below is highlighted one of the specific special projects.—A special project was awarded to Old Dominion University, Norfolk, VA over a 3-year period to compare the effectiveness of utilizing a case management system implemented by a family nurse practitioner in a mobile health unit to assess, coordinate, and deliver services to individuals 65 years of age or older in a rural setting with the current method of providing services. The project will focus on providing access to health care services for those individuals who have difficulty obtaining care because of illness, transportation problems, or financial factors. The nurse practitioner associated with the project will provide nursing services in the home as well as at designated community sites via the mobile health unit.

The proposed project will study changes in access to care, functional status, health status, and health promotion behaviors after implementation of the project as well as evaluate the impact of the project on the community, and test the cost effectiveness of the service delivery model. It is anticipated that data from this project will be useful in determining the health status of the rural elderly and provide a better understanding of the life conditions affecting health in a rural area.

ACTIVE CONTRACTS UNDER TITLE VII OF THE PHS ACT

Funding—FY 1994
Project
State University of New York at Buffalo
"Categorization of Secondary Outcomes of GEC Activities"
8/30/94–2/28/95—$24,349.

The purposes of this project area: (1) to categorize the secondary outcomes identified under HRSA contract number HRSA 93–901(P) to delineate the multiple types of secondary outcomes possible through GEC activities; (2) to review and revise the existing primary outcomes reporting instrument; and (3) to propose categories for secondary outcomes identification and recommendations for their adaptation by GECs.

Project
240–BHPr–1(4)
1/1/94–1/1/95—$137,693.
Baylor College of Medicine

The purpose of this contract is to plan, develop, and conduct a workshop, including logistical support, which will enable key staff from Geriatric Education Centers (GECs) to interact, exchange information, share strategies, and jointly plan needed actions to accomplish GEC purposes.

Project
HRSA 94–750(P)
7/8/94–1/8/95—$24,993.50
Baylor College of Medicine

The purpose of this contract is to provide logistic services for meetings of three Study Groups of the National Forum for Geriatric Education and Training to be held before and during the 9th Workshop for Key Staff of Geriatric Education Centers.

PUBLICATIONS

"GEC Materials Related to Minority Aging." Bibliography. Revised September 1994.

"Selected Materials Produced by Geriatric Education Centers." Updated listing of approximately 500 curriculum guides, conference proceedings, audiovisual materials, and monographs. October 1993.

Georgia J. Anetzberger, Ph.D., "Elder Abuse Programming Among Geriatric Education Centers", Journal of Elder Abuse & Neglect. Haworth Press. Vol. 5(3) 1993.

Gary L. Mancil, O.D., Sheree J. Aston, O.D., Ph.D., Tanya L. Carter, O.D., Rosalie A. Gilford, Ph.D.; "Geriatric Optometry Faculty Preparedness in Schools and Colleges of Optometry" accepted for publication in Journal of Optometry Education.

EVENTS

White House Conference on Aging Mini-Conference—Ninth GEC Workshop, "The Challenge of the Next Ten Years" held in Washington, D.C., August 25–28, 1994.

"Evolution of GEC Evaluation Efforts" presented at the Ninth GEC Workshop in Washington, D.C., August 27, 1994.

"Faculty Training in Geriatric Optometry" presented at the 47th Annual Scientific Meeting of the Gerontological Society of America in Atlanta, GA, November 20, 1994.

"Integrated Learning Among Fellows in the Faculty Training Projects in Geriatric Medicine and Dentistry" presented at the 47th Annual Scientific Meeting of the Gerontological Society of America in Atlanta, GA, November 20, 1994.

"Analysis of Secondary Outcomes Data from Geriatric Education Center (GEC) Programs" presented at the 47th Annual Scientific Meeting of the Gerontological Society of America in Atlanta, GA, November 20, 1994.

"Health Professions Reform, Directives & Policy Formation: Geriatric Education in the New Century" presented at the 47th Annual Scientific Meeting of the Gerontological Society of America in Atlanta, GA, November 20, 1994.

FUNDING FACTORS USED IN BHPr TRAINING PROGRAMS

The Bureau utilizes several funding factors to address national priority areas. These factors are designed to place applicants responding to these national needs in a more competitive funding position. The following programs used a geriatric funding priority in awarding funds in FY 1994:

Geriatric Education Centers—section 777(a).
Geriatric Faculty Fellowships—section 777(b).

The following programs used a geriatric special consideration in awarding funds in FY 1994:

Advanced General Dentistry—section 749.
Allied Health Special Projects—section 767.

NATIONAL INSTITUTES OF HEALTH—NATIONAL INSTITUTE ON AGING

INTRODUCTION

Finding ways to provide effective health care for the rapidly expanding population of older Americans and keeping costs down is one of the greatest challenges faced by our Nation. The success of this balancing act depends upon persistent efforts to avoid doing the same old things in the same old way. Research into age-related processes provides the underpinnings to this progress. Of equal importance is our success at communicating these scientific advances to physicians so they can be applied in clinical settings. This report highlights a number of research advances made during 1994 conducted or funded by scientists by the National Institutes of Health (NIH), the principal biomedical research arm of the Federal Government. Part of NIH, the National Institute of Aging (NIA), is the primary sponsor of aging research in the United States. The first section of this report outlines some key research advances conducted or funded by the NIH. The second section covers recent advances in Alzheimer's disease (AD), an NIA research priority.

UNDERSTANDING AGING

NIA scientists and grantees take a multidisciplinary approach to finding ways to improve the ability of doctors to diagnose, treat, and prevent the health problems of older adults. Other NIH components conducting or supporting aging research are the National Cancer Institute; the National Center for Research Resources; the National Eye Institute; the National Heart, Lung, and Blood Institute; the National Institute for Nursing Research; the National Institute of Arthritis and Musculoskeletal and Skin Diseases; the National Institute of Dental Research; the National Institute of Diabetes and Digestive and Kidney Diseases; the National Institute of Mental Health; the National Institute on Alcohol Abuse and Alcoholism; and the National Institute and Other Communication Disorders.

Pumping Iron Improves Strength, Mobility of 80- and 90-Year-Olds

Pumping iron at 90? Is there really any point? Absolutely, according to a recent NIA study. In fact, frail people in their eighties and nineties became stronger and more mobile with high-intensity weight training in a clinical trial conducted by Dr. Maria Fiatarone at the Hebrew Rehabilitation Center of Aged, a long-care facility in Boston Massachusetts.

Fiatarone and her colleagues found that a carefully designed program of strength training for the muscles of the hips and knees can counteract muscle weakness in very old people. Ultimately, this type of intervention could be a key to reducing disability and its costs as people age, and may help delay entry into a nursing home altogether.

The study found an average 113-percent increase in muscle strength among the participants, compared with 3 percent improvement in people who did not take part in the exercise program. The exercisers experienced a 12-percent increase in walking speed and a 28-percent increase in ability to climb stairs. People in the exercise group even showed an increase of 34 percent in their levels of spontaneous activity, such as walking to meals and participating in art and educational activities. In addition, after doing the exercises, several participants required the support of only a cane rather than a walker. Earlier groundbreaking research by Fiatarone had suggested that strength training could build muscle strength in the very old and frail. But these latest findings go a step further by demonstrating the practical benefits of increased muscle strength and size.

This study is especially important because it shows that improvements in strength translate to significant improvements in mobility. For some, this is the difference between being able to go to the dining room for a meal instead of having to stay in their rooms.

The findings are among the first reported from FICSIT (Frailty and Injuries: Cooperative Studies of Intervention Techniques) clinical trials funded by NIA and launched in 1990 to reduce and prevent frailty. Funding for Fiatarone's work was also provided by the U.S. Department of Agriculture Human Nutrition Research Center on Aging at Tufts University.

The study included 63 women and 37 men, ranging from 72 to 98 years of age. More than one-third of participants were 90 and older. The participants were divided into four groups, comparing resistance training (in which muscles are worked against weights), nutritional supplements, both interventions together, and neither. People assigned to the exercise training group participated in a program of high-intensity progressive resistance training of the hip and knee extensor muscles under

professional supervision 3 days a week for 10 weeks. Training sessions lasted 45 minutes.

The researchers note that this study is also important for its finding that nutritional supplements alone are ineffective in increasing the strength or physical activity of nursing home patients. The supplement used in the study boosted calories by about 20 percent and provided one-third of the recommended daily allowance of vitamins and minerals, like supplements commonly ordered by physicians for nursing home patients. In the Boston study, when the supplement was given without exercise, people cut down on the amount of food they ate, essentially replacing their food with the supplement. The exercisers, however, increased their caloric intake significantly when given the supplement, suggesting that activity might work to increase appetites in older people.

Physical frailty represents one of the biggest threats to older people's functioning and quality of life. Studies like this will help improve everyday life for America's aging population and may eventually contribute to reducing health care costs.

A number of national health surveys indicate that substantial numbers of older Americans report difficulties in the ability to climb 10 steps, walk one-quarter mile, or lift 10 pounds. Frailty increases the risk of institutionalization among older people, whose annual nursing home care costs are estimated to be well over $30 billion. Frailty also greatly raises the risk of falls in older people, and 10 percent of falls result in serious injury, such as fracture. An estimated $7 billion is spent on the 250,000 hip fractures that occur each year among older Americans, almost all due to falls.

One More Reason to Exercise

There is yet another reason for older people to exercise. According to new studies by NIA scientists, regular exercise, such as walking or gardening, is associated with nearly a 50-percent reduction in the risk of severe gastrointestinal (GI) hemorrhage in older people. The study is the first to show an association between physical activity and reduced risk of serious intestinal bleeding.

The study is one of two which analyze the risks of severe GI hemorrhage. The second report looks at the other end of the spectrum, finding that physical disability increases the risk of severe GI bleeding in older people.

The first group of findings, associating physical activity with a reduced risk of serious intestinal bleeding, are important in showing a possible way to prevent GI hemorrhage without drugs or surgery. It is already known that people who engage in regular physical activity are less likely to develop coronary heart disease, diabetes, obesity, and other conditions that may cause disability and death. Now, scientists are closer to adding to the list a reduced risk for severe GI hemorrhage, a problem that affects large numbers of older people each year. However, additional research is needed to confirm these findings and to explain how exercise and fitness may reduce the risk of GI hemorrhage. The analysis was led by Dr. Marco Pahor, a visiting scientist to NIA from the department of gerontology, Catholic University, Rome, Italy, and his colleagues, who include Dr. Jack Guralnik, NIA's chief of the Office of Epidemiology and Demography.

Some 8,205 people age 65 and older, participants from three communities of NIA's Established Populations for Epidemiologic Studies of the Elderly, were asked by researchers about the frequency of taking walks, gardening, and doing vigorous physical activity and were followed for 3 years. People engaged in these activities three or more times per week were compared to the other study participants for GI hemorrhage. Scientists also looked at other factors linked to intestinal bleeding including age, gender, body-mass index, blood pressure, chronic diseases, hospitalizations, and certain drugs. The mean age of participants was 76.8 years.

Overall, people who were inactive were 40 percent more likely to experience a GI hemorrhage than those with regular exercise. Regular walking, for example, a common activity of older people, was associated with a 50-percent reduced risk of severe intestinal bleeding.

The investigators believe the results, though new, make sense biologically. Under physical stress, chronic disease, or overexertion, the blood flow to issues (such as the intestine) may be reduced and fall below the threshold of how much blood and oxygen is needed. When that flow is inadequate, there is a disruption that may lead to anything from a minor dysfunction to death of some tissues. The lining of the intestine is a vital organ and very sensitive to that kind of stress; it may not be able to regenerate cells normally when the blood supply is compromised. This can lead to damaged tissues and bleeding. The scientists hypothesize that people who are active and physically fit have a better blood flow and may be better able to avoid these problems.

People over age 65 are about five times more likely to be admitted to the hospital for intestinal bleeding than middle-age adults. The most recent data show that GI hemorrhage was the main reason for more than 300,000 hospitalizations annually in the late 1980's. Death rates for the disease have not changed much in the past decade despite advances in medical and surgical care.

Half of Men Over Age 40 Experience Impotence

Fifty-two percent of men between ages 40 and 70 have at least some degree of impotence, with the risk increasing significantly with age. NIA grantee Dr. John B. McKinlay and colleagues at the New England Research Institute also found that while the risk of impotence was linked to age, heart disease, and hypertension and their treatments further increased risk for older men. In addition, cigarette smoking nearly doubled the risk for those being treated for these diseases.

This study is among the first to report on impotence in healthy people. Based on questionnaire responses from over 1,200 men participating in the Massachusetts Male Aging Study, the finding suggests that, in light of its high prevalence, impotence is a major health concern.

The finding may also point to ways that impotence among older men can be greatly alleviated. For example, the study shows that many of the problems associated with impotence may be modifiable, such as cigarette smoking, as well as other risk factors for vascular disease.

A Challenge to Traditional Views on Treating Urinary Tract Infections in Older Women

Routine screening and treatment of older women for silent urinary tract infection is not warranted, according to research from a team of scientists at the Medical College of Pennsylvania. Their 9-year study found that urinary tract infections without symptoms do not increase the risk of death for older women, contrary to a view held by some in the medical community.

The NIA-supported study is one of the most comprehensive to date on the contested issue of bacteriuria, or urinary tract infection, and mortality. A longitudinal component of the study monitored death rates among a group of women in Philadelphia with and without asymptomatic infection and found no increased risk of death in the infected group. In the second arm of the study, a controlled clinical trial, women who were treated for asymptomatic infection had no significant differences in mortality compared with untreated women. Death rates were 13.8 per 100,000 in the treated group and 15.1 per 100,000 for the group not treated.

This study provides the strongest evidence to date against a link between asymptomatic bacteriuria and mortality, according to the study's principal investigator Dr. Elias Abrutyn. He suggests that on the strength of this effort, physicians rethink their approach in treating older women without symptoms. While women with symptoms (e.g., burning and increased frequency of urination) should be treated, older women with asymptomatic infection should not be subjected to unnecessary antibiotic therapy.

According to the National Center for Health Statistics, in 1991 there were nearly 1.5 million urinary tract infections diagnosed in women 65 and older.

The research included women age 65 and older who were living at a geriatric center and 21 continuing care communities in the Philadelphia area. In this longitudinal study, 318 women with urinary tract infections were older and sicker than the 1,173 uninfected residents. The analysis showed, however, that higher death rates in the infected group were not linked to infection. Increased age and a poor self rating of health by the women were much stronger predictors of a higher risk of death. In the clinical trial, mortality in the 166 treated residents was comparable to that of the 192 untreated residents.

New Techniques for Managing Urinary Incontinence

Urinary incontinence (UI) affects an estimated 10 million Americans. Because people who suffer from urinary incontinence UI often are too embarrassed to seek treatment, the actual number of people with the condition may far exceed this estimate. Urinary incontinence is a condition that can lead to social isolation and depression. It is a primary reason for nursing home admissions in the United States where more than half the residents suffer from UI at an annual cost to the Nation of approximately $3.3 billion.

NIA scientists at the Gerontology Research Center in Baltimore, MD studied the benefits of a prompted voiding schedule on nursing home patients with UI. They also looked at how benefits could be maintained in a normal nursing home situation.

The scientists studied 41 nursing home residents. Of the 18 men and 23 women, 39 needed staff assistance to get to the bathroom, and all spent more than 50 percent of their day in a chair. For 2 weeks, researchers measured the participants'

incontinence frequency and evaluated their demographic, psychological, function, and medical characteristics.

In phase two of the study the participants were checked for incontinence every 2 hours for a 2-week period. Based on the data, researchers divided the participants into three groups. Group number 1 was prompted every hour and then returned to a 2-hour schedule. Group number 2 was shifted to a 3-hour routine, and group number 3 remained on the 2-hour protocol for the duration of the study. For approximately 2 months each patient, regardless of group assignment, was checked for wetness every 2 hours and monitored for liquid intake and voiding.

Phase three returned the group to their original nursing home facility where researchers had trained the nursing staff in prompting voiding procedures. The study results showed that prompted voiding is an effective treatment for urinary incontinence and that management procedures developed by the research team can be successfully carried out by nursing home staff. The 3-hour schedule was superior to the 2-hour schedule for some residents.

A common problem for nursing home staff is the frequent and repetitive patient requests for assistance in toileting and other activities. A schedule of prompted voiding cut down the number of requests—an important step in helping nursing home care become less custodial and more rehabilitative

New Detection Method for Cancer Drugs and Environmental Toxins Developed

A highly sensitive detection method for cancer drugs and environmental toxins has been developed by Doctors Vilhelm Bohr and Nicholas J. Rampino at NIA's Gerontology Research Center in Baltimore.

The scientists developed a very sensitive assay (or test), allowing them to measure specific activities on a DNA strand where toxic damage can occur. These activities are affected by various enzymes (called polymerases and exonucleases), which could be blocked by the chemotherapy drug cisplatin. Cisplatin is used to treat ovarian cancer, but is very toxic and difficult to tolerate for many patients. Failure to tolerate the drug is often accompanied by an acquired resistance to the drug. Previous assays have used a fairly high dosage of cisplatin in order to achieve verifiable results. The sensitivity of this new assay may enable researchers to better understand the mechanisms by which cisplatin acts on ovarian cancers and allow them to modify dosages for greater tolerance and lower toxicity of the drug.

The investigators sought to find out which mechanisms of DNA damage and repair were responsible for making cisplatin toxic to tumor cells at doses that normal cells could tolerate. The methods developed here should be applicable to a broad variety of chemotherapy drugs and environmental toxins.

Drs. Bohr and Rampino developed their assay by introducing cisplatin to ovarian cancer cells in a laboratory dish and by examining the effects of the drug on DNA repair activity. DNA is often called "the building-block of life" and its structural integrity is crucial for the development of healthy new cells. When the structure of DNA is altered, lesions or deletions may occur that can lead to tumors and other harmful side effects, including age-associated diseases. The body has its own repair mechanisms for removing lesions, but sometimes repairs are not effective or may even introduce new "errors" into the DNA. The drug cisplatin apparently works by forming DNA lesions that significantly distort the structure of the DNA double helix and by doing so, enhances the effect of the drug on tumor cells.

Additionally, Doctors Bohr and Rampino were measuring the DNA repair process in relation to cell cycle timing. Because timing is important to the aging process, where a defect in timing alters cell aging, understanding the principles involved in the regulation of timing is central to our understanding of aging. Moreover, a better understanding of this process could lead to better therapies for age-associated diseases, such as cancer and less toxic drugs for treatment.

How Exercise Effects the Aging Heart

The mechanisms of how the aging heart works while under the stress of exercise are now better understood due to research done by scientists at NIA's Gerontology Research Center. Dr. Edward G. Lakatta, Chief, Laboratory of Cardiovascular Science, and his research team examined men from their twenties to their seventies to study the effects of vigorous aerobic exercise on the heart and how aging changes these effects. This is one of the first studies to examine these effects in older people and helps expand our understanding of the aging heart.

Dr. Lakatta's team studied the impact of age on a specific nerve receptor in the heart that controls heart rate and function during exercise. This receptor, the beta-adrenergic receptor, is responsible for the large increases in heart rate and pumping function that occur with vigorous exercise. Researchers often use drugs which block the beta-receptors, called "beta-blockers," to study the importance of this receptor

system in heart function. Using the beta blocking agent propranolol, the scientists studied the importance of the beta-adrenergic receptor on heart performance in younger versus older men at rest and during exercise.

Participants were chosen from the Baltimore Longitudinal Study of Aging. This long-term study begun by the NIA in 1958, is examining men and women for a large variety of physiological and psychological changes as they age. Men selected for the aging heart study were separated into control and test groups. They were studied at rest and during exhaustive exercise on a stationary bicycle. The participants were given the blocking drug, propranolol, before the start of exercise, and examined for the effect of the drug on their heart. Control participants exercised without the drug. The researchers measured heart rate, blood pressure, and several measures of cardiac size and performance.

Scientists hypothesized that the deficits in cardiac performance observed during strenuous exercise in older adults were due to a lessened beta-adrenergic response. This study proves the hypothesis true. The effect of propranolol in reducing cardiac performance during exercise was greater in younger men than in older men as would be expected since older men usually have a lessened beta-adrenergic response to exercise. Thus, the blocking effect would not be expected to be as great as in their younger counterparts.

Dr. Lakatta's team was particularly interested in the contraction function of the left ventricle of the heart. The left ventricle is the main pumping chamber of the heart. Contraction of its walls propels blood into the aorta and then on to the rest of the body. Inhibition of beta-adrenergic receptors by propranolol caused a decrease in left ventricle contractile ability. The inhibition of the left ventricle's contractile ability was also more prominent in younger than older men as would have been expected. This finding is of particular note due to the left ventricle's importance in the health and vitality of the human body, since it is the heart chamber most commonly affected by disease.

These studies point the way for more extensive investigations into this phenomenon for the population as a whole.

Gene Mutation Doubles the Lifespan of Worms

Longevity research moved a step forward with the finding that a mutated gene more than doubles the lifespan of a worm—the largest life extension yet reported in any organism. Dr. Cynthia Kenyon, and colleagues at the University of California at San Francisco found that a mutated form of the *daf*–2 gene enabled healthy, active worms to live more than 5 weeks, a dramatic contrast to their normal lifespan of about 2½ weeks.

The *daf*–2 mutation affected aging as well as length of life. When all the worms without the mutation had died or become immobile, 90 percent of the long-lived worms were still active, signifying a slower rate of aging.

The finding adds a new clue to a string of findings in recent years concerning genes that affect longevity. Researchers have pinpointed more than a dozen such genes both in fruit flies and in the microscopic worms called *Caenorhabditis elegans* or *C. elegans* used in Kenyon's laboratory.

How the *daf-2* mutation extends lifespan is still a mystery. What scientists do know about the gene is that it helps regulate one stage of development in *C. elegans.* Normally the worm turns into an adult by passing through several larval stages. But in an unfriendly environment—where there is crowding or a good shortage—*C. elegans* pauses at one of the larval stages. This is where the *daf-2* gene comes in, enabling the larva to enter a sort of holding pattern and become what is called a dauer. The dauer can live for months in this arrested state until conditions improve and the worm is able to continue developing into an adult.

In Kenyon's study, however, the mutated *daf-2* gene appeared to work outside the dauer state. The mutated form of the gene affected lifespan even though the long-lived worms had not spent time as a dauers. Thus *daf-2* could have some effects other than those that regulate the pathway to becoming a dauer.

Discovering what these effects are now is an important goal. So far, the researchers know that *daf-2* is just one of many genes that regulate dauer formation. They have learned that it is a key gene, regulating many of the other genes that are activated later in the dauer formation process. One of these, *daf-16,* must also be active to bring about the doubled lifespans seen in this study.

Findings to date raise the possibility that the longevity of the dauer is not simply a consequence of its arrested growth, according to Kenyon and her colleagues. Instead, they hypothesize, *daf-2* and *daf-16* may be part of a regulated lifespan extension mechanism that can act independently of other aspects of dauer formation. Now underway are studies to learn more about that mechanism. The findings should lead to a deeper understanding of the basic biology of longevity and aging.

Older Americans at Risk of HIV Infection Take Few Precautions

While human immunodeficiency virus (HIV) infection is present in an increasing proportion of Americans age 50 and older, many older people at high risk take few precautions against infection, according to a new study by scientists at the University of California at San Francisco (UCSF). Older Americans account for 10 percent of all acquired immunodeficiency syndrome (AIDS) cases nationwide. The proportion of cases attributed to heterosexual contact is among the highest of any age group. But there has been little research in behavioral risk among older people.

A study supported by NIA and the National Institute of Mental Health (NIMH), found that older at-risk heterosexual individuals are one-sixth as likely to use condoms during sex and one-fifth as likely to have been tested for HIV when compared with a group of people in their twenties who take the same risks. The findings, say study scientists, point to the need for including at-risk older Americans in AIDS education programs and for improving communication between health care providers and patients about aging and sexuality.

Doctors Ron Stall and Joe Catania of the Center for AIDS Prevention Studies at UCSF analyzed data from the National AIDS Behavioral Surveys taken in 1990 and 1991. The data are among the first to look at risk behaviors among those age 50 and older. Analysis shows that the most prevalent types of behavioral risks reported in this age group were having multiple sexual partners, having a partner with a known behavioral risk, and those who had a blood transfusion between 1979 and 1985.

Research Advances on Aging Supported and Conducted by Other NIH Institutes

NATIONAL CANCER INSTITUTE

A new study funded by the National Cancer Institute (NCI) evaluating the effect of age on a breast cancer prognosis has shown that younger women diagnosed with early stage breast cancer have a poorer prognosis than older women. This study involved 1,398 breast cancer patients who were diagnosed at being similar stages and were treated at one institution. Patients under age 35 had a worse prognosis than older patients in terms of overall recurrence, distant recurrence, and overall survival. Researchers also studied whether certain pathologic features could explain the worsened prognosis for younger women. While younger patients more frequently demonstrated poor prognostic factors (such as estrogen receptor negativity) than older patients, age had an effect on disease outcome independent of these factors. The researchers suggest that these results may indicate that the aggressive disease in younger women may have a different biological basis than the disease of older women. Additional research is necessary to identify the genetic defects responsible for breast cancer and to determine how such factors differ between young and older women.

Over the past three decades, large numbers of women have used estrogen therapy to relieve menopausal symptoms. In recent years, long-term use of estrogen replacement therapy has been advocated for its beneficial effects in preventing osteoporosis and coronary heart disease. Since breast cancer appears to be influenced by the length of exposure to endogenous ovarian hormones, exposure to exogenous hormones may also increase breast cancer risk. An NCI-supported collaboration with Swedish investigators has shown when the combination therapy of estrogen and progestin was used the use of progestins did not appear to eliminate the risks associated with estrogen. Moreover, there is some indication that use of the combined therapy might be more harmful than using estrogen alone. Data from followup evaluations of participants in a large, NCI-funded multicenter breast screening program will further investigate this issue.

Few advances have been made in recent years in the treatment of adult acute myelogenous leukemia (AML). While most patients achieve a complete remission—and intensive regimens can prolong disease-free and overall survival—50 to 70 percent of patients still relapse and die from the disease. A number of clinical trials are evaluating the use of biologic therapies as adjuncts to standard regimens. Several recently completed trials have evaluated hematopoietic growth factors in the treatment of older AMA patients. One trial suggested that myeloid growth factors reduce the toxicity of conventional chemotherapy and prolong time of remission and overall survival. This observation was not confirmed by a second study, but the promising results will be pursued in future research.

Rhabdomyosarcoma is a solid tumor of striated muscle that usually occurs during childhood, but occasionally presents in adults. Adults with rhabdomyosarcoma seem to have a poorer prognosis than children and adolescents with the disease. A recent

analysis of medical records was done on a broad age range of patients with rhabdcomyosarcoma to learn if age exerts an effect on survival independent of known prognostic factors including tumor stage, therapeutic intensity, or histologic subtype. Results suggest age is an important, independent predictor of survival. This was especially true for people with invasive but nonmetastatic tumors who were considered at intermediate risk for recurrence. The biologic determinants underlying the effect of age on survival are still unknown, but establishing age as a useful prognostic factor will aid in the clinical management of disease.

NATIONAL CENTER FOR RESEARCH RESOURCES

Studies of the normal aging process conducted by the National Center for Research Resources (NCRR) include research at the Regional Primate Research Centers (RPRCs) nationwide. Diagnostics such as positron emission topography (PET) and metabolic tracers are used to identify regional cerebral metabolic rates for glucose in older monkeys. Insulin responses to intravenous glucose challenge are lower in aged animals. Tentative observations support the thesis that deficits in cerebral glucose metabolism occur in older animals in some brain regions, especially the temporal cortex, while other brain regions appear to be spared. The effects of aging on a wide variety of physiological functions have also been examined. Scientists are correlating declines in T-cell function with adrenal steroid hormone (DHEA) levels to determine if DHEA reverses aging's adverse effects and prevents increases in blood cholesterol, lipoproteins and other lipids. Characterizing the aging process in older monkeys is being assessed relative to body composition, food and water intake and other physiological parameters. Moderate food restriction will not only reduce the incidence and slow the onset of age-related diseases, but also slows the rate of aging and prolongs the lifespan of primates. Finally, investigators have found that exposure to dioxin places monkeys at greater risk for developing endometriosis as they age.

NATIONAL EYE INSTITUTE

The mission of the National Eye Institute (NEI) is to conduct and support research, training, health information dissemination, and other programs with respect to blinding eye diseases, visual disorders, mechanisms of visual function, preservation of sight, and the special health problems and requirements of the blind. Many diseases of the eye and visual pathway that result in blindness or reduced vision are directly related to aging.

Age-Related Macular Degeneration (AMD)

Age-related macular degeneration (AMD) is a deterioration or degeneration of the macula, the area of the retina responsible for sharp central vision. It is the leading cause of blindness in Americans age 65 and older. Although NEI-supported research has demonstrated the effectiveness of laser treatment for the neovascular or wet form of AMD, there is no proven way either to prevent or to treat the vast majority of people who have the dry form of the disease. The major goal of the NEI research AMD is to prevent or delay its progression. In a large NEI-supported epidemiologic study of neovascular AMD, scientist found an increased risk was associated with cigarette smoking and higher levels of serum cholesterol, and a decreased risk was associated with postmenopausal use of estrogens and higher levels of serum carotenoids. These results are consistent with a hypothesis linking risk factors for cardiovascular disease with AMD.

Cataract

Cataract, the third leading cause of blindness in the United States, is an opacity of the normally transparent lens that interferes with vision. It is three to four times more prevalent in the diabetic population than in the nondiabetic population. As the American population ages, the prevalence of the disease will increase.

The Framingham Offspring Eye Study (FOES) was designed to examine familial relationships for age-related cataract and age-related macular degeneration, among 1,086 parents examined in the Framingham Eye Study (1973–75) and 896 of their children examined from 1989–91. Strong statistical associations were found between siblings for nuclear and posterior subcapsular opacities, suggesting that there is clustering of lens opacities within families. The clustering may be due to genetic or environmental factors.

Researchers conducting the Italian-American Natural History Study of Age-Related Cataract have estimated the incidence and progression of cortical, nuclear, and posterior subcapsular opacities in a large follow-up study. The 3-year cumulative incidence for persons age 65–74 years (the largest group studied) was 18 percent, 6 percent, and 6 percent for cortical, nuclear, and posterior subcapsular opacities. Pro-

gression was much higher than incidence for each type of opacity. The study suggested that patient age, baseline lens status, cataract grading system, definition of change, and analytic methodology may have important effects on estimates of cataract incidence and progression.

Diabetic Retinopathy

Diabetes affects a number of ocular tissues, but exerts its most harmful effects on the retina where it causes progressive breakdown of the normal vascular system, a condition called diabetic retinopathy. Diabetic retinopathy accounts for approximately 12 percent of new cases of blindness each year among persons age 20–74 years in the United States. Diabetes increases the risk of blindness 25-fold over that of the general population, and it is estimated that 24,000 Americans become blind each year as a result of diabetic retinopathy.

The Wisconsin Epidemiologic Study of Diabetic Retinopathy (WESDR) is a population-based epidemiologic study of the incidence and progression of diabetic retinopathy that was conducted in southern Wisconsin. The study focused on insulin-taking diabetics who were diagnosed with the disease before age 30. Among those initially free of retinopathy, 59 percent developed the disease by the 4-year visit, and 11 percent of the 713 individuals initially free of proliferative retinopathy developed this severe disease by the 4-year visit. Overall, 41 percent of the 996 diabetics surveyed showed a deterioration of retinopathy. Increased blood pressure was shown to almost double the risk of developing retinopathy. Other important risk factors were higher levels of an altered form of the oxygen-carrying molecule hemoglobin (glycosylated hemoglobin) and a longer duration of diabetes. These data provide important information regarding the eye health care needs of patients with diabetes and emphasize the need for adequate control of hypertension.

Glaucoma

Glaucoma is a heterogeneous group of disorders characterized by a distinct type of optic nerve damage that can lead to blindness. In the United States about 2 million people have glaucoma, but because of the insidious nature of the disease, many are unaware of its presence. Additionally, about 5 million Americans, some of whom will develop glaucoma, have elevated intraocular pressure (IOP). Primary open angle glaucoma (PAOG) is the most severe form of the disease and is most common in people over the age of 60. Approximately 80,000 people with this form of the disease will become blind this year.

The mechanism by which the optic nerve is damaged by glaucoma is unknown. The relative influence of genetic and environmental factors is also unclear. However, there is some hope for understanding the cause of the disease since juvenile onset glaucoma, a form of the disease characterized by early adulthood onset and elevated IOP, displays an autosomal dominant pattern of inheritance. Several NEI-supported scientists have identified a number of families with sufficient individuals with glaucoma that make it now possible to perform genetic linkage studies. Recently, one disease-associated gene has been mapped by linkage analysis to chromosome 1. Corroborating data from different laboratories using different families have confirmed this location. Linkage analysis has placed the gene to within approximately a 20–80 gene region on the chromosome. Isolation and characterization of the gene responsible for one form of glaucoma is a significant step in identifying a least one causal factor of this disease and holds great promise for eventually understanding, treating, and preventing age-related and other forms of glaucoma.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

A recent report from the National Heart, Lung, and Blood Institute (NHLBI) report6s on risk factors for cardiovascular disease (CVD), the leading cause of death in older people. An important public health/medical paradox results from improved survival for younger individuals with CVD, which increases the population of older persons at high risk for heart attack or stroke, both associated with substantial disability and morbidity. The report emphasizes primary prevention, especially risk factor reduction as the major focus of CVD prevention and research. Research on lifestyle changes in older persons in needed to evaluate interventions for risk factor modifications and their effects on functional impairment and quality of life. Related issues for the elderly include identification of determinants and precursors of CVD, and the relationships of systolic blood pressure to vascular disease and risk of stroke and heart attack.

Heart failure, a frequent consequence of ischemic heart disease, represents a major disturbance in the heart's function to collect venous blood, deliver it to the lungs for oxygenation, and pump oxygenated blood throughout the body. It is both more prevalent and more severe in the elderly. The NHLBI Task Force on Research

in Heart Failure examined the state of the science and research opportunities for treatment and prevention of heart failure. Its recently published report describes ". . . the great potential for preventing heart failure through early and vigorous treatment of hypertension, prevention of myocardial infarction, and limitation of infarct size by restoring blood flow early." Among the ways cited to achieve this objective, the report advise that ". . . research should be undertaken to provide a better understanding of the molecular effects of age on the heart."

Magnetic resonance imaging can detect cerebral abnormalities, including those of unknown significance. A report from the NHLBI Cardiovascular Health Study (CHS) describes prevalence and correlates of such abnormalities in 303 men and women aged 65–95 years. Measures of cerebral atrophy increase with age and are greater in men than in women. In the CHS, cerebral atrophy and white matter hyperintensity, common in the elderly, correlate with advanced age, prior stroke, and known cardiovascular risk factors. However, their wide variability and associations with CVD do not support the suggestion that they represent normal aging, but do emphasize the need to identify modifiable risk factors for these abnormalities.

The Systolic Hypertension in the Elderly Program (SHEP), a randomized clinical trial, reports the results of medical treatment compared to placebo for systolic hypertension in older adults. SHEP investigators describe the effects of treatment on progression of carotid stenosis, an arterial obstruction associated with increased risk of stroke. Measurement of changes in carotid blood flow velocity ratios are reported for 129 study participants. Stenosis progression was found in 22 percent (28/129) of patients and regression in 16 percent (8/49) of a subgroup. Progression was significantly more frequent in the placebo group than in those treated (31 percent versus 14 percent). All of the patients with regression received active treatment. The study shows that treatment of systolic hypertension slows progression of carotid stenosis, and similar effects on intracranial vessels may account for the substantial decrease in stroke observed in SHEP participants assigned to active treatment.

NATIONAL INSTITUTE FOR NURSING RESEARCH

The National Institute for Nursing Research (NINR) funds research directed toward the development of strategies that help older people maintain optimum health, the highest functioning ability, and best quality of life.

Sensory Organization Test

With the rising occurrence of falls in older people, it is important that health care providers use the best balance test available to clinically identify those at risk for falling. Balance problems associated with a decline in the sensory or motor systems must be distinguished from those associated with specific pathological processes. Dr. Jean F. Wyman and colleagues at the Virginia Commonwealth University in Richmond, Virginia, found that the Sensory Organization Test—which uses a computerized force platform and loss-of-balance episodes—performed well overall (ICC .66) and over time. The percent of agreement for loss of balance in all protocol conditions, and over time, was 77 to 100 percent. Participants were, age 65 and over, without hip or knee replacement and walking without a quad cane or walker.

The test is administered with a computerized system using a movable forceplate and a movable visual screen. The volunteers are evaluated on visual, vestibular, and proprioceptive ability. The results showed that the instrument appropriately measures postural control and performs in a consistent pattern over time with the same client. The test can help clinicians detect instability in older adults identify conditions placing them at risk of falling. The scientists recommend modifying the current scoring on the test to incorporate a weighted score to further improve the test's usefulness.

Hospital Discharge Planning

The quality of hospital discharge planning available for people age 65 and older has been rated very poor by a national panel of experts. In addition, increasing pressure to contain costs raises serious concerns about the continued access to older patients to the quality of care they need. Interventions are needed to facilitate the discharge of older people from hospitals to their homes in a way that prevents poor outcomes and reduces health care costs.

A study was conducted to compare the effectiveness of a comprehensive discharge planning protocol design specifically for older people. Cardiac patients in medical and surgical DRG groups were included in the experimental and control groups. The protocol was implemented by gerontological nurse specialists (GNS). The protocol was compared to routine hospital discharge planning on the outcomes for the patients and caregivers and to the costs of the care.

From the initial hospital discharge to 6 weeks after discharge, patients in the experimental group had fewer readmissions, fewer total days rehospitalized, lower readmission charges, and lower charges for health care services after discharge than the control group. When the investigators controlled for the rate of post-surgical infections, the readmission rate for the experimental group was half of the rate for the control group. Studies are continuing to determine if additional interventions by the GNSs, including home visits, can further improve the outcomes in these chronically ill older people.

NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES

The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) has had a landmark year of research achievements related to aging. These activities have included the announcement of a major genetic finding related to osteoporosis, leadership of two NIH consensus development conferences—one on optimal calcium intake and the other on total hip replacement—and establishment of a national resource center on osteoporosis.

Osteoporosis is a bone disease characterized by low bone density and an increase in bone fragility. It is a leading cause of fractures in postmenopausal women and older adults. NIAMS-funded scientists report that a variation in a single gene may account for a large part of the total genetic effect on bone density. The gene codes for the vitamin D receptor, a protein that enables vitamin D to exert its actions on bone and on calcium metabolism. The prospect of a genetic marker of bone loss that may help to identify, early in life, individuals at high risk for osteoporosis may foster early intervention to prevent the disease.

Calcium is an essential nutrient for developing and maintaining strong bones and reducing the incidence of fractures due to osteoporotic bone loss. At an NIH Consensus Development Conference in June 1994, panelists made recommendations for calcium intake at each stage of life, confirming previously recommended levels for older women and putting new emphasis on calcium intake for adolescent females and older men.

Total hip replacement is most commonly performed in men age 65 to 74 and women 75 to 84, many of whom suffer from advanced arthritis. The current state of practice and technology was the subject of a September 1994 NIH Consensus Development Conference on Total Hip Replacement. The consensus panel concluded that hip replacement is one of the most successful and cost-effective surgical procedures performed today. The panel also highlighted the effectiveness of the combination of a cemented femoral (thigh) component and a porous-coated pelvic component.

To accelerate the pace at which new research information reaches the public, patients, and health professionals, the NIAMS established a National Resource Center for Osteoporosis and Related Bone Diseases. The center will include materials on such topics as Paget's disease, a chronic disorder of older persons and the second most common bone disorder after osteoporosis.

NATIONAL INSTITUTE OF DENTAL RESEARCH

One of the highest priorities of the National Institute of Dental Research (NIDR) is to preserve the oral health of older adults. This commitment reflects the results from the National Survey of the Oral Health of U.S. Adults, a 1985–86 study supported by NIDR that identifies people age 65 and over as those most prone to severe oral health problems.

Responding to this survey data, NIDR began a number of initiatives, which include funding for the Research Centers on Oral Health in Aging. Currently the center at the University of Texas Health Science Center at San Antonio, will conduct five studies aimed at understanding and diminishing the causes of poor oral health in older people. One study will include a focus on the oral health of Hispanics of varying socioeconomic and educational backgrounds. Researchers at another center, located at the University of Iowa, will conduct basic and epidemiological studies of mouth diseases that affect older people, including candida infections, human papilloma virus infections, and oral cancer.

At the University of Washington in Seattle, researchers are trying to improve the oral health of low-income Caucasian and minority older people who receive care in dental public health clinics. Initial results suggest that some of the observed ethnic differences in risk for oral health problems may be accounted for by different patterns of systemic illness and medication use. For example, low-income, older African Americans use blood pressure drugs that cause dry mouth more frequently than those in other ethnic groups.

NIDR also funds a longitudinal study at the University of Washington, examining the cost-effectiveness of preventive dental regimens for high risk older people. The

regimens range from behavioral/educational interventions to administration of mouthwashes alone and in combination with a fluoride varnish, to scaling and curettage. Comparisons are being made between men and women and across ethnics groups. Of the 250 participants, over one-third are minorities. Preliminary results show African Americans and Asians had a higher risk for periodontal disease and tooth loss than whites and Hispanics. The risk of cavities, on the other hand, was not related to ethnicity. Data on the time and costs involved in delivering the interventions are being collected and will be entered into the calculation of the effectiveness of each of the preventive methods.

Results are encouraging from a randomized controlled trial of a group oral hygiene intervention for older periodontal patients enrolled in a group health insurance program serving the northwestern states. Researchers found that the intervention is practical and acceptable for older patients and results in positive health and behavioral effects, even after 3- and 12-month followups.

NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) conducts and supports research on several diseases affecting middle-age or older adults. One of these is benign prostatic hyperplasia (BPH), or prostate enlargement—a common disorder affecting older men, with symptoms usually occurring in men over age 40. Approximately 75 percent of men over 50 have some symptoms of BPH, and 20 percent of all men will require surgery for this disease by the time they reach 80. BPH is the second leading cause of surgery in men. The NIDDK funds research to understand the processes of normal development and abnormal prostate growth and to develop effective therapies. For example, the NIDDK has begun the pilot phase of a randomized clinical trial that will study the role of new drugs in delaying the progression of BPH symptoms.

A recent advance in prostate research is the finding that estradiol, a female sex hormone, is involved in regulating prostate growth. This finding may help researchers solve the long-standing puzzle as to why BPH increases in prevalence as men age, at the stage in life when plasma androgens are decreasing. The investigators present data showing that estradiol—acting in concert with other chemicals—produces an increase in the intracellular accumulation of cyclic AMP. This demonstrates the cell-specific, powerful effect of estradiol on the human prostate.

Non-Insulin-Dependent Diabetes Mellitus (NIDDM) is another disease that affects a large segment of older Americans. The incidence of NIDDM increases rapidly with age. It affects almost one in five people age 65. About one-third of diabetics from age 65 to 74 are hospitalized each year. The diagnosis of people with diabetes who are over age 65 is expected to increase 44 percent during the next 20 years, to 3.9 million. Also, minority populations (including blacks, Hispanics, Native Americans, Hawaiians, and Alaskans) are disproportionately affected by this form of diabetes and its enormous cost burden.

NIDDK-funded researchers, reporting on clinical trials that studied the effect of varying carbohydrate contents of diets in patients with NIDDM. They found diets high in carbohydrates caused a persistent deterioration of the control of blood sugar, as well as increased levels of fat in the blood stream, effects which may not be desirable.

NIDDK also supports research on urinary tract infections (UTIs), which affect many postmenopausal women. Institute grantees report the results of a study of 93 postmenopausal women showing that recurrent UTIs could be prevented with the intravaginal administration of estradiol, a form of estrogen.

NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES

The National Institute of Environmental Health Sciences (NIEHS) conducts and supports research investigating the environmental contribution of diseases or conditions of older people, basic research on the mechanisms of aging, and the effect of environmental agents on the aging process.

A Gene for Breast Cancer

NIEHS intramural scientists and colleagues at the University of Utah were the first to isolate and sequence a breast cancer susceptibility gene known as BRCA1. Inheritance of a mutated form of this gene is implicated in 5 to 10 percent of all breast cancer cases and 85 percent of women who inherit it will develop breast cancer. The gene in its normal form is thought to be a tumor suppressor gene whose normal function is to regulate the growth of breast tissue. The mutated form of this gene functions abnormally thus allowing the uncontrolled growth found in cancer.

The gene is associated with the early onset breast cancer. Its role in postmenopausal breast cancer is currently under investigation.

The next step is to develop a screening test enabling physicians to identify women with the mutated form of the gene. This test could be done at an early age to detect the cancer when it is more easily and effectively treated.

The Role of Cadmium in Bone Loss

In another NIEHS-funded study, scientists are investigating the mechanism by which cadmium (Cd) causes bone loss in ovariectomized laboratory animals and the relevance of these findings to humans exposed to Cd. So far, researchers have found Cd increases calcium loss from bone at levels well within reported ranges for humans exposed to Cd in cigarettes or industrial settings. Additional analyses will determine whether Cd influences bone indirectly by causing decreases in the gastrointestinal absorption of calcium, kidney dysfunction, or changes in the adrenal or pituitary glands. Results indicate that pregnant, nursing, and postmenopausal women have an increased sensitivity to Cd. Determining the mechanism by which Cd increases bone loss in ovariectomized animals may provide insight into mechanisms that control increased bone loss in postmenopausal women.

Cancer and Aging

Cancer remains one of the major health problems associated with aging, yet the specific interaction between aging process and cancer remains uncertain. To better understand the interaction, NIEHS intramural scientists have been studying aging at the molecular level using cellular models of aging. Cellular senescence is a state of irreversible cell damage in which normal cells fail to enter DNA synthesis following stimulation. The NIEHS team has shown that defects in the senescence program of cells can be corrected in the laboratory by introducing normal human chromosomes into immortalized cells. These studies mapped senescence genes to nearly 10 chromosomes. These genes have been shown to control different pathways that regulate the senescence programs in cells. Studies were also conducted to determine whether proteins required for single cell cycle progression were irreversibly downregulated in senescent cells in culture. Significant extensions of life-span were seen in cells that expressed two transfected genes, suggesting that multiple gene products may be important in controlling the life-span of cells.

NATIONAL INSTITUTE OF MENTAL HEALTH

The National Institute of Mental Health (NIMH) conducts a broad program of research on mental disorders and behavioral dysfunction that often occurs in later life. NIMH encourages research in the areas of Alzheimer's disease and related dementias (see the Alzheimer's disease section of this report), psychotic disorders and schizophrenia; mood, anxiety, and personality disorders; suicide; sleep disorders; and the interaction between physical illness and mental disorders.

The following are some recent research advances from NIMH:

Using combined pharmacotherapy and psychotherapy, researchers found that treatment of consecutive episodes of major depression in older patients is as successful in late-life as in mid-life patients. Ninety percent of people finishing treatment had a remission of depressive symptoms.

Older patients, with a "reversible" dementia have nearly five times greater risk of developing true dementia at followup as compared to cognitively intact, depressed patients.

The complex relationships between depression and physical disability in older patients appears to be primarily unidirectional—depression causes disability more often than disability causes depression. This suggests that treatment of depression may prevent disability.

Neuroleptic induced tardive dyskinesia (TD), is a major iatrogenic disorder that is especially prevalent among older patients (cumulative 3-year incidence of 60 percent). This is five to six times higher than the incidence in younger adults. Significant risk factors are cumulative amount of high potency neuroleptics, history of alcohol abuse/dependence, borderline neurimuscular disorder and tremor at baseline.

Bright light suppresses melatonin output in humans and results in significant phase-shifting of the circadian system, or the "biological clock." Timed exposure to bright light has been demonstrated to be effective in alleviating age-related insomnia and other sleep and behavioral problems.

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) conducts and supports biomedical and behaviorial research on the causes, consequences, treat-

ment, and prevention of alcohol-related problems. NIAAA is particularly interested in studying how to reduce alcohol-related problems among older people. These problems include difficulties resulting from the reduced tolerance to alcohol that accomplishes aging, medication interactions, falls, accidents, fires, social isolation, negative affect, and reduced quality of life from cognitive impairment.

A research center devoted exclusively to the study of alcohol and aging processes is supported by NIAAA at the Univerisity of Michigan. This center, and other NIAAA-funded research, explores the interaction between age-related changes and the effects of alcohol on the central nervous system, the immune system, cognitive, affective states, and various organs. The effects of the chronic use of alcohol on the cerebellum and frontal lobes have been identified and associated with specific functional deficits. Current evidence suggests that the greater physiological and functional deficits experienced by older alcoholics occur because age renders them more vulnerable to the effects of alcohol. The center developed and evaluated an alcohol screening test specifically for older adults, called the Michigan Alcohol Screening Test-Geriatric Version (MAST–G). This instrument is easily administered, and will provide valuable for future research and for clinical practice in preventing for treating alcohol problems in older adults.

NIAAA researchers are also investigating patterns of alcohol use in the older population, predictors of change, and age-specific treatments. Alcohol consumption does not appear to be stable in this group, and patterns of drinking may change over time. The Institute's ongoing epidemiologic study will provide more information.

NATIONAL INSTITUTE ON DEAFNESS AND OTHER COMMUNICATION DISORDERS

The National Institute on Deafness and Other Communication Disorders (NIDCD) conducts and supports research and research training in hearing, balance, smell, taste, voice, speech, and language. Each of these areas of human communication is affected by the physiological changes that occur with aging.

Of the 1.5 million individuals with Parkinson's disease, a progressive neurodegenerative disorder, at least 75 percent have a breakdown in their ability to communicate orally. Several NIDCD-supported scientists are focusing on therapy for the deteriorating voice and speech disorders associated with Parkinson's disease. One clinical investigation examines the voice characteristic in patients before and after voice therapy. The long-term goals are to evaluate the efficacy of a model of voice treatment for these patients and explore the physiologic and neural mechanisms underlying voice and speech changes related to the treatment and speech changes related to the treatment and the progression of the disease.

In another study, a number of patients with Parkinson's disease were evaluated on different aspects of the physiology of speech production before and after voice treatment. The researchers found that all dimensions of speech were improved, and the patient's vocal loudness and speech intelligibility increased significantly after treatment. In most cases improvements lasted 1 to 2 years without additional therapy. After voice treatment, patients reported that they spoke more often and had more confidence that their speech was understood. These findings show that Parkinson's disease patients can make physiological changes in their speech production mechanisms with voice treatment that will improve their ability to communicate.

In the United States, more than 10 million older people are hearing aids. Currently hearing aids are designed to amplify sound. In a noisy environment a hearing aid will increase all sounds including background noise, thus increasing the difficulty of understanding speech. NIDCD-supported scientists have discovered how the loudness of the sounds humans are capable of hearing is perceived.

This new finding shows that two mechanisms, rather than one, help determine variations in loudness. This discovery promises to improve the design and function of prosthetic hearing devices such as hearing aids. By designing devices that present high- and low-pitched sounds differently to the hearing nerve, the capabilities of these devices could be improved.

ALZHEIMER'S DISEASE

Alzheimer's disease (AD) is the most common cause of dementia, or mental deterioration, among people age 65 and older. A slowly degenerative brain disease, AD is marked by changes in behavior and personality and by an irreversible decline in intellectual abilities. It impairs thinking, memory, and judgment, advancing in stages that range from mild forgetfulness to severe dementia. The course of the disease varies from person to person, as does the rate of decline. The average duration of AD is from 4 to 8 years.

People with this disease may forget how to do simple tasks, like brushing their teeth or combing their hair. Often, they are unable to think clearly or remember

the right names of familiar objects or people. Eventually, they become completely dependent on others for their care.

Risk for AD increases with advancing age. After age 65, the percentage of people who suffer from AD or other dementias doubles with every decade of life However, AD is not a part of normal aging. AD and other dementing disorders of old age are caused by specific diseases. Without disease, the human brain continues to function well, often into the tenth decade of life.

Prevalence and Costs of Alzheimer's Disease

Currently, an estimated 4 million Americans suffer from AD. In addition, the lives of countless caregivers are affected by this devastating illness. Families experience emotional, physical, and financial stress. They watch their loved ones become increasingly forgetful, agitated, and confused. Many caregivers, most of them women, juggle child care and jobs while caring at home for relatives with AD who cannot function on their own. As the disease progresses and the abilities of people with AD steadily decline, family members face painful decisions about the long-term care of their loved ones.

Moreover, AD puts a heavy economic burden on society. A recent study estimated that the cost of caring for one person with AD is more than $47,000 a year, whether the patient lives at home or in a nursing home. For a disease that can range in duration from 2 to 20 years, the overall costs of AD to families and to society are staggering.

Others factors in our changing society compound the problem of AD. Life expectancy has been increasing since the turn of the last century. During the past three decades, improvements in public health measures, diet, and health behavior have brought about dramatic demographic changes, including a lower birthrate. Thus, today in most industrialized countries, the 85+ age group is the fastest growing segment of the population. In addition, the challenge of paying for health care for all Americans has yet to be tackled.

In light of these issues, AD, which primarily affects older people, represents a major health concern and expense for the United States. Until researchers find a way to cure or prevent AD, the number of people living to very old age (85+) and at risk for AD will continue to increase dramatically. Providing and financing the care of a growing older population present special challenges for our health care system.

Research Directions

AD research falls into three broad, overlapping areas of emphasis: cause(s)/risk factors, diagnosis, and treatment/caregiving. Research into the basic neurobiology of aging is critical to understanding what goes wrong in the brain affected by AD. Understanding the mechanisms by which nerve cells lose their ability to communicate with each other and the reasons for selective nerve cell death is at the heart of the worldwide scientific effort to discover the cause, or causes, of AD. Epidemiology is an important research tool in determining risk factors and identifying potential interactions between genetic and nongenetic factors. Recent discoveries about the possible roles of inherited traits and education as risk factors for AD have taken researchers in new directions in their search for answers. In addition, researchers are looking for better ways to diagnose and treat AD, improve a patient's ability to function, and support the caregivers of people with AD.

The NIA has primary responsibility for research aimed at finding ways to prevent, treat, and cure AD.

This section of the report highlights recent progress in AD research conducted or supported by the NIA and other components of the NIH, including the:

National Institute of Diabetes and Digestive and Kidney Diseases
National Institute of Neurological Disorders and Stroke
National Institute of Arthritis and Musculoskeletal and Skin Diseases
National Institute on Deafness and Other Communication Disorders
National Institute of Mental Health
National Center for Research Resources
National Eye Institute
National Institute of Allergy and Infectious Diseases

Additional AD research projects, which are not summarized in this report, are supported by the: National Cancer Institute; National Heart, Lung, and Blood Institute; National Institute of Dental Research; National Institute of Child Health and Human Development; National Institute of Environmental Health Sciences; National Institute of Nursing Research; National Center for Human Genome Research; and Fogarty International Center.

THE STRUCTURE AND FUNCTION OF THE BRAIN

The brain integrates, regulates, and controls functions for the whole body, governing cognition, personality, and the senses. We are able to speak, move, and remember because of complex chemical processes that take place in the brain. The brain also regulates (controls) body functions that occur without our knowledge or direction, such as our heartrate and breathing.

The human brain is made up of billions of nerve cells, called neurons, which communicate with one another through a large array of biological and chemical signals. Even more numerous are glial cells, which surround, support, and nourish neurons. Each neuron has a cell body, an axon, and dendrites. The nucleus within the cell body controls the cell's activities. The axon, which emanates from the cell body, transmits messages to other neurons. Dendrites receive messages from axons of other nerve cells or from specialized sense organs.

Communications between neurons and other organs are transmitted through synthesis and release of chemicals. When a nerve impulse reaches the end of the neuron, the signal triggers the release of chemicals. The chemicals reach other nearby neurons and trigger them to send signals. Each neuron connects with many other neurons in the brain and may connect with neurons in the peripheral nervous system. A synapse is the place where the nerve impulse moves from one neuron to another. Neurotransmitters are chemicals that carry messages from the axons of nerve cells across the synapse to the dendrites of other neurons. In this way, signals can travel back and forth across the brain in a fraction of a second. And millions of signals flash through the brain every moment. Moreover, groups of neurons in the brain have certain jobs. For example, the cerebral cortex is a collection of neurons involved in thinking, learning, remembering, and planning.

Survival of nerve cells in the brain depends on the proper functioning of many interrelated systems that normally work in harmony. These systems control nerve cell activity related to communication, metabolism, and repair, The first system, communication between nerve cells, is described above. The loss or absence of any of several chemical messengers disrupts cell-to-cell communication and interferes with normal brain function.

The second system, metabolism, refers to the process whereby cells and molecules break down substances (chemicals and nutrients) into energy. Efficient metabolism in nerve cells depends on blood circulation to supply the cells with important nutrients, such as oxygen and glucose (a sugar). A sustained reduction in the supply of these nutrients can lead to nerve cell death.

The third system repairs and cleans up nerve cells. Unlike most other body cells, neurons live a long time. When neurons die, they cannot grow back or be replaced. Instead, living neurons constantly remodel themselves. Any disruption in cell clean-up and repair can have disastrous consequences for cell functioning. Research shows that the damage seen in AD is associated with changes in all three systems: communication, metabolism, and repair.

Communication Breakdown in Alzheimer's Disease

In AD, the intricate process of communication between nerve cells breaks down. The destructive forces involved in AD ultimately cause nerve cell dysfunction, loss of connections between nerve cells, and death of some nerve cells. Death of neurons in key parts of the AD brain severely affects memory, cognition, and behavior.

AD destroys neurons in parts of the brain involved with cognition, especially the hippocampus (a structure deep in the brain that plays an important role in memory encoding). As the hippocampal nerve cells degenerate, short-term memory falters, and often, the ability to perform familiar tasks begins to decline as well. AD also attacks the cerebral cortex (the outer layer of the brain). The greatest damage occurs in areas of the cerebral cortex responsible for functions such as language and reasoning. Here, AD begins to take away language and change a person's judgment. Emotional outbursts and disturbing behaviors, such as wandering and agitation, appear with increasing frequency as the disease progresses.

In the final stages, AD wipes out the affected person's ability to recognize close family members or communicate in any way; the person becomes totally dependent on others for care. People with AD live for years, ultimately succumbing to a number of other diseases, but most often pneumonia.

PLAQUES AND TANGLES IN ALZHEIMER'S DISEASE

Two abnormal structures are found in the AD brain—amyloid plaques and neurofibrillary tangles. Located outside and around neurons, plaques contain dense deposits of an amyloid protein and other associated proteins. Neurofibrillary tangles are twisted fibers inside neurons. Progress has been made in determining the make-

up of amyloid plaques and neurofibrillary tangles and in proposing mechanisms that could account for their buildup in AD.

Amyloid Plaques

In AD, plaques develop in areas of the brain related to memory. These plaques consist of beta-amyloid mixed with dendritic debris from surrounding cells. Beta-amyloid is a protein fragment clipped from a larger protein (amyloid precursor protein) during metabolism. However, researchers do not know whether amyloid plaques cause AD or result from it.

Amyloid precursor protein (APP) is a member of a larger gene family of membrane proteins. During metabolism, APP pokes through the nerve cell membrane (wall), part inside the cell, part outside. Pausing there only briefly, it is replaced by new APP molecules being produced in the cell. While APP is embedded in the membrane, enzymes called proteases split APP in two. Only when the splitting occurs at a particular spot on APP is beta-amyloid the substance that is set free.

After the splitting, how the beta-amyloid segment moves through or around the nerve cells is less clear. However, in the final stages of its journey, it is known to join up with other beta-amyloid filaments and fragments of dead and dying dendrites. Together, these form the dense and insoluble plaques that characterize AD.

Large numbers of beta-amyloid deposits in the brain can occur in older humans and some other mammals without surrounding nerve cell changes. This finding suggests that beta-amyloid initiates and/or is only an early disordered product in a slow, multi-step process that ultimately leads to brain cell malfunction.

Several studies have centered on how beta-amyloid is processed and how APP is broken down by enzymes. Other investigations are seeking clues in beta-amyloid's environment. For example, substances near beta-amyloid may bind to it normally and thus keep it in solution. But in AD, according to one theory, something causes the beta-amyloid to drop out of solution and form insoluble plaques. Another candidate for the role of keeping beta-amyloid in solution is a form of a protein called apolipoprotein E (ApoE).

Other areas of research center on how beta-amyloid affects neurons. In one laboratory study, hippocampal neurons died when beta-amyloid was added to the cell culture, suggesting that the protein is toxic to neurons. Results of another recent study suggest that beta-amyloid breaks into fragments, releasing free radicals that attack neurons. Free radicals are unstable molecules that can do damage in the body. In AD a buildup of oxygen free radicals, leading to breakdown of nerve cell membranes, is thought to play a role in cell death.

The precise mechanism by which beta-amyloid may cause nerve cell death is a mystery. However, one recent finding suggests that beta-amyloid forms small channels in neuron membranes. These channels may allow excess amounts of calcium to enter the nerve cell, a lethal event.

Other recent studies indicate that beta-amyloid disrupts potassium channels, which also could affect calcium levels. Yet another study links beta-amyloid to reduced choline levels in nerve cells. Since choline is an essential component of acetylcholine, a neurotransmitter; this finding suggests a link between beta-amyloid and acetylcholine.

Beta-amyloid is not the only protein implicated in AD. Not long after the discovery of beta-amyloid, scientists found the protein that is the principal component of neurofibrillary tangles, the other hallmark of AD.

Neurofibrillary Tangles

Neurofibrillary tangles are abnormal collections of twisted threads found inside nerve cell bodies. They are the remains of the neuron's microtubules, the cell's internal support structures. The chief component of tangles is a protein called A68, a form of *tau*.

In healthy neurons, microtubules are formed like train tracks, long parallel rails with crosspieces, that guide nutrients from the bodies of the cells down the ends of the axons. In cells affected by AD, these structures collapse. *Tau* normally forms the crosspieces of the microtubules, but in AD it twists into paired helical filaments, two threads wound around each other. These paired helical filaments are the major component of neurofibrillary tangles. No one has discovered yet why the microtubules collapse, but according to one theory, it may be due to the presence of a gene product called ApoE4.

The collapse of nerve cell supports may result in the breakdown of communication between nerve cells and finally cause neurons to die. Still unknown, however, is whether abnormal processing causes *tau* to come away from the nerve cell supports or whether abnormal processing is the result of *tau* being gathered into the paired

helical filaments. In addition, abnormal *tau* processing may simply indicate problems with metabolism of other, as yet unknown, nerve cell proteins. Sustained triggering of a single enzyme may disrupt other normal body functions that affect the survival of brain cells. To determine why some nerve cells are vulnerable to AD and others are not, researchers first must understand the causes of abnormal processing and the regulation of certain enzymes.

Scientists may be able to develop animal models using mice that produce excess enzymes involved in *tau* processing. Further clues may lie in recent research using "knockout" mice (mice in which the regulation of an enzyme that helps process *tau* is altered). These and other routes could lead to an animal model for use in testing drugs to reverse or limit early brain cell damage caused by AD.

ADVANCES IN IDENTIFYING POTENTIAL RISK FACTORS FOR ALZHEIMER'S DISEASE

Although healthy aging does not result in dementia or AD, aging remains the most strongly associated risk factor for AD. Family history is another important risk factor. A history of AD in a parent or sibling increases the odds of developing AD by three to four times. Researchers believe that genetic (inherited) factors may be involved in more than half of the cases of AD. In addition, a severe head injury that leads to a brief loss of consciousness doubles the risk of developing AD later on in life. These three risk factors—age, family history, and head injury—meet the accepted epidemiologic criteria for causal factors: they provide a plausible biological explanation, and their effects are strong and consistent.

Other risk factors that do not meet the above criteria have been studied, including exposure to environmental toxins (such as aluminum) or to chemicals (such as benzene and toluene). The detection of aluminum, zinc, and other metals in the brain tissue of people with AD is being studied to see whether such deposits influence the disease process or whether they are the result of disrupted brain structures. In addition, gender may play a role in the disease. Further research is needed to confirm recent data showing higher rates of AD among women. This finding may only reflect the effects of age, since women live longer, on average, than men.

It is becoming clear that the cause of AD is not a single factor, but a host of factors that interact differently in different people. In most cases, genetic factors alone are not enough to bring on AD. Genetic indicators have been found in some patients with the disease and in their relatives who do not yet show signs of impairment. Other risk factors may combine with a person's genetic makeup to increase the chances of developing AD.

Researchers studying the incidence and prevalence of AD and related dementias in later life seek to identify specific risk factors for AD and to show how and why AD develops. Incidence refers to the rate at which new cases of a disease occur. Prevalence is the percentage of the entire population with the disease at a given time. By studying people in different ethnic, racial, and social groups, scientists may discover additional risk factors for AD. These risk factors, in turn, may suggest new theories that can be tested regarding the disease's origin.

In the past year, researchers have examined risk factors that may speed up or slow down the onset of AD and increase or decrease a person's risk of AD. They focused on determining whether ApoE, education and occupation levels, a gene on chromosome 14, or zinc, aluminum, and other metals are related to AD. Their findings eventually may lead to treatment and prevention strategies.

The Link Between Alzheimer's Disease and ApoE

A gene is the biologic unit of heredity that has a precise location on a chromosome. Chromosomes are structures in the nucleus of cells that transmit hereditary information using a molecule called DNA. Genes direct the manufacture of every enzyme, hormone, growth factor, and other protein in the body. They help determine a person's traits, for example, what he or she looks like. Genes are made up of four chemicals, or bases, arranged in various patterns within the DNA. Each gene has a different sequence of bases, and each one directs the manufacture of a different protein. Even slight alterations in the DNA code of a gene can produce a faulty protein. And a faulty protein can lead to cell malfunction and eventually disease.

Genetic research has turned up evidence of three gene alterations that are more common in AD patients than in the general population. One, the ApoE4 gene on chromosome 19, has been linked to the most common form of AD, called late-onset AD, which appears in older people. Researchers also have found genes on chromosomes 14 and 21 that are more common among people who develop AD earlier, in middle age.

Everyone has ApoE, which helps transport cholesterol in the blood throughout the body. The gene for ApoE occurs in three versions: ApoE2, ApoE3, and ApoE4. Every

person inherits two ApoE genes, one from each parent. Scientists are studying people with different versions of this gene. ApoE3 is the most common one found in the general population. However, ApoE4 occurs in about two-thirds of all late-onset AD patients and is not limited to people with a family history of AD.

Collaborating researchers at the Duke University General Clinical Research Center and the Joseph and Kathleen Bryan Alzheimer's Disease Research Center in Durham, North Carolina, studied the relationship between ApoE4 and AD. Their research was supported by the NIA and the National Center for Research Resources (NCRR). These scientists found that the risk for AD in people with the gene for ApoE4 is three times greater than that for other people. For example, a 78-year-old person with two copies of the gene for ApoE4 has a 98 percent chance of having the disease, with one copy a 60 percent chance, and with no copies a 25 percent chance.

In addition, their data show that the presence of ApoE4 also lowers the age of onset of AD. On average, people with two copies of the gene for ApoE4 start showing AD symptoms before age 70 and are eight times more likely to develop AD than those who have two copies of the more common ApoE3 version. For those with no copies of ApoE4, the average age of onset is older than 85 years. According to these scientists, AD risk increased because the age of onset decreased. In some unknown way, ApoE4 may speed up the AD process.

These researchers also found that ApoE is localized in the senile plaques and neurofibrillary tangles found in AD. Moreover, Duke University researchers now believe that ApoE is located in all neurons in both healthy and AD brains.

Researchers at the Mayo Clinic in Rochester, Minnesota, followed 71 older patients with mild memory impairment. Almost half had clinical dementia after 3 years. Over two-thirds of those with clinical dementia with a copy of the gene for ApoE4 continued to decline, and ApoE4 best predicted who would decline. ApoE4 appears to mark susceptibility to AD. However, the presence of ApoE4 in a blood sample does not predict AD. A person can have ApoE4 and not get the disease, and a person can get AD without having ApoE4.

The relatively rare protein ApoE2 may protect people against the disease; it seems to lower the risk for AD and increase the age of onset. For instance, people with one ApoE2 gene and one ApoE3 gene have only one-fourth the risk of developing AD as people with two ApoE3 genes.

Some researchers supported by the NIA and NCRR exploring the function of the protein product of ApoE4 point to beta-amyloid. While the ApoE4 protein binds rapidly and tightly to beta-amyloid, the ApoE3 protein does not. Normally, beta-amyloid is soluble, but when the ApoE4 protein latches on to it, the amyloid becomes insoluble. This may mean that it is more likely to be deposited in plaques. Studies of brain tissue suggest that ApoE4 increases deposits of beta-amyloid and that it directly regulates APP.

Other researchers believe that the presence of ApoE in neurons may affect certain cell processes and how synapses function. Also, scientists conducting test tube studies found marked differences in the rates at which ApoE3 and ApoE4 bind to *tau* protein and to a similar protein found in dendrites. One hypothesis suggests that the ApoE4 product allows the microtubule structure to come undone in some way, leading to the neurofibrillary tangles.

While still controversial and far from proven, the hypotheses surrounding ApoE4 are driving new research. One next step is to see how *tau* and beta-amyloid react with ApoE in its several forms in living cells. Other experiments will be designed to determine the actions and role of ApoE. Once these are clear, it should be easier to understand how ApoE's function might be affected by drugs. For instance, if ApoE2 turns out to be beneficial, then substances that mimic its effects might be developed to help slow or prevent the progress of AD.

Theories surrounding ApoE4 are not confined to the proteins. Its effect on dendrites intrigues some scientists, because of findings that dendrites in patients with the ApoE4 gene are shorter, pruned back apparently by some unknown agent. The result may be that, compared to normal dendrites, these pruned dendrites cannot form as many connections with other nerve cells. Although this pruning also can occur in people without the ApoE4 gene, it happens 20 to 30 years earlier in people with ApoE4.

In addition, environmental factors may interact with genetic factors. Researchers at the Neurological Institute in New York City believe that repeated head injuries do not increase the risk of developing AD without ApoE4. However, when ApoE4 is present, these scientists found that repeated head injuries increase risk for AD by 10 times.

With ApoE, scientists have a biological indicator for AD for the first time. ApoE can be used by researchers to sort populations and follow the subgroups with the

hope of finding other risk factors. Scientists still must learn how ApoE and its various genes function in the brain and relate to other risk factors for AD. Larger population-based studies are needed to clarify the link between ApoE4 and AD, and to confirm the protective effect of ApoE2. Further explanation of preliminary findings may lead to ways to reduce the effects of ApoE4, develop drugs to treat or prevent AD, and ultimately, decrease the occurrence of AD. Moreover, some scientists suggest that testing for the ApoE4 gene someday may help in the diagnosis of AD.

Genes in Early-Onset Alzheimer's Disease

AD can strike early and often in some families—often enough to be singled out as a separate form of the disease, called early-onset familial AD (FAD). Combing through the DNA of some of these early-onset FAD families, researchers have found an abnormality in one gene on chromosome 21 that is common to a few of the families. And they have mapped another gene, which occurs in a much larger portion of early-onset families, to a region on chromosome 14.

The gene on chromosome 21 carries the code for an abnormal form of APP, the parent protein for beta-amyloid. The discovery of this gene supports the theory that beta-amyloid plays a central role in some forms of AD, although it has been found only in about 5 percent of early-onset FAD families. In addition, the gene on chromosome 21 is the gene involved in Down syndrome. Down syndrome is similar to AD in one respect. People with Down syndrome have an extra version of chromosome 21, and, as they grow older, usually develop plaques and tangles like those found in AD.

Compared to the chromosome 21 gene, the gene on chromosome 14 occurs more often in people with FAD. However, so far, no one knows exactly what gene it is. The gene has been tracked to a specific region on chromosome 14. Scientists still are trying to find the gene among the 10,000 or so DNA bases in this region.

Lower Educational and Occupational Levels Associated With Alzheimer's Disease

Scientists at Columbia University in New York City have established a relationship between increased risk for AD and lower educational and occupational levels. The researchers found that people with either lower educational or occupational levels have at least twice the risk for developing AD, compared to those who have had 6 to 8 or more years of schooling. The risk is three times greater when low occupation and low education occur together.

For 4 years, researchers administered yearly neuropsychologic tests to 593 people age 60 and older to see if any of them began to show signs of dementia. The results were analyzed based on educational level (kindergarten through college) and occupational level. A low level of education was set at 8 years of schooling, and occupational levels were based on U.S. Census categories. At the study's end, over 25 percent of the participants showed some sign of dementia.

These researchers do not know why low occupation and education are linked with AD. They believe that higher occupational and educational backgrounds may allow people to cope better with the effects of AD for a longer time before symptoms occur. People with more education may develop a protective reserve of brain cells or synapses. Also, increased mental capacity may allow these people to find additional ways to do daily activities. Or, education may be related to another factor, such as socioeconomic or nutritional status, which may be the reason for increased risk.

This study adds information about psychosocial factors related to AD. Investigators and caregivers now have another factor to consider when evaluating whether failing memory and confusion are signs of AD or some other, possibly treatable, problem. If some aspects of life experience can delay the onset of AD for even a short time, the overall prevalence, and costs, of the disease will be reduced significantly. This also could enhance the quality of life for many people.

Environmental Suspects

Certain environmental factors, such as metals and poisons carried in foods, may play a role in the development of AD. The most studied of these factors are aluminum and zinc. Researchers continue to study whether some metals are related to the development of disease markers such as plaques and tangles in brain tissue of AD patients. To date, no conclusive evidence links metals such as zinc or aluminum to AD.

One of the most publicized and controversial hypothesis in AD research concerns aluminum. This aluminum theory goes back to the 1970's, when researchers found traces of aluminum in the brains of AD patients. Many studies since then have either not been able to confirm this finding or have produced questionable results.

Aluminum does turn up in higher-than-normal amounts in some, but not all, autopsy studies of AD patients. Further doubt about the importance of aluminum comes from the possibility that the aluminum found in some studies did not all

come from the brain tissues being studied. Instead, some could have come from the special substances used in the laboratory to study brain tissue.

Other studies have shown that groups of people exposed to unusually high levels of aluminum have no increased risk of AD. Moreover, aluminum in cooking utensils does not get into food, and the aluminum that does occur naturally in some foods, such as potatoes, is not absorbed well by the body. On the whole, most scientists now believe that there is little chance that exposure to aluminum causes AD.

Zinc has been implicated in AD in two ways, some reports suggesting that too little zinc is a problem, others that too much zinc is at fault. Too little zinc was suggested by autopsies that found low levels of zinc in the brains of AD patients, especially in the hippocampus. There is some evidence that zinc deficiency can add to the symptoms of AD.

On the other hand, results of a recent study suggest that too much zinc might be the problem. In this laboratory experiment, zinc caused soluble beta-amyloid from cerebrospinal fluid to form clumps similar to the plaques of AD. Current experiments with zinc are pursuing this lead in laboratory tests that more closely mimic conditions in the brain.

ADVANCES IN DIAGNOSING ALZHEIMER'S DISEASE

A definitive diagnosis of AD is based on the presence of plaques and tangles in the brain. Plaques and tangles can be found only by examining brain tissue, and this procedure usually is done only as part of an autopsy (or brain biopsy).

Currently, no definitive test exists to diagnose AD. However, a probable diagnosis of AD can be made based on the patient's medical history, a physical examination, and tests of mental ability. Several other conditions, some of which are treatable, also may cause memory or other cognitive deficits and must be ruled out. These include thyroid gland problems, drug reactions, depression, brain tumors, and dementia cause by blood vessel disease in the brain.

A patient history includes a review of present and past medical problems, as well as an examination of current ability to carry out daily activities. Clinical analyses used to decide whether a person has AD or another disease include tests of blood and urine samples and an examination of a small sample of cerebrospinal fluid.

Neuropsychological tests are used to evaluate a person's mental abilities in many areas, including memory, problem solving, attention, calculation, and language. Brain imaging also may be used to detect abnormalities in the brain. The results of all tests and the patient's medical history help the doctor determine if symptoms are caused by AD or by another condition.

Early and accurate diagnosis of AD has a major affect on the progress of research on dementia and is of utmost concern to patients and their families. Although the early and accurate diagnosis of AD is difficult, a reliable diagnosis with 80 to 90 percent accuracy (when compared to autopsy findings) can be obtained in many specialized centers.

Improving the diagnosis of AD using various procedures would allow patients and their families to know what stage of the illness they are dealing with and help them plan for the future. It also would improve the planning and design of drug trials, because drugs may work more effectively to alter the course of disease in patients with less severe illness. These methods would help identify patients early in the course of the illness when they have experienced the smallest degree of nerve cell damage and cognitive loss. The earlier and more accurate the diagnosis, the greater the gain in managing the clinical course of the illness, determining its natural history, and providing information about its causes and treatment.

The NIA supports research to identify dementia indicators; develop tests and methods related to differential diagnosis, screening, etiology (the study of the causes of the disease), risk factors, and family history; improve research designs; and refine diagnostic criteria.

One goal of current research is to develop an accurate test for AD. The search continues for a biological indicator that can identify AD cases very early in the course of the disease, when treatment still could be effective. Neuropsychologic tests are needed that pinpoint the stages of AD. These tests would separate people who are in the earliest stages of AD from people who have cognitive deficits that are related to healthy aging. Brief cognitive screening tools are proliferating. However, the relationship of the results of one test to another, to careful clinical diagnosis of abnormalities, and ultimately to brain cell death remains unknown.

Experimental technology for imaging the brain continues to develop rapidly. New procedures include positron emission tomography (PET), single photon emission computed tomography (SPECT), magnetic resonance imaging (MRI), and magnetic resonance spectroscopy imaging (MRSI). MRI provides high-resolution images of the

brain. MRSI allows observation of various metabolites in the brain without the use of radioactive tracers. Metabolites are substances that are produced when energy is made available for cell use. Scientists are working to learn how metabolites change with aging and with AD and how to relate these changes to cognitive impairment. MRSI may offer a way to establish early diagnosis, determine prognosis, monitor patients, and evaluate treatment efficacy.

Researchers have yet to understand the relationship between the results of various brain imaging methods and the person's clinical condition. In addition, methods used to analyze imaging results need to be standardized. In the future, researchers hope to put information from imaging techniques that evaluate structure and those that analyze function together into a unified diagnostic summary.

Research on an Eye Test for Diagnosing Alzheimer's Disease

Researchers at the Harvard Medical School in Boston, Massachusetts, are working on developing a simple eye test for detecting the presence of AD. Eventually this test may help diagnose patients with AD. Preliminary results suggest that monitoring pupil dilation (expansion) after exposure to certain eye drops may one day be the basis of an easy, accurate way to diagnose AD.

Data in this study suggest that the pupils of healthy people or those with non-AD dementia dilated about 5 percent after receiving the eye drops. The pupils of people with AD dilated 23 percent. This test pointed to Ad in 18 of 19 people believed to have AD. Furthermore, pupils seemed to be sensitive to the chemical very early in the course of the disease, when emerging treatments are likely to be most effective. This test now must be studied in many more people to determine whether it holds up in different types of people with different types of AD, and distinguishes AD from other neurologic illnesses.

Changes in Immediate Visual Memory Predict Cognitive Impairment

NIA researchers have found that changes occurring over 6 years in immediate visual memory performance, assessed by the Benton Visual Retention Test (BVRT), predict AD before the onset of cognitive symptoms. Immediate visual memory refers to the ability to remember and name, within seconds, things seen. The BVRT requires subjects to reproduce geometric designs from memory after study them for 10 seconds. Each test consists of 10 separate designs with 1 or more figures, and the score is the total number of errors made in reproducing the designs.

Researchers in the NIA's Baltimore Longitudinal Study of Aging examined data for 254 men and 117 women, who were administered cognitive, neuropsychologic, and neurologic tests between 1986 and 1992. These people were generally healthy and ranged in age from 55 to 95 at the initial testing. Six of them had probable AD, and one had definite AD.

Compared to those without AD, subjects with the disease had larger changes in the numbers of errors in immediate memory performance over the 6 years prior to the onset of AD. This finding implies that AD may be identified by changes in memory performance sooner than other changes can be detected by clinical evaluation. Six-year change in immediate visual memory performance also predicted cognitive performance from 6 to 15 years and from 16 to 22 years later. This was true even after adjusting for the influences of age, general ability, and initial immediate memory.

In addition, these results suggest that change in recent memory performance, a critical component in diagnosing AD, may be an important precursor of the development of the disease. Recent memory performance generally refers to recall after a short delay, such as 20 minutes.

The results show the value of longitudinal studies because predictions of risk for subsequent disease are possible only when baseline and followup data are gathered before the onset of disease. This is particularly important for AD, because little is known about the earliest stages of AD. However, this period is likely to be when the disease is most responsive to treatment.

ADVANCES IN TREATING AND PREVENTING ALZHEIMER'S DISEASE

There currently is no effective way to treat or prevent AD. However, several substances are being tested to see if they can slow or reverse the decline in those behavioral and cognitive skills that are impaired by AD. Pharmacologic and behavioral treatments for the noncognitive behavioral symptoms related to AD also are being studied. These symptoms include aggression, agitation, wandering, depression, sleep disturbances, and delusions.

The drug tacrine (also known as THA or Cognex) may temporarily slow the rate of decline in memory and thinking ability in some patients who are in the mild and moderate stages of the disease. Experimental drug treatments may be available to

AD patients through clinical trials conducted at large teaching hospitals and universities. Several of these experimental drugs have shown promise in easing symptoms in some patients.

Moreover, medications may help control behavioral symptoms, thereby making some patients more comfortable and making their management easier for caregivers. For example, several drugs now in use may improve sleep patterns, reduce agitation and wandering, or ease anxiety and depression.

Scientists studying drug and nondrug treatments seek to reduce disruptive behaviors, allow patients to live in the least restrictive manner possible while maximizing their dignity and independence, reduce caregiver stress, and keep or re-establish patients' self-care abilities. In addition, effective treatments would decrease significantly the economic costs to families and society by reducing the need to institutionalize patients. Overall, these research efforts are designed to increase the intellectual, emotional, and social well-being of patients, families, and caregivers.

In September 1994, the NIA funded a 5-year study to screen for potential toxic effects of new drugs to treat AD. The data gathered will be used to file Investigational New Drug requests with the Food and Drug Administration so that compounds can be taken quickly from animal testing into human clinical trials.

Thirty-five sites in the Alzheimer's Disease Cooperative Study Unit (ADCSU) are located primarily at the Alzheimer's Disease Research Centers and Alzheimer's Disease Core Centers. The ADCSU is conducting trials of deprenyl and vitamin E, drugs used to treat agitation, an anti-inflammatory agent, and estrogen. In addition, the ADCSU is testing neuropsychologic instruments in the areas of cognitive change, behavioral change, global assessment, and activities of daily living. The ADCSU also is adapting instruments for use with people who are severely impaired and with those who do not speak English. Future ADCSU work will be to design trials to evaluate whether a substance can prevent AD.

In addition, postmenopausal estrogen replacement therapy, long-term use of anti-inflammatory drugs, and cigarette smoking have been implicated as having a protective effect against AD. These all need to be confirmed by further and more careful studies.

Inverse Association of Anti-Inflammatory Drugs and Alzheimer's Disease

Anti-inflammatory drugs are used to ease symptoms of arthritis or related conditions. Recently, they have been proposed as a means of slowing the progression of AD symptoms. Studies of twins show how environmental factors, such as the use of anti-inflammatory agents, may relate to the etiology and prevention of AD.

NIA-funded researchers at the Duke University Medical Center and Johns Hopkins University School of Hygiene and Public Health studied 50 sets of older twins with AD. They found a lower incidence of AD among those who had used anti-inflammatory drugs to treat arthritis. These findings suggest that inflammatory mechanisms may be involved in the development of AD. They also indicate that anti-inflammatory agents may prevent or delay the onset of AD symptoms.

Estrogen

Preliminary data from previous animal and human studies suggest that estrogen may protect older women against AD. However, recent research has generated some conflicting results. Initial results from one study by researchers at the University of Washington, Seattle, provide no evidence that post-menopausal estrogen replacement therapy influenced the risk of AD in women. Using computerized pharmacy data, these researchers compared use of estrogen replacement therapy by 107 women with AD and 120 women without AD. Estrogen use was not associated with AD.

Other NIA-funded researchers at the University of Southern California School of Medicine, Los Angeles, analyzed data for 138 older women who had died and whose death certificates listed AD or related dementias. Their results suggest that risk of AD and related dementia was lower in estrogen users than in non-users. Risk of AD decreased significantly with increasing estrogen dose and with increasing duration of estrogen use. Risk of AD also was associated with variables related to estrogen levels produced naturally in women. Data also suggest that risk of AD increased with increasing age at the onset of menstruation and decreased with increasing weight.

This study suggests that the increased incidence of AD in older women who have undergone menopause may be due to estrogen deficiency. Further research is needed to determine whether estrogen replacement therapy can slow down AD-related nerve cell death, and delay the onset of AD or prevent it altogether. Additional studies will allow researchers to analyze how and why these and other studies have conflicting results.

Research on Dementia Special Care Units

Another line of AD research sponsored by the NIA concerns the effectiveness of special care units (SCU's) across the Nation. These units provide services in long-term care settings to patients with AD and related dementias. The results of these studies may provide ways to improve care for these patients.

Dementia SCU's are long-term care settings designed to meet the needs of people with AD and related mental impairments. SCU's emerged in the 1980's as a care option for patients with AD. Forces creating a demand for specialized care include the growing numbers of older people, the recognition that the care needs of people with dementia differ from those of physically frail people, and the widespread concern that standard nursing home care has been unresponsive to the special needs of people with AD and related disorders, their families, and caregivers.

Since their beginnings, SCU's have proliferated rapidly and grown in diversity. The 1990–91 National Survey of Special Care Units in Nursing Homes found that of the Nation's 15,555 licensed nursing homes, 9.6 percent (1,497 nursing homes) had SCU's, with an estimated capacity of about 47,878 SCU residents. While most nursing homes with SCU's present some features considered important for SCU's, only 647 met all of them. Projections from this survey suggest that 16.7 percent of all nursing homes will offer SCU's in 1995.

To explore the effectiveness of SCU's, the NIA funded a 5-year multi-center Special Care Unit Initiative, beginning in 1991. Under this program, the NIA financed 10 research projects to examine SCU's throughout the United States.

Several research issues have emerged since 1991. There is a lack of standardization about what constitutes an SCU versus a non-SCU. Use of uniform descriptive data is critical because SCU's vary in size, age of patients, and whether or not patients are segregated from the general nursing home population. SCU's also can differ in how they recruit residents for participation in studies. Research studies need to establish the diagnosis and cognitive level of residents to identify a sample group for study.

The proliferation of SCU's means that for the first time in the United States, administrators and staff members in numerous nursing homes are developing methods of care specifically for their residents with dementia. Better methods of care cannot be realized without formal research to describe, compare, and evaluate the various methods being used. There still is a need for more research on classification, design characteristics, costs, and effectiveness of SCU's. For public policy purposes, the most important research questions pertain to the effectiveness of SCU's for their residents, the residents' families, and the unit staff members and the impact of SCU's on residents with and without dementia in nonspecialized nursing home units.

Further research will provide a better idea of what constitutes "special care" and identify which features of SCU's are most important in terms of environment, staffing, activities, care planning, admission policies, size, and patient segregation. Additional studies will determine whether effective SCU's cost more than traditional nursing home units. Eventually, the results of these studies will enable caregivers and health care insurers to compare options when shopping for long-term care facilities.

Alzheimer's Disease Centers Program

The NIA funds 28 Alzheimer's Disease Centers (ADC's) at major medical institutions across the Nation. The centers conduct a wide range of research, including studies on the causes of AD and investigations aimed at diagnosing, treating, and managing the symptoms of the disease. The ADC Program promotes research, training, and education, technology sharing, and multi-center and cooperative studies of diagnosis and treatment. Each ADC has administrative, clinical, neuropathology, and education and information-sharing cores, or sections. Some ADC's include additional cores, such as neuroimaging and data analysis.

Fifteen comprehensive ADC's have fully-funded basic, clinical, and behavioral research projects. Areas of study range from the basic mechanisms of AD to managing the symptoms and helping families cope with the effects of the disease. The other 13 ADC's are Alzheimer's Disease Core Centers, which provide resources and knowledge to AD researchers.

A program was initiated in 1990 to add satellite clinics linked to the ADC's. Currently, 27 satellite clinics at 21 ADC's offer diagnostic and treatment services and collect research data in underserved, rural, and minority communities. These programs allow members of culturally and ethnically diverse communities to take part in research and clinical drug trials associated with parent ADC's.

Much of the success of AD research in this country during the last 10 years can be attributed to resources provided at the ADC's, including the recent discovery of

the importance of chromosome 14 in FAD and the identification of inherited risk factors related to ApoE. The ADC's enhance AD research by providing a network for sharing new ideas as well as research results.

Other initiatives funded by the NIA depend on the ADC's, including regular research grants, the Consortium to Establish a Registry for Alzheimer's Disease, and the Alzheimer's Disease Cooperative Study Unit. The ADC's provide resources for these efforts, such as patient data, brain and other tissue samples, and molecular probes.

RESEARCH ADVANCES ON ALZHEIMER'S DISEASE SUPPORTED AND CONDUCTED BY OTHER NIH INSTITUTES

NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) research that relates to AD generally falls within two areas. The first focuses on mechanisms involved in abnormal metabolic processes. The second concerns the molecular and biochemical mechanisms of cells, including the roles of neurotransmitters and ion channels.

This year, NIDDK grantees reported progress in understanding the metabolic processes leading to the formation of abnormal amyloid protein (AAP), a major component of plaques in the brain. Although the ultimate cause of neuronal cell death remains undetermined, some evidence suggests that the buildup of AAP may be involved in this process.

One goal of NIDDK-supported research is to understand the biochemical mechanisms underlying amyloid diseases. Researchers are learning how AAP, a normally soluble protein, is transformed into the insoluble fibers that build up in AD plaques. This work focuses on a form of AAP that has been implicated in amyloid polyneuropathy, a neurologic disease. This form of AAP is similar but not identical to the form found in AD. These researchers identified a gene mutation that alters an intermediate step in the formation of amyloid and appears to be related to AAP production. The findings suggest that certain gene mutations may have metabolic effects that determine the development of amyloid disease.

NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE

The National Institute of Neurological Disorders and Stroke (NINDS) is the principal source of support for neurological research in the United States and a major participant in the study of AD. Basic studies are aimed at determining the underlying causes of AD with the ultimate goal of prevention. Clinical research seeks to improve the diagnosis and treatment of patients.

Scientists at the NINDS and the NIA have discovered that adding beta-amyloid to normal skin cells causes them to undergo the same type of failure at the molecular level previously shown in skin cells of patients with AD. By placing a solution with low levels of beta-amyloid in culture with normal human skin cells, the scientists produced changes in potassium channel function similar to those seen in skin cells from AD patients. Beta-amyloid is the main component of plaques found in brain tissue in AD. This finding suggests that beta-amyloid may cause the abnormal process that leads to memory loss even before it congeals into plaques. This research may lead to alternative explanations of the causes of memory loss, one of the earliest and most common symptoms of the disease.

Last year, researchers in the same laboratory showed that skin cells from people with AD have defects that interfere with the cell's ability to regulate its concentrations of potassium and calcium ions. The flow of potassium and consequent uptake of calcium are especially critical in cells responsible for memory formation and information storage. Results of current research suggest that after treating one group of the cells with soluble beta-amyloid for 48 hours, a specific potassium channel was absent in all but one of the cells. However, a functional potassium channel was present in 94 percent of untreated cells. Results of further testing suggest that beta-amyloid selectively targets this specific potassium channel, which had been absent in skin cells of AD patients.

These researchers now are working to see if similar potassium channel dysfunction occurs in central nervous system neurons. The scientists have discovered similar defects in nerve cells of the olfactory system (related to the sense of smell) suggesting that such defects may be present in brain cells.

NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES

Researchers at the National Institute of Arthritis and Musculoskeletal and Skin Diseases have made strides in finding a treatment for amyloidosis (a buildup of

amyloid protein in various body tissues). This research may lead to a possible treatment for AD, because a major feature of AD is brain deposits of amyloid or amyloid-like material.

Some forms of amyloidosis are inherited. One of these forms, familial amyloid polyneuropathy (FAP), is caused by a mutation of the transthyertin (TTR) protein. Scientists have developed a method for separating normal and mutant TTR in bodily fluids, allowing rapid screening and diagnosis. This method also allows the ration of normal to mutant TTR to be measured over time.

These researchers also have reported on liver transplants in patients with FAP. Almost all normal and abnormal TTR is produced in the liver. Patients undergoing liver transplants for advanced disease showed important improvements in their conditions. The amount of mutant TTR present after the transplant was reduced markedly. After surgery, patients and only normal TTR. This is the first successful therapy in patients with FAP.

NATIONAL INSTITUTE ON DEAFNESS AND OTHER COMMUNICATION DISORDERS

The National Institute on Deafness and Other Communication Disorders (NIDCD) studies the normal and disordered processes of balance, smell, taste, voice, speech, hearing, and language. The NIDCD's chemosensory (smell and taste) research program includes studies of the olfactory receptor cell (a nerve cell in the part of the nose that senses smell). Normally, these nerve cells are replaced continually in the body. An important aspect of this research is the potential for developing new strategies to treat nerve cell loss caused by aging, injury, and diseases, such as AD.

Scientists supported by the NIDCD recently examined the development of human olfactory neurons transplanted into the brains of animals. They studied the interaction of these transplanted neurons with other brain cells. The transplanted neurons not only survived, but developed and grew nerve fibers that entered and mingled with the animal's other nerve cells. The fact that donor olfactory neurons developed and integrated with other nerve cells means that the possibility exists of forming new neuronal connections.

The capacity of transplanted olfactory neurons to produce new nerve cells is of wide interest not only with respect to chemosensory function, but also as a model for studying neuron replacement. Further research on transplanted neurons may mean that biological repair of nerve damage from neurodegenerative diseases, including AD, is possible.

NATIONAL INSTITUTE OF MENTAL HEALTH

National Institute of Mental Health (NIMH) research on AD spans from the genetics and molecular biology of the disease to the psychosocial stresses faced by family members.

The NIMH Diagnostic Centers for Psychiatric Linkage Studies of Alzheimer's Disease identify siblings with and without AD for ongoing studies. Their goal is to establish a national resource of cell lines and clinical data from people with AD and their key relatives.

Advances in the molecular genetic study of AD may show how the disorder develops and offer ways to identify those at risk for the purposes of early intervention. Neurofibrillary tangles found in the AD brain largely consist of abnormal forms of the cellular protein *tau*. In the normal brain, *tau* binds to microtubules (cylindrical formations) that provide structural support for cells, including neurons. In AD, *tau* takes the form of twisted fibers and does not bind to microtubules.

Using techniques from molecular genetics, NIMH researchers have identified tissue at risk for AD and other neurodegenerative processes. They also have developed a new probe, an antibody that identifies and interacts exclusively with neurons that are vulnerable to the disease. Antibodies are immune system molecules. Antigens stimulate the production of antibodies. Each antibody has a unique amino acid sequence that allows it to interact with only a certain antigen. The above antibody probe stains for a different antigen than expected. This finding suggests that a host of unknown pathologic indicators or gene products may occur in AD.

In test tube studies, NIMH scientists have been able to grow neuroblasts (immature nerve cells), which were taken from inside the noses of AD patients and healthy people. They have found that AD neuroblasts have increased levels of APP fragments. These fragments are thought to include the toxic protein beta-amyloid. The amount of fragments decreases when theophylline is added to the cells, suggesting toxicity and a potential therapeutic intervention.

Recent advances in basic neuroscience research link brain structures and functions involved in AD and help explain some AD symptoms. Using animal models, NIMH-supported researchers have found a connection between two areas of the

brain, one of which allows people to forget an emotion-linked memory that no longer is useful. When this part of the brain is damaged, it may fail to erase an emotional memory or prevent an emotional response. This research may bear on AD patients' inappropriate emotional responses or inability to remember emotionally significant information.

NIMH researchers strive to reduce problematic symptoms of AD and help families care for these patients. They are studying the relationship between disturbed sleep, altered sleep-wake cycles, episodes of stopped breathing, daytime sleepiness, and sundowning (or nighttime confusion). By doing so, NIMH-funded researchers hope to decrease sleep problems and confusion and reduce some disability in AD patients. Preliminary studies of patients with dementia and normal breathing during sleep show they have less confusion in the morning or the same amount of confusion as during the previous night. This finding suggests that increased confusion related to a decrease in the amount of oxygen breathed in during sleep may represent an early phase of sundowning. Studies also are being done of the clinical efficacy of several medications commonly used for sundowning.

An NIMH-supported program for caregiving spouses of AD patients delayed nursing home placements up to 6 months. This program offered individual and family counseling and a caregiver support group. Compared to other caregivers not in the program, the supported spouses showed less decline in their own mental and physical health and derived more satisfaction from their social support networks. Results suggest that psychosocial interventions may relieve some burdens of long-term caregiving for chronically impaired older adults. This relief may translate into major cost reductions for health care delivery systems. These findings are important, given the high cost of nursing home care and the increasing number of people with AD.

NIMH-funded research indicates that caregiving stress negatively affects the caregiver's mental health (increased depression), immune system function, and physical health. These studies show that AD caregivers perform lower on measures of their bodies' ability to fight diseases and have more infectious disease episodes than do non-caregivers. Older, caregiving spouses' immune functions fail to return to the level of controls over a sustained period. Caregivers also show a lower antibody buildup in response to influenza vaccination.

Male caregivers may be at risk for the cardiovascular effects of caregiving stresses. Higher levels of triglycerides ("bad" cholesterol) and lower levels of high-density lipoproteins ("good" cholesterol) have been found among male caregivers. Male caregivers also have higher levels of anger, coronary-prone behavior, and use of avoidance when coping. These results provide the foundation for more targeted interventions with caregivers who can be identified as more or less at risk for mental health and physical health problems.

Although most older Americans lead healthy lives unaffected by significant mental disorder, up to 12 percent of people age 65 or older experience an anxiety disorder, depression, or some form of dementia, Mental disorders in late life are not an outcome of normal aging. Instead, they are illnesses that result in significant disability, dependency, and early death. Sleep problems can lead to inappropriate use of sleeping pills, fatigue, and disorientation, which in turn reduce quality of life and increase the chances of illness. Of the 5 percent of older Americans in nursing homes, up to one-fifth suffer from some form of unnecessary depression, which increases the risk of mortality.

Mental disorders in older people often occur along with physical illness and pain symptoms. Older people are less likely to seek mental health services, and many seek assistance from primary care physicians when faced with mental illness. Unfortunately, mental disorders in older people typically go undetected, and many do not receive available treatments. This is particularly tragic for depressed older people who commit suicide. More than 70 percent of older men (the highest risk group for suicide in this country) visit their primary care physicians within 1 month before their suicides.

Safe and effective treatments are available for depression, anxiety, and sleep disorders. Efforts to refine treatments include studies of how people metabolize psychotropic medications (drugs that act on the mind) with and without other medications for physical disorders. Research on psychosocial treatments alone and in combination with medications over long periods are providing important data for recommended treatment practices. Like other diseases, it appears that many mental disorders require long-term treatments.

NATIONAL CENTER FOR RESEARCH RESOURCES

Through its national network of clinical, animal, and other research resource centers, the NCRR supports studies to advance understanding and treatment of AD and other disorders affecting older Americans.

In addition to research at Duke University on ApoE, the NCRR supports several potential therapies for AD at Regional Primate Research Centers (RPRC's). Researchers at the University of Washington RPRC have used a compound (leupeptin) that accelerates brain aging in rats to stimulate an effect similar to AD in aged monkeys.

At the California RPRC, scientists found that age-related neuron weakening in part of the brain can be prevented by adding nerve growth factor (NGF) in primates. A NGF is a protein that fosters development of nerve cells and may protect certain nerve cells from damage. It supports cells that produce the vital neurotransmitter, acetylcholine. Other neurotrophic factors (components that help maintain body tissues and are regulated by nervous functions) also may be useful in therapy for this degeneration. Using gene therapy techniques, researchers have found that NGF-producing fibroblasts (cells that are part of the tissue that binds together and supports the various body structures) survive up to 6 months in the adult primate brain.

At the Wisconsin RPRC, scientists are mapping the distribution of neurotrophins and their receptors. This work will help identify growth factors that may allow rescue of neurons in brain centers affected by AD.

NATIONAL EYE INSTITUTE

The National Eye Institute continues to support a study of human binocular vision and motion perception. Binocular vision is the merging of images from both eyes into a single image perceived by the visual cortex of the brain. Motion perception is the ability to perceive clearly the direction and speed of a moving object. This research focuses on interactions among the neurological mechanisms underlying these aspects of vision and stereopsis. Stereopsis is the ability to combine the images of two pictures of an object seen from slightly different viewpoints. It refers to how people see something as both a solid and three-dimensional object. These study areas may provide important clues about the perceptual consequences of neurologic dysfunctions in AD.

Specific areas under study are: (1) the coexistence of stereopsis and binocular competition; (2) the regions in the brain associated with binocular suppression (relative to the analysis of motion information) and visual attention; (3) interactions between stereopsis and depth perception in specifying structure from motion; and (4) motion perception and stereopsis in AD patients.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

Studies conducted by the National Institute of Allergy and Infectious Diseases (NIAID) with the greatest relevance to aging and AD involve research to develop a drug to prevent scrapie. Scrapie is an infectious, neurodegenerative disease of sheep and goats. Scrapie is similar to AD in that accumulations of abnormal protein from anyloid plaques in the brain. One advantage of scrapie research is that, unlike AD research, animal and cell culture models already exist in which to study amyloid formation and therapeutic strategies. Current NIAID research on scrapie offers potential for understanding the clinical development of AD.

The agent that causes scrapie is an unusual infectious particle that contains no nucleic acid and consists of a single protein, called Prp-res. NIAID scientists found that when a normal protein typically found in the brain (Prp-sen) interacts with an altered form of itself, the altered form is converted to Prp-res. When Prp-res builds up in the brain, amyloid plaques form. Although the major proteins forming plaques differ in scrapie and AD, an understanding of how amyloid is formed in scrapie may provide insights about plaque formation in the AD brain.

NIAID intramural scientists have found that Congo red, a chemical dye, can delay the onset of scrapie in mice by preventing the buildup of PrP-res in the brain infected with scrapie. The fact that Congo red shows some efficacy in preventing the development of scrapie in laboratory animals suggests that a similar substance might be useful in preventing the development of AD in humans.

NIAID scientists also are conducting test tube studies related to aging. Using a new technique, NIAID researchers have isolated almost all classes of stem cells (the earliest development form of blood cells) from mouse bone marrow. This isolation process does not appear to alter the cells' normal behavior, suggesting that stem cells are reliable for studying normal blood cell development. Isolated stem cells now can be used to evaluate the effects of the aging process on blood cell development.

OUTLOOK

Scientists have learned a great deal about AD in the past year. Projects in 1995 will seek to identify the gene on chromosome 14 responsible for one form of early-onset AD and to understand better how ApoE works as a risk factor for AD. More specifically, researchers are interested I learning how ApoE relates to plaques and tangles. Scientists also will look for ways to enhance the use of imaging techniques, especially MRI, as early diagnostic tools for AD. Improved MRI technology is expected to allow researchers to identify initial changes in the hippocampus in AD. Clinical studies of estrogen and anti-inflammatory agents will build on evidence gained from previous epidemiologic studies. Another important area of research in the next few years will focus on behavioral interventions for patients and training programs for caregivers. Taken together, these avenues of research will help scientists to understand the causes of AD to diagnose the disease earlier, and to improve treatment and caregiving strategies.

The breadth of the selected scientific findings in this report demonstrates NIH's success in implementing its research agenda. The achievements by NIH scientists provide information needed by physicians to better treat their older patients. The various NIH components—including NIA as the lead Federal agency responsible for conducting health research on older adults—are achieving rapid progress on several fronts. Scientists are clarifying the differences between normal againg processes and disease states; they are identifying the basic biological mechanisms that control aging; and they are training geriatricians as research scientists and physicians. With an increasing body of scientific knowledge and more doctors trained in geriatrics, a better quality of health care will be available to older people in decades ahead as ever larger numbers of Americans reach and surpass age 65.

NATIONAL INSTITUTE ON AGING ACTIVE GRANTS IN FY94

GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
5 P01AG00001-20	PETERS, ALAN NEURAL SUBSTRATES OF COGNITIVE DECLINE	03-10-94/01-31-95	BOSTON UNIVERSITY	848,528
2 T32AG00029-19	COHEN, HARVEY J BEHAVIOR AND PHYSIOLOGY IN AGING	08-01-94/06-30-95	DUKE UNIVERSITY	249,846
3 R01AG00029-19S1	PATTERSON, DAVID GENE EXPRESSION IN SOMATIC CELLS IN THE AGING PROCESS	04-08-94/06-30-94	ELEANOR ROOSEVELT INST FOR CANCER R	21,013
5 R01AG00029-20	PATTERSON, DAVID GENE EXPRESSION IN SOMATIC CELLS IN THE AGING PROCESS	07-25-94/06-30-95	ELEANOR ROOSEVELT INST FOR CANCER R	398,736
3 R01AG00029-20S1	PATTERSON, DAVID GENE EXPRESSION IN SOMATIC CELLS IN THE AGING PROCESS	09-30-94/06-30-95	ELEANOR ROOSEVELT INST FOR CANCER R	63,799
5 T32AG00030-18	STORANDT, MARTHA A AGING AND DEVELOPMENT	09-05-94/08-31-95	WASHINGTON UNIVERSITY	239,265
5 T32AG00037-18	BENGTSON, VERN L MULTIDISCIPLINARY RESEARCH TRAINING IN GERONTOLOGY	09-01-94/08-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	488,208
5 T32AG00045-18	MITTENESS, LINDA S TRAINING IN SOCIOCULTURAL GERONTOLOGY	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	276,788
5 T32AG00048-17	ZARIT, STEVEN H INTERDISCIPLINARY TRAINING IN GERONTOLOGY	07-15-94/06-30-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	228,353
5 T32AG00057-17	MARTIN, GEORGE M GENETIC APPROACHES TO AGING RESEARCH	05-12-94/04-30-95	UNIVERSITY OF WASHINGTON	412,222
5 T32AG00078-15	HOLLOSZY, JOHN O EXERCISE AS PREVENTIVE MEDICINE IN THE AGING PROCESS	07-10-94/06-30-95	WASHINGTON UNIVERSITY	181,719
5 T32AG00080-15	OLDSTONE, MICHAEL B A NEUROBIOLOGIC AND IMMUNOLOGIC ASPECTS OF AGING	07-01-94/06-30-95	SCRIPPS RESEARCH INSTITUTE	227,772
5 T35AG00086-15	SISKIND, GREGORY W SHORT-TERM TRAINING STUDENTS IN HEALTH PROF SCHOOLS	04-21-94/04-14-95	CORNELL UNIVERSITY MEDICAL CENTER	27,824
5 T32AG00093-13	FINCH, CALEB E TRAINING IN ENDOCRINOLOGY AND NEUROBIOLOGY OF AGING	09-20-94/08-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	395,114
5 T32AG00096-12	COTMAN, CARL W TRAINING IN THE NEUROBIOLOGY OF AGING	02-15-94/01-31-95	UNIVERSITY OF CALIFORNIA IRVINE	201,596

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GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
7 N03AG00102-11	PROVIDE SUPPORT SERVICES/UTILITIES--GERONTOLOGY RESEARCH	01-01-94/12-31-94	JOHNS HOPKINS BAYVIEW MEDICAL CENTE	2,722,203
7 N03AG00102-12	PROVIDE SUPPORT SERVICES/UTILITIES--GERONTOLOGY RESEARCH	04-05-94/12-31-94	JOHNS HOPKINS BAYVIEW MEDICAL CENTE	136,988
3 T32AG00105-10S1	CAPLAN, ARNOLD I CELLULAR AND MOLECULAR AGING	09-30-94/01-31-96	CASE WESTERN RESERVE UNIVERSITY	67,742
3 N03AG00106-08	RENTAL OF COMPACTOR AND REMOVAL OF TRASH	10-01-93/08-14-94	SSC SMALL BUSINESS MARYLAND	13,227
7 N03AG00106-09	RENTAL OF COMPACTOR AND REMOVAL OF TRASH	08-11-94/08-14-95	SSC SMALL BUSINESS MARYLAND	13,867
2 T32AG00107-11	COLEMAN, PAUL D TRAINING IN GERIATRICS AND NEUROBIOLOGY OF AGING	03-01-94/02-28-95	UNIVERSITY OF ROCHESTER	279,033
5 T32AG00110-10	VON EYE, ALEXANDER TRAINING IN AGING RESEARCH METHODOLGY	05-15-94/04-30-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	
5 T32AG00114-10	FAULKNER, JOHN A MULTIDISCIPLINARY RESEARCH TRAINING IN AGING	09-10-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	277,193
5 T32AG00115-10	POLGAR, PETER R PRE- AND POSTDOCTORAL TRAINING IN BIOCHEMISTRY OF AGING	07-05-94/06-30-95	BOSTON UNIVERSITY	40,330
3 T32AG00115-10S1	POLGAR, PETER R PRE- AND POSTDOCTORAL TRAINING IN BIOCHEMISTRY OF AGING	09-30-94/06-30-95	BOSTON UNIVERSITY	29,403
5 T32AG00117-10	DUNKLE, RUTH E SOCIAL RESEARCH TRAINING ON APPLIED ISSUES OF AGING	07-01-94/05-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	108,249
5 T32AG00120-08	ROTH, JESSE RESEARCH TRAINING IN GERONTOLOGY AND GERIATRICS	02-17-94/12-31-94	JOHNS HOPKINS UNIVERSITY	267,164
3 T32AG00129-08S1	BUMPASS, LARRY L POPULATION LIFE COURSE AND AGING	09-25-94/08-31-95	UNIVERSITY OF WISCONSIN MADISON	60,551
5 T32AG00131-10	CRISTOFALO, VINCENT J TRAINING IN THE CELLULAR AND MOLECULAR ASPECTS OF AGING	07-01-94/04-30-95	MEDICAL COLLEGE OF PENNSYLVANIA	130,012
5 T32AG00134-09	WEISSERT, WILLIAM G PUBLIC HEALTH AND AGING	09-15-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	152,793

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GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
5 T32AG00139-08	MANTON, KENNETH G SOCIAL AND MEDICAL DEMOGRAPHY OF AGING (COMPETING CONTIN	12-01-93/11-30-94	DUKE UNIVERSITY	194,466
5 T32AG00140-19	GOLDSCHEIDER, FRANCES K DEMOGRAPHY OF AGING	07-15-94/06-30-95	BROWN UNIVERSITY	83,055
5 T32AG00144-08	KOWAL, JEROME RESEARCH TRAINING IN GERIATRIC MEDICINE	08-01-94/07-31-95	CASE WESTERN RESERVE UNIVERSITY	150,215
2 Y02AG00146-04	LENFANT, CLAUDE HONOLULU AGING STUDY	10-01-93/09-30-94	U.S. NATIONAL HEART LUNG & BLOOD IN	497,000
5 T32AG00149-08	BRANDT, JASON RESEARCH TRAINING IN DEMENTIAS OF AGING	08-01-94/07-31-95	JOHNS HOPKINS UNIVERSITY	143,238
3 T32AG00149-08S1	BRANDT, JASON RESEARCH TRAINING IN DEMENTIAS OF AGING	09-30-94/07-31-95	JOHNS HOPKINS UNIVERSITY	27,858
5 T32AG00153-07	KASL, STANISLAV V RESEARCH TRAINING IN THE EPIDEMIOLOGY OF AGING	07-01-94/06-30-95	YALE UNIVERSITY	214,992
2 T32AG00155-07	ELDER, GLEN H, JR DEMOGRAPHY OF AGING AND THE LIFE COURSE	09-01-94/08-31-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	102,847
2 T32AG00158-07	BURING, JULIE E TRAINING PROGRAM IN EPIDEMIOLOGIC RESEARCH ON AGING	07-01-94/06-30-95	BRIGHAM AND WOMEN'S HOSPITAL	129,274
2 T32AG00164-07	DEMENT, WILLIAM C RESEARCH TRAINING IN GERIATRIC SLEEP DISORDERS MEDICINE	09-10-94/06-30-95	STANFORD UNIVERSITY	110,853
5 T32AG00165-07	BOWMAN, BARBARA H TRAINING PROGRAM IN MOLECULAR BASIS OF AGING	04-18-94/03-31-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	100,307
5 T32AG00172-07	BENSON, FRANK D DEMENTIA AND BEHAVIORAL NEUROLOGY: RESEARCH FELLOWSHIP	07-15-94/06-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	72,956
5 T32AG00175-07	SMITH, ANDERSON D RESEARCH TRAINING IN COGNITIVE AGING	07-01-94/04-30-95	GEORGIA TECH RESEARCH CORPORATION	156,023
5 T32AG00177-06	PRESTON, SAMUEL H DEMOGRAPHY OF AGING	09-01-94/08-31-95	UNIVERSITY OF PENNSYLVANIA	119,230
5 T32AG00180-05	GILCHREST, BARBARA A RESEARCH TRAINING IN AGING AND CELL PROLIFERATION	01-01-94/06-30-95	BOSTON UNIVERSITY	62,282

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GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
3 T32AG00180-05S1	GILCHREST, BARBARA A RESEARCH TRAINING IN AGING AND CELL PROLIFERATION	01-01-94/06-30-95	BOSTON UNIVERSITY	22,846
2 T32AG00182-06	ETTINGER, WALTER H, JR TRAINING GRANT: GERONTOLOGY AND GERIATRIC MEDICINE	08-01-94/06-30-95	WAKE FOREST UNIVERSITY	297,235
2 T32AG00183-06	DARLINGTON, GRETCHEN J CELL & MOLECULAR BIOLOGY OF AGING	08-01-94/06-30-95	BAYLOR COLLEGE OF MEDICINE	241,869
5 T32AG00184-05	HU, TEH-WEI ECONOMICS OF AGING AND HEALTH SERVICES	01-01-94/12-31-94	UNIVERSITY OF CALIFORNIA BERKELEY	106,249
3 T32AG00184-05S1	HU, TEH-WEI ECONOMICS OF AGING AND HEALTH SERVICES	09-30-94/12-31-94	UNIVERSITY OF CALIFORNIA BERKELEY	35,696
2 T32AG00186-06	WISE, DAVID A ECONOMICS OF AGING TRAINING PROGRAM -- EXTENSION	07-01-94/06-30-95	NATIONAL BUREAU OF ECONOMIC RESEARC	143,977
5 T32AG00189-05	LIEM, RONALD K CELLULAR AND NEUROBIOLOGICAL ASPECTS OF AGING	01-01-94/09-29-94	COLUMBIA UNIVERSITY NEW YORK	211,702
2 T32AG00189-06	LIEM, RONALD K CELLULAR AND NEUROBIOLOGICAL ASPECTS OF AGING	09-30-94/04-30-95	COLUMBIA UNIVERSITY NEW YORK	257,773
2 T32AG00194-06	HAMERMAN, DAVID AGING TRAINING GRANT	07-01-94/06-30-95	YESHIVA UNIVERSITY	325,577
2 T32AG00196-06	MEYER, EDWIN M TRAINING IN THE NEUROBIOLOGY OF AGING	08-20-94/06-30-95	UNIVERSITY OF FLORIDA	79,197
5 T32AG00198-05	MALETTA, GABE J BEHAVIORAL NEUROSCIENCE OF AGING	09-01-94/04-30-95	UNIVERSITY OF MINNESOTA TWIN CITIES	116,143
5 T32AG00204-05	WINGFIELD, ARTHUR COGNITIVE AGING IN A SOCIAL CONTEXT	05-15-94/04-30-95	BRANDEIS UNIVERSITY	82,417
3 T32AG00205-04S1	YU, BYUNG P NUTRITIONAL GERONTOLOGY TRAINING-SUPPLEMENT	02-15-94/04-30-94	UNIVERSITY OF TEXAS HLTH SCI CTR SA	27,389
5 T32AG00205-05	YU, BYUNG P NUTRITIONAL GERONTOLOGY	05-15-94/04-30-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	64,616
3 T32AG00206-03S1	THORBECKE, GEERTRUIDA J GERIATRIC RESEARCH INSTITUTIONAL TRAINING (GRIT) AWARD	09-30-94/06-30-95	NEW YORK UNIVERSITY	42,099

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GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
5 T32AG00208-05	HOGAN, DENNIS P POPULATION BIOLOGY, GENERATIONS, AND COHORT SUCCESSION	07-15-94/04-30-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	88,897
5 N03AG00208-08	ALZHEIMERS DISEASE EDUCATION AND REFERRAL CENTER	11-01-93/01-31-94	JOHNSON, BASSIN AND SHAW, INC.	117,074
5 T32AG00209-05	RUSSELL, ROBERT M NUTRITION AND AGING	06-01-94/05-31-95	TUFTS UNIVERSITY BOSTON	99,375
5 T32AG00212-04	SCHWARTZ, JANICE B GERONTOLOGY AND GERIATRIC MEDICINE	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	179,532
7 N03AG00212-05	GERONTOLOGY RESEARCH CENTER GROUNDS MAINTENANCE	03-20-94/03-19-95	SSC SMALL BUSINESS MARYLAND	36,000
3 N03AG00212-06	GERONTOLOGY RESEARCH CENTER GROUNDS MAINTENANCE	03-20-94/03-19-95	SSC SMALL BUSINESS MARYLAND	
5 T32AG00213-04	ERSHLER, WILLIAM B BIOLOGY OF AGING AND AGE RELATED DISEASES	07-01-94/06-30-95	UNIVERSITY OF WISCONSIN MADISON	145,175
2 Y02AG00214-01	BENOWITZ, STEVEN C PERMANENT TRANSFER OF ROBERT P HUYCK	10-01-93/09-30-94	U.S. NATIONAL INSTITUTES OF HEALTH	30,000
5 T32AG00214-04	HEISTAD, DONALD D INTERDISCIPLINARY RESEARCH TRAINING PROGRAM ON AGING	07-01-94/06-30-95	UNIVERSITY OF IOWA	364,301
5 T32AG00216-03	GAGE, FRED H TRAINING IN THE NEUROPLASTICITY OF AGING	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	290,297
5 T32AG00219-03	GOLDBERG, ANDREW P RESEARCH TRAINING OF GERONTOLOGY AND EXERCISE PHYSIOLOGY	07-10-94/06-30-95	UNIVERSITY OF MARYLAND BALT PROF SC	191,678
3 T32AG00220-01A1S1	MARKSON, ELIZABETH W MULTIDISCIPLINARY TRAINING PROGRAM IN AGING RESEARCH	09-30-93/06-30-95	BOSTON UNIVERSITY	38,178
5 T32AG00221-03	HERMALIN, ALBERT I TRAINING IN THE DEMOGRAPHY OF AGING	09-01-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	214,962
5 T32AG00222-03	POTTER, HUNTINGTON TRAINING IN THE MOLECULAR BIOLOGY OF NEURODEGENERATION	09-10-94/08-31-95	HARVARD UNIVERSITY	299,529
1 T32AG00223-01A1	RAMSDELL, JOE W GERIATRIC RESEARCH INSTITUTIONAL TRAINING GRANT	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	74,658

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5 T32AG00226-02	KEMPER, SUSAN RESEARCH TRAINING PROGRAM IN COMMUNICATION AND AGING	08-01-94/07-31-95	UNIVERSITY OF KANSAS LAWRENCE	124,568
5 T35AG00230-02	RICHARDSON, ARLAN G SHORT-TERM TRAINING STUDENTS IN HLTH PROF SCHOOLS	05-20-94/04-30-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	51,786
5 T32AG00231-02	LEVY, PAUL S EPIDEMIOLOGY AND BIOSTATISTICS IN AGING RESEARCH	09-01-94/08-31-95	UNIVERSITY OF ILLINOIS AT CHICAGO	117,918
1 T32AG00237-01	SCHOEN, ROBERT POSTDOCTORAL TRAINING IN THE DEMOGRAPHY OF AGING	07-01-94/06-30-95	JOHNS HOPKINS UNIVERSITY	58,712
1 T32AG00238-01	BURKHAUSER, RICHARD V ECONOMICS & DEMOGRAPHY OF AGING	07-01-94/06-30-95	SYRACUSE UNIVERSITY AT SYRACUSE	60,294
1 T32AG00241-01	KAHANA, EVA F PREDOC TRNG: SOCIAL ASPECTS OF HEALTH RESEARCH AND AGING	09-30-94/07-31-95	CASE WESTERN RESERVE UNIVERSITY	94,178
1 T32AG00242-01	WISE, PHYLLIS M MOLECULAR AND CELLULAR BASIS OF BRAIN AGING	09-30-94/04-30-95	UNIVERSITY OF KENTUCKY	186,451
1 T32AG00243-01	WAITE, LINDA J NOT STATED	09-30-94/04-30-95	UNIVERSITY OF CHICAGO	170,786
1 T32AG00244-01	KAROLY, LYNN A POSTDOCTORAL TRAINING IN THE STUDY OF AGING	09-30-94/04-30-95	RAND CORPORATION	67,260
7 N03AG00267-04	ADP SUPPORT SERVICES	09-29-94/09-29-95	SSC SMALL BUSINESS MARYLAND	202,844
5 K12AG00294-10	WEI, JEANNE Y PHYSICIAN SCIENTIST PROGRAM	08-01-94/07-31-95	HARVARD UNIVERSITY	546,210
2 R01AG00322-20	RACKOVSKY, SHALOM R AGING--CONFORMATIONAL CHANGES OF COLLAGEN	08-10-94/06-30-95	MOUNT SINAI SCHOOL OF MEDICINE	130,245
5 K12AG00353-08	SEEGMILLER, J EDWIN PHYSICIAN SCIENTIST PROGRAM AWARD	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	232,604
2 P01AG00378-22A1	CRISTOFALO, VINCENT J CELLULAR SENESCENCE AND CONTROL OF CELL PROLIFERATION	01-05-94/12-31-94	MEDICAL COLLEGE OF PENNSYLVANIA	691,479
3 P01AG00378-22A1S1	CRISTOFALO, VINCENT J CELLULAR SENESCENCE AND CONTROL OF CELL PROLIFERATION	03-10-94/12-31-94	MEDICAL COLLEGE OF PENNSYLVANIA	71,192

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5 K01AG00414-06	VERDERY, ROY B NUTRITIONAL AND METABOLIC FACTORS IN AGING	04-01-94/03-31-95	UNIVERSITY OF ARIZONA	87,104
5 R01AG00424-32	WALFORD, ROY L LIFE EXTENSION EFFECT OF CALORIC RESTRICTION	05-01-94/04-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	330,154
5 R37AG00425-30	HOLLOSZY, JOHN O EXERCISE INDUCED BIOCHEMICAL AND ANATOMIC ADAPTATIONS	07-01-94/06-30-95	WASHINGTON UNIVERSITY	243,020
5 K08AG00437-05	COLVIN, PERRY L, JR DIETARY ACCLIMATION	12-01-93/11-30-94	WAKE FOREST UNIVERSITY	73,131
3 K01AG00440-05S1	KING, ABBY C EXERCISE AND STRESS RELATED RESPONSE IN OLDER ADULTS	03-10-94/06-30-94	STANFORD UNIVERSITY	1,248
5 K04AG00443-05	KEMPER, SUSAN LANGUAGE ACROSS THE LIFE-SPAN	01-01-94/12-31-94	UNIVERSITY OF KANSAS LAWRENCE	67,088
5 R37AG00443-20	SCHIFFMAN, SUSAN S GUSTATORY AND OLFACTORY CHANGES WITH AGE	12-01-93/11-30-94	DUKE UNIVERSITY	224,725
5 K11AG00454-05	NORTON, PEGGY A CONNECTIVE TISSUE AND ETIOLOGY OF GENITOURINARY PROLAPSE	04-01-94/03-31-95	UNIVERSITY OF UTAH	88,020
5 K08AG00455-06	DAVIS, KENNETH M PHYSIOLOGY OF VOLUME REGULATION IN THE ELDERLY	07-01-94/06-30-95	NORTH MISSISSIPPI MED CTR (TUPELO,	81,000
5 K07AG00461-05	CASSEL, CHRISTINE K GERIATRIC LEADERSHIP ACADEMIC AWARD	02-01-94/01-31-95	UNIVERSITY OF CHICAGO	85,471
7 K01AG00463-04	REDFERN, MARK S POSTURAL CONTROL IN THE ELDERLY	06-15-94/04-30-95	UNIVERSITY OF PITTSBURGH AT PITTSBU	92,340
5 K04AG00465-03	JOHNSON, LARRY BIOLOGY OF THE AGING HUMAN TESTIS	12-05-93/11-30-94	TEXAS A&M UNIVERSITY HEALTH SCIENCE	69,002
5 K07AG00469-05	MASORO, EDWARD J GERIATRIC LEADERSHIP ACADEMIC AWARD	04-01-94/03-31-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	97,200
5 K07AG00474-05	POTTER, JANE F GERIATRIC LEADERSHIP ACADEMIC AWARD	04-01-94/03-31-95	UNIVERSITY OF NEBRASKA MEDICAL CENT	86,400
5 K08AG00481-02	RUBIN, CRAIG D TREATMENT OF SENILE OSTEOPOROSIS	03-01-94/02-28-95	UNIVERSITY OF TEXAS SW MED CTR/DALL	70,686

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5 K07AG00485-05	ERSHLER, WILLIAM B GERIATRIC LEADERSHIP ACADEMIC AWARD	07-01-94/06-30-95	UNIVERSITY OF WISCONSIN MADISON	97,280
5 K11AG00486-05	JONAS, ELIZABETH A MODULATION OF CA++ CURRENT IN APLYSIA BAG CELL NEURONS	08-01-94/07-31-95	YALE UNIVERSITY	94,815
5 K08AG00487-05	STINEMAN, MARGARET G GERIATRIC REHABILITATION PROGNOSTIC STAGING SYSTEM	07-01-94/06-30-95	UNIVERSITY OF PENNSYLVANIA	82,620
5 K12AG00488-04	CASSEL, CHRISTINE K GERIATRIC ACADEMIC PROGRAM AWARD	09-01-94/08-31-95	UNIVERSITY OF CHICAGO	314,761
5 K12AG00489-05	HAHN, THEODORE J GERIATRICS	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	384,858
5 K01AG00491-06	BURGIO, LOUIS D URINARY INCONTINENCE IN THE NURSING HOME	07-01-94/06-30-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	89,640
5 K04AG00492-05	SCHWARTZ, LAWRENCE M MOLECULAR ANALYSIS OF CELL DEATH GENES	09-01-94/08-31-95	UNIVERSITY OF MASSACHUSETTS AMHERST	76,685
5 K08AG00495-06	WEISS, JOHN HIRAM CHRONIC NEUROTOXICITY OF BMAA AND NON-NMDA AGONISTS	07-05-94/06-30-95	UNIVERSITY OF CALIFORNIA IRVINE	80,460
5 K08AG00497-06	KATZEL, LESLIE I DYSLIPOPROTEINEMIA IN MYOCARDIAL ISCHEMIA	07-01-94/06-30-95	UNIVERSITY OF MARYLAND BALT PROF SC	81,000
5 K08AG00499-04	BRANDEIS, GABRIEL H URINARY INCONTINENCE IN FRAIL ELDERLY WOMEN	08-05-94/07-31-95	BOSTON UNIVERSITY	74,196
5 K12AG00503-04	ABRASS, ITAMAR B GERIATRIC ACADEMIC PROGRAM AWARD	01-01-94/12-31-94	UNIVERSITY OF WASHINGTON	337,935
3 K12AG00503-04S1	ABRASS, ITAMAR B GERIATRIC ACADEMIC PROGRAM	02-01-94/12-31-94	UNIVERSITY OF WASHINGTON	176,040
3 K12AG00503-04S2	ABRASS, ITAMAR B GERIATRIC ACADEMIC PROGRAM AWARD	01-15-94/12-31-94	UNIVERSITY OF WASHINGTON	
5 K08AG00504-04	BLACK, RONALD S UBIQUITIN IN ALZHEIMERS DISEASE	02-17-94/01-31-95	WINIFRED MASTERSON BURKE MED RES IN	81,000
5 K01AG00508-04	LEVKOFF, SUE E EXCESS DISABILITY IN COGNITIVELY IMPAIRED AGED	07-01-94/06-30-95	HARVARD UNIVERSITY	91,260

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5 K11AG00509-04	JURIVICH, DONALD A REGULATION OF HEAT SHOCK GENE EXPRESSION IN SENESCENCE	09-01-94/08-31-95	NORTHWESTERN UNIVERSITY	85,590
5 K08AG00510-05	GURWITZ, JERRY H DRUG INDUCED ILLNESS IN THE ELDERLY--NSAIDS AS A MODEL	07-15-94/06-30-95	BRIGHAM AND WOMEN'S HOSPITAL	81,540
5 K11AG00516-04	CHOI, AUGUSTINE M GENETIC RESPONSES OF THE AGING LUNG TO OXIDATIVE STRESS	04-01-94/03-31-95	JOHNS HOPKINS UNIVERSITY	90,410
5 K08AG00518-03	CAMPBELL, JAMES W MEASUREMENT OF FAMILY FUNCTION IN ELDERLY PERSONS	02-15-94/01-31-95	CASE WESTERN RESERVE UNIVERSITY	74,795
5 K01AG00519-04	ALEXANDER, NEIL B AGING, CHAIR MOBILITY, AND MUSCULOSKELETAL IMPAIRMENT	09-01-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	90,720
5 K08AG00520-03	OBEID, LINA M TRANSCRIPTIONAL REGULATION OF PROTEIN KINASE C BETA	04-01-94/03-31-95	DUKE UNIVERSITY	75,944
5 K12AG00521-04	WEINER, LESLIE P NEUROGERONTOLOGY	08-01-94/07-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	309,792
5 K08AG00524-04	INOUYE, SHARON K CLINICAL PREDICTORS OF DELIRIUM IN THE ELDERLY	07-01-94/06-30-95	YALE UNIVERSITY	76,950
5 K08AG00526-04	SCHMADER, KENNETH E EPIDEMIOLOGY OF HERPES ZOSTER AND POSTHERPETIC NEURALGIA	09-10-94/08-31-95	DUKE UNIVERSITY	71,479
5 K11AG00533-04	VOCI, JAMES M NT4 CHARACTERIZATION OF A NOVEL NEUROTROPHIC FACTOR	07-05-94/06-30-95	CASE WESTERN RESERVE UNIVERSITY	84,780
5 K08AG00537-05	RUBINSTEIN, DANIEL BRURION IMMUNE SENESCENCE, AUTOIMMUNITY, AND AGING	08-10-94/07-31-95	UNIVERSITY HOSPITAL (BOSTON)	76,615
5 P01AG00538-18	COTMAN, CARL W BEHAVIORAL AND NEURAL PLASTICITY IN THE AGED	08-01-94/06-30-95	UNIVERSITY OF CALIFORNIA IRVINE	904,729
5 K08AG00540-03	DUBEAU, CATHERINE E DIAGNOSIS OF PROSTATIC OBSTRUCTION	05-16-94/02-28-95	BRIGHAM AND WOMEN'S HOSPITAL	76,140
5 P01AG00541-17	SCHWAB, RISE IMMUNOBIOLOGY OF AGING	09-15-94/06-30-95	CORNELL UNIVERSITY MEDICAL CENTER	1,148,635
5 K08AG00542-03	WISNIEWSKI, THOMAS DIFFUSE LEWY BODY DISEASE AND GELSOLIN	09-10-94/08-31-95	NEW YORK UNIVERSITY	76,680

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5 K01AG00544-03	ADER, MARILYN ETIOLOGY OF GLUCOSE INTOLERANCE OF AGING	01-01-94/12-31-94	UNIVERSITY OF SOUTHERN CALIFORNIA	73,629
5 K08AG00546-03	REED, RICHARD L GROWTH HORMONE AND MUSCLE STRENGTH	09-01-94/08-31-95	UNIVERSITY OF MINNESOTA TWIN CITIES	70,660
5 K01AG00547-03	COHEN-MANSFIELD, JISKA TREATMENT OF AGITATION IN AGED PEOPLE	01-01-94/12-31-94	GEORGETOWN UNIVERSITY	79,115
5 K08AG00548-03	GRAVENSTEIN, STEFAN ANTIBODY DIVERSITY, AGE AND INFLUENZA VACCINE EFFICACY	02-10-94/12-31-94	UNIVERSITY OF WISCONSIN MADISON	82,117
5 K01AG00551-03	HOPP, JANE F AGED MUSCLE METABOLIC ADAPTATIONS TO RESISTANCE EXERCISE	07-01-94/06-30-95	UNIVERSITY OF ILLINOIS AT CHICAGO	64,777
5 K04AG00553-03	SNOWDON, DAVID A EPIDEMIOLOGY OF AGING AND ALZHEIMER'S DISEASE	01-01-94/12-31-94	UNIVERSITY OF KENTUCKY	65,542
5 K01AG00554-02	HORIUCHI, SHIRO RELATIONSHIPS BETWEEN AGING AND MORTALITY	07-01-94/06-30-95	ROCKEFELLER UNIVERSITY	79,920
5 K07AG00555-03	BURKHAUSER, RICHARD V GERIATRIC LEADERSHIP ACADEMIC AWARD	07-01-94/06-30-95	SYRACUSE UNIVERSITY AT SYRACUSE	81,600
5 K01AG00558-02	JUDGE, JAMES O REDUCING RISK FACTORS FOR FALLS	09-01-94/08-31-95	UNIVERSITY OF CONNECTICUT HEALTH CE	84,833
5 K08AG00559-03	SHORR, RONALD I GERIATRIC PHARMACOEPIDEMIOLOGY	04-01-94/09-15-94	VANDERBILT UNIVERSITY	27,056
7 K08AG00559-04	SHORR, RONALD I GERIATRIC PHARMACOEPIDEMIOLOGY	09-20-94/03-31-95	UNIVERSITY OF TENNESSEE AT MEMPHIS	43,830
5 K01AG00561-03	POWE, NEIL R ECONOMIC CONSEQUENCES OF ILLNESS IN AN AGING SOCIETY	08-01-94/07-31-95	JOHNS HOPKINS UNIVERSITY	80,170
5 K04AG00563-03	SAPOLSKY, ROBERT M GLUCOCORTICOIDS AND ALZHEIMER'S-LIKE HIPPOCAMPAL DAMAGE	08-20-94/07-31-95	STANFORD UNIVERSITY	70,578
5 K04AG00564-04	POEHLMAN, ERIC T PHYSICAL ACTIVITY EFFECTS ON ENERGY METABOLISM	09-30-94/08-31-95	UNIVERSITY OF MARYLAND BALT PROF SC	71,820
5 K01AG00565-02	RAHMAN, MOHAMMED O IMPACT OF KIN NETWORKS	04-20-94/03-31-95	RAND CORPORATION	114,104

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5 K11AG00566-04	SEIFER, DAVID B ENDOCRINOLOGIC BASIS OF REPRODUCTIVE AGING	09-30-94/08-31-95	WOMEN AND INFANTS HOSPITAL-RHODE IS	90,222
5 K01AG00567-04	GUCCIONE, ANDREW A DEVELOPMENT OF COMORBIDITY INDEX FOR ARTHRITIS RESEARCH	09-01-94/08-31-95	MASSACHUSETTS GENERAL HOSPITAL	86,913
5 K11AG00568-03	EIDE, FERNETTE F NEUROTROPHINS AND THE HIPPOCAMPUS	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	85,860
5 K08AG00571-03	ROBIN, DEBORAH W DRUG EFFECT ON BALANCE IN THE ELDERLY	09-01-94/08-31-95	VANDERBILT UNIVERSITY	76,950
5 K01AG00577-03	OLSHANSKY, STUART J INTERDISCIPLINARY TRAINING PROGRAM ON AGING	09-01-94/08-31-95	UNIVERSITY OF CHICAGO	78,030
5 K01AG00578-03	CEFALU, WILLIAM T CALORIC RESTRICTION AND CARDIOVASCULAR AGING	09-01-94/08-31-95	WAKE FOREST UNIVERSITY	72,681
7 K08AG00580-03	LACHS, MARK S PREDICTORS OF ELDER MISTREATMENT	07-01-94/06-30-95	CORNELL UNIVERSITY MEDICAL CENTER	76,680
5 K01AG00581-03	ROGERS, MARK W PROTECTIVE STEPPING RESPONSES AND FALLS IN THE ELDERLY	08-05-94/07-31-95	NORTHWESTERN UNIVERSITY	62,871
5 K08AG00583-02	CALLAHAN, CHRISTOPHER M GERIATRIC DEPRESSION IN PRIMARY CARE	07-01-94/06-30-95	INDIANA UNIV-PURDUE UNIV AT INDIANA	74,833
5 K01AG00585-02	BROWN, MARYBETH SIMULATED BEDREST AND TREATMENT EFFECTS ON AGING MUSCLE	04-01-94/03-31-95	WASHINGTON UNIVERSITY	74,466
5 K01AG00586-03	SEEMAN, TERESA E PSYCHOSOCIAL FACTORS & NEUROENDOCRINE FUNCTION IN AGING	08-01-94/07-31-95	YALE UNIVERSITY	81,362
5 K01AG00587-02	PARNELL, ALLAN M FAMILY DEMOGRAPHY OF AGING	09-01-94/08-31-95	DUKE UNIVERSITY	81,757
5 K01AG00588-02	EWBANK, DOUGLAS C DEMOGRAPHY AND ECONOMICS OF ALZHEIMERS DISEASE	07-01-94/06-30-95	UNIVERSITY OF PENNSYLVANIA	80,455
1 K01AG00593-01A1	HEADEN, ALVIN E JR RACE, LTC SERVICE MIX, AND CAREGIVER TIME COST	01-01-94/12-31-94	NORTH CAROLINA STATE UNIVERSITY RAL	77,094
5 K04AG00594-02	MEDRANO, ESTELA E SENESCENCE IN THE MELANOCYTE	04-01-94/03-31-95	UNIVERSITY OF CINCINNATI	69,939

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1 K08AG00599-01A1	DUGAN, LAURA L FREE RADICAL MECHANISMS IN NEURAL INJURY IN VITRO	02-01-94/01-31-95	WASHINGTON UNIVERSITY	75,955
5 P01AG00599-17	MINAKER, KENNETH L PROGRAM PROJECT IN BIOMEDICAL OUTCOMES OF AGING	06-15-94/05-31-95	BETH ISRAEL HOSP (BOSTON)	750,160
5 K01AG00602-02	SCHMIDT, ANN M AGING, DIABETES AND VASCULAR DISEASE	07-01-94/06-30-95	COLUMBIA UNIVERSITY NEW YORK	82,890
5 K08AG00605-03	MANGIONE, CAROL M IMPACT OF CATARACT EXTRACTION IN VISUCAL FUNCTIONAL STAT	07-15-94/06-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	78,419
5 K07AG00608-02	GOLDBERG, ANDREW P GERIATRIC LEADERSHIP ACADEMIC AWARD	07-01-94/06-30-95	UNIVERSITY OF MARYLAND BALT PROF SC	86,400
1 K08AG00615-01A1	WALLACE, JEFFREY I WEIGHT LOSS AND FAILURE TO THRIVE	04-20-94/03-31-95	UNIVERSITY OF WASHINGTON	71,280
1 K07AG00618-01A1	GOODWIN, JAMES S LEADERSHIP ACADEMIC AWARD	04-20-94/03-31-95	UNIVERSITY OF TEXAS MEDICAL BR GALV	86,400
1 K08AG00619-01A1	BILIR, BAHRI M GENE EXPRESSION IN AGING LIVER	08-01-94/07-31-95	UNIVERSITY OF COLORADO HLTH SCIENCE	80,465
5 K11AG00621-02	LEEHEY, MAUREEN A MITOCHONDRIAL DNA ANALYSIS IN HUNTINGTONS DISEASE	08-01-94/07-31-95	UNIVERSITY OF COLORADO HLTH SCIENCE	79,380
1 K07AG00622-01	KANE, ROBERT L GERIATRIC LEADERSHIP ACADEMIC AWARDS	01-15-94/12-31-94	UNIVERSITY OF MINNESOTA TWIN CITIES	76,650
1 K08AG00623-01	MAHONEY, JANE E FALLS AFTER HOSPITAL DISCHARGE	01-01-94/12-31-94	UNIVERSITY OF WISCONSIN MADISON	76,472
1 K08AG00627-01A1	HEUSER, MARK D FAILURE TO THRIVE IN ELDERS	09-01-94/08-31-95	WAKE FOREST UNIVERSITY	73,980
1 K08AG00629-01	BAUER, DOUGLAS C THYROID FUNCTION AND OSTEOPOROSIS	05-01-94/04-30-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	73,440
1 K04AG00631-01	ZAKERI, ZAHRA MECHANISMS OF PROGRAMMED CELL DEATH	05-01-94/04-30-95	QUEENS COLLEGE	69,120
1 K01AG00633-01	TULLY, CHRISTINE L ZINC, B12 AND COGNITIVE DECLINE IN THE ELDERLY	07-01-94/06-30-95	UNIVERSITY OF KENTUCKY	75,847

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1 K04AG00634-01	GOATE, ALISON M GENETIC APPROACH TO THE ETIOLOGY OF ALZHEIMER DISEASE	05-01-94/04-30-95	WASHINGTON UNIVERSITY	65,498
1 K07AG00635-01	WISE, DAVID A GERIATRIC LEADERSHIP ACADEMIC AWARD	04-18-94/03-31-95	NATIONAL BUREAU OF ECONOMIC RESEARC	86,379
1 K08AG00639-01	BARZILAI, NIR AGING AND PERIPHERAL AND HEPATIC GLUCOSE METABOLISM	09-01-94/08-31-95	YESHIVA UNIVERSITY	79,920
1 K08AG00642-01	MONANE, MARK ANTIHYPERTENSIVES AND THE ELDERLY	01-01-94/12-31-94	BRIGHAM AND WOMEN'S HOSPITAL	75,900
1 K08AG00643-01	WEINER, DEBRA K CHRONIC PAIN IN THE NURSING HOME	09-01-94/07-31-95	DUKE UNIVERSITY	71,940
1 K01AG00645-01	MORIN, CATHERINE L INTERACTION OF TNF ALPHA & NUTRITION IN AGED ADIPOSE TIS	09-01-94/08-31-95	UNIVERSITY OF COLORADO HLTH SCIENCE	49,026
1 K01AG00646-01	ELIAS, PENELOPE K AGE, HYPERTENSION, AND COGNITIVE FUNCTIONING	08-10-94/07-31-95	BOSTON UNIVERSITY	90,591
1 K01AG00647-01	WONG, REBECCA ECONOMICS OF INTERGENERATIONAL TRANSFERS--US HISPANICS	08-20-94/07-31-95	JOHNS HOPKINS UNIVERSITY	64,973
1 K08AG00648-01	MARCANTONIO, EDWARD R REDUCING DELIRIUM AFTER HIP FRACTURE--A PROACTIVE MODEL	08-15-94/07-31-95	BRIGHAM AND WOMEN'S HOSPITAL	76,140
1 K11AG00649-01	YUEN, ERIC C BDNF AND OXIDATIVE INJURY IN MOTOR NEURONS	09-01-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	76,140
1 K01AG00657-01	GARDNER, ANDREW W EXERCISE REHABILITATION OF YOUNGER AND OLDER CLAUDICANTS	03-15-94/01-31-95	UNIVERSITY OF MARYLAND BALT PROF SC	75,733
3 R01AG00677-16S1	RUTHERFORD, CHARLES L ALTERNATE PATHWAYS IN CELLULAR AGING	05-01-94/06-30-94	VIRGINIA POLYTECHNIC INST AND ST UN	46,050
2 R01AG00677-17	RUTHERFORD, CHARLES L ALTERNATE PATHWAYS IN CELLULAR AGING	07-25-94/03-31-95	VIRGINIA POLYTECHNIC INST AND ST UN	134,274
5 R01AG00783-15	WEIGLE, WILLIAM O AGING EFFECT ON IMMUNE STATES	03-18-94/12-31-94	SCRIPPS RESEARCH INSTITUTE	242,370
5 R01AG00947-17	STEIN, GRETCHEN H GROWTH REGULATION--SENESCENT VS NONSENESCENT CELLS	07-20-94/06-30-95	UNIVERSITY OF COLORADO AT BOULDER	254,302

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3 R01AG01121-14S1	COLEMAN, PAUL D COMPUTER AIDED STUDY OF DENDRITES IN AGING HUMAN BRAIN	09-30-94/03-31-95	UNIVERSITY OF ROCHESTER	172,700
5 R37AG01136-17	YEN, SHU-HUI C AGING BRAIN--IMMUNOHISTOLOGY AND BIOCHEMISTRY	07-05-94/06-30-95	YESHIVA UNIVERSITY	311,109
3 R37AG01136-17S1	YEN, SHU-HUI C AGING BRAIN--IMMUNOHISTOLOGY AND BIOCHEMISTRY	07-10-94/06-30-95	YESHIVA UNIVERSITY	17,388
5 R01AG01159-18	MANTON, KENNETH G DEMOGRAPHIC STUDY OF MULTIPLE CAUSES OF DEATH	12-01-93/11-30-94	DUKE UNIVERSITY	167,860
5 P01AG01188-16	YU, BYUNG P NUTRITIONAL PROBE OF THE AGING PROCESS	06-05-94/05-31-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	1,095,256
3 P01AG01188-16S1	YU, BYUNG P NUTRITIONAL PROBE OF THE AGING PROCESS	06-10-94/05-31-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	1,378
5 R37AG01228-16	WRIGHT, WOODRING E GENE EXPRESSION IN AGING AND DEVELOPMENT	12-30-93/11-30-94	UNIVERSITY OF TEXAS SW MED CTR/DALL	299,691
3 R37AG01228-16S1	WRIGHT, WOODRING E GENE EXPRESSION IN AGING AND DEVELOPMENT	07-01-94/11-30-94	UNIVERSITY OF TEXAS SW MED CTR/DALL	5,000
5 R37AG01274-16	GRACY, ROBERT W MOLECULAR BASIS FOR ABNORMAL PROTEINS IN AGING CELLS	04-01-94/01-31-96	UNIVERSITY OF NORTH TEXAS HLTH SCI	263,908
5 R01AG01548-11	RICHARDSON, ARLAN G DIETARY RESTRICTION EFFECT ON GENE EXPRESSION	04-01-94/03-31-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	211,996
5 P01AG01743-15	KLINMAN, NORMAN R IMMUNOBIOLOGY OF AGING	02-15-94/01-31-95	SCRIPPS RESEARCH INSTITUTE	788,480
5 P01AG01751-16	MARTIN, GEORGE M GENE ACTION IN THE PATHOBIOLOGY OF AGING	08-01-94/07-31-95	UNIVERSITY OF WASHINGTON	1,513,336
3 P01AG01751-16S2	MARTIN, GEORGE M GENE ACTION IN PATHOBIOLOGY OF AGING	09-30-94/07-31-95	UNIVERSITY OF WASHINGTON	14,586
5 R01AG01760-14	KLAG, MICHAEL J PRECURSORS OF PREMATURE DISEASE AND DEATH	07-01-94/06-30-95	JOHNS HOPKINS UNIVERSITY	358,686
3 R01AG01760-14S1	KLAG, MICHAEL J PRECURSORS OF PREMATURE DISEASE AND DEATH	08-10-94/06-30-95	JOHNS HOPKINS UNIVERSITY	67,046

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5 R01AG01822-15	SHEARN, ALLEN D SPECIFIC GENES AND IMAGINAL DISC DETERMINATION	05-01-94/03-31-95	JOHNS HOPKINS UNIVERSITY	197,998
5 R37AG02049-15	GARRY, PHILIP J PROSPECTIVE STUDY OF NUTRITION IN THE ELDERLY	02-15-94/01-31-95	UNIVERSITY OF NEW MEXICO ALBUQUERQU	346,280
3 R37AG02049-15S1	GARRY, PHILIP J PROSPECTIVE STUDY OF NUTRITION	04-20-94/01-31-95	UNIVERSITY OF NEW MEXICO ALBUQUERQU	58,718
5 N01AG02102-13	RUSSELL, ROBERT J COLONY OF AGED FISCHER 344 RAT STRAINS	06-30-94/07-31-96	HARLAN SPRAGUE DAWLEY, INC.	1,174,856
3 N01AG02105-28	OSTFELD, ADRIAN ESTABLISH POPULATIONS FOR EPIDEMIOLOGICAL STUDIES	11-23-93/12-31-93	YALE UNIVERSITY	
3 N01AG02105-29	OSTFELD, ADRIAN ESTABLISH POPULATIONS FOR EPIDEMIOLOGICAL STUDIES	04-19-94/02-28-94	YALE UNIVERSITY	
3 N01AG02107-32	TAYLOR, JAMES O ESTABLISH POPULATIONS FOR EPIDEMIOLOGICAL STUDIES	04-18-94/06-30-94	BRIGHAM AND WOMEN'S HOSPITAL	
7 N01AG02109-04	ALLEN, ANTON M PATHOLOGY MONITORING--F344 RAT COLONY	04-05-94/02-28-95	MICROBIOLOGICAL ASSOCIATES, INC.	36,259
5 R01AG02128-14	FESSLER, JOHN H BASEMENT MEMBRANE BIOSYNTHESIS	05-12-94/04-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	332,838
2 P01AG02132-14	PRUSINER, STANLEY B DEGENERATIVE AND DEMENTING DISEASES OF AGING	03-18-94/12-31-94	UNIVERSITY OF CALIFORNIA SAN FRANCI	1,602,716
5 R01AG02163-13	MADDEN, DAVID J AGE AND SELECTIVE ATTENTION IN VISUAL SEARCH	04-01-94/03-31-95	DUKE UNIVERSITY	237,711
2 P01AG02219-14	MOHS, RICHARD C CLINICAL AND BIOLOGIC STUDIES IN EARLY ALZHEIMERS	04-20-94/03-31-95	MOUNT SINAI SCHOOL OF MEDICINE	1,202,166
5 R37AG02224-15	WISE, PHYLLIS M NEUROENDOCRINE AND NEUROCHEMICAL FUNCTION DURING AGING	07-01-94/06-30-95	UNIVERSITY OF KENTUCKY	280,609
3 R37AG02224-15S1	WISE, PHYLLIS M NEUROENDOCRINE AND NEUROCHEMICAL FUNCTION DURING AGING	09-01-94/06-30-95	UNIVERSITY OF KENTUCKY	19,841
5 R01AG02325-13	LEES, SIDNEY MECHANO-ULTRASONIC PROPERTIES OF BONE IN AGING	12-01-93/11-30-94	FORSYTH DENTAL CENTER	223,856

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GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
5 R01AG02329-18	YUNIS, EDMOND J IMMUNOLOGICAL ASPECTS OF AGING	05-10-94/03-31-95	DANA-FARBER CANCER INSTITUTE	206,321
5 R01AG02331-13	CLEMMONS, DAVID R CONTROL OF FIBROBLAST REPLICATION BY IGF-BINDING PROTEIN	08-01-94/07-31-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	239,234
4 R37AG02452-15	LIGHT, LEAH L DIRECT AND INDIRECT MEASURES OF MEMORY IN OLD AGE	09-10-94/08-31-95	PITZER COLLEGE	186,754
5 R01AG02467-13	KUSHNER, IRVING INDUCTION OF ACUTE PHASE PROTEIN BIOSYNTHESIS	03-01-94/02-28-95	CASE WESTERN RESERVE UNIVERSITY	250,673
5 R37AG02577-12	NIMNI, MARCEL E OSTEOGENESIS--DEVELOPMENT, MODULATION, AND AGING	12-01-93/11-30-94	CHILDREN'S HOSPITAL OF LOS ANGELES	192,063
5 R01AG02711-16	ANCOLI-ISRAEL, SONIA PREVALENCE OF SLEEP APNEA IN AN AGED POPULATION	04-01-94/03-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	132,724
5 R37AG02751-13	HOWARD, DARLENE V AGING, SEMANTIC PROCESSING AND MEMORY	05-12-94/04-30-95	GEORGETOWN UNIVERSITY	163,685
5 P01AG02908-14	BERG, PAUL DNA TRANSACTIONS AND GENOME INTEGRITY IN AGING	08-10-94/07-31-95	STANFORD UNIVERSITY	859,687
5 R01AG03051-11	REISBERG, BARRY AGING AND DEMENTIA--LONGITUDINAL STUDY	07-10-94/06-30-95	NEW YORK UNIVERSITY	254,069
3 R37AG03055-12S2	ELIAS, MERRILL F AGE HYPERTENSION AND INTELLECTIVE PERFORMANCE	06-01-94/06-30-94	UNIVERSITY OF MAINE	5,000
5 R37AG03055-13	ELIAS, MERRILL F AGE, HYPERTENSION AND INTELLECTIVE PERFORMANCE	07-01-94/06-30-95	UNIVERSITY OF MAINE	352,231
5 R37AG03188-13	WOODBURY, MAX A LONGITUDINAL MODELS OF CORRELATES OF AGING AND LONGEVITY	06-15-94/05-31-95	DUKE UNIVERSITY	201,146
2 R01AG03362-08A2	HARTLEY, JOELLEN T AGING AND PROSE MEMORY--BEHAVIORAL AND EEG PREDICTORS	06-01-94/05-31-95	CALIFORNIA STATE UNIVERSITY LONG BE	155,592
2 R01AG03376-13A1	BARNES, CAROL A NEUROBEHAVIORAL RELATIONS IN SENESCENT HIPPOCAMPUS	09-30-94/04-30-95	UNIVERSITY OF ARIZONA	145,388
5 R01AG03417-14	FERNANDES, GABRIEL DIET AND AUTOIMMUNITY AND AGING	07-20-94/06-30-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	206,177

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5 R37AG03501-13	LEVENTHAL, HOWARD SYMPTOM & EMOTION STIMULI TO HEALTH ACTION	07-01-94/06-30-95	RUTGERS THE STATE UNIV NEW BRUNSWIC	327,962
3 R37AG03501-13S1	LEVENTHAL, HOWARD SYMPTOM AND EMOTION STIMULI TO HEALTH ACTION	09-30-94/06-30-95	RUTGERS THE STATE UNIV NEW BRUNSWIC	5,000
5 R01AG03527-12	CHATTERJEE, BANDANA AGE & HORMONE-DEPENDENT REGULATION OF A HEPATIC PROTEIN	05-20-94/04-30-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	177,600
5 R01AG03578-09	CHEN, KUANG Y TRANSACTING FACTORS AND CELLULAR AGING	07-01-94/06-30-95	RUTGERS THE STATE UNIV NEW BRUNSWIC	183,584
5 R01AG03763-08	WHISLER, RONALD L CELLULAR MECHANISMS OF HUMAN IMMUNOSENESCENCE	02-15-94/12-31-94	OHIO STATE UNIVERSITY	180,257
5 P01AG03934-12	KAYE, DONALD TEACHING NURSING HOME	06-01-94/04-30-95	MEDICAL COLLEGE OF PENNSYLVANIA	685,535
5 P01AG03949-13	LIPTON, RICHARD B TEACHING NURSING HOME	07-10-94/06-30-95	YESHIVA UNIVERSITY	1,284,499
2 P01AG03991-11	BERG, LEONARD HEALTHY AGING AND SENILE DEMENTIA	02-15-94/12-31-94	WASHINGTON UNIVERSITY	1,433,042
5 R01AG04058-10	WERNER, JOHN S OPTICAL AND NEURAL CHANGES IN THE AGING VISUAL SYSTEM	03-01-94/02-28-95	UNIVERSITY OF COLORADO AT BOULDER	107,133
5 R37AG04085-11	MURPHY, CLAIRE L CHEMOSENSORY PERCEPTION AND PSYCHOPHYSICS IN THE AGED	07-01-94/06-30-95	SAN DIEGO STATE UNIVERSITY	130,463
5 R01AG04100-10	KIPPS, THOMAS J IMMUNOLOGIC AGING AND AUTOIMMUNITY	09-30-94/08-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	224,209
5 R01AG04145-12	YEN, SHU-HUI C AGING AND ALZHEIMER DEMENTIA--ROLE OF FIBROUS PROTEIN	05-10-94/04-30-95	YESHIVA UNIVERSITY	278,156
5 R01AG04212-11	OWSLEY, CYNTHIA SPATIAL VISION AND AGING--UNDERLYING MECHANISMS	04-01-94/03-31-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	184,112
3 R37AG04287-11S2	STEVENS, JOSEPH C CHEMICAL SENSES AND AGING	06-20-94/08-31-94	JOHN B. PIERCE LABORATORY, INC.	5,000
5 R37AG04287-12	STEVENS, JOSEPH C CHEMICAL SENSES AND AGING	09-01-94/08-31-95	JOHN B. PIERCE LABORATORY, INC.	224,742

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5 R01AG04306-09	HASHER, LYNN A AGE, INHIBITION, AND THE CONTENTS OF WORKING MEMORY	08-01-94/07-31-95	DUKE UNIVERSITY	197,430
5 R37AG04307-12	CHASE, MICHAEL H STATE-DEPENDENT SOMATOMOTOR PROCESSES IN OLD AGE	08-01-94/07-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	303,062
2 P01AG04342-11	OLDSTONE, MICHAEL B AGING DISEASE--TRANSGENIC/VIROLOGIC/IMMUNOLOGY STUDIES	02-10-94/11-30-94	SCRIPPS RESEARCH INSTITUTE	934,303
5 R37AG04344-11	PORTER, JOHN C AGING AND MOLECULAR NEUROENDOCRINE IMPAIRMENT	02-15-94/01-31-95	UNIVERSITY OF TEXAS SW MED CTR/DALL	200,881
5 R01AG04360-12	FARR, ANDREW G AGE DEPENDENT MODULATION OF T CELL FUNCTION	07-20-94/06-30-95	UNIVERSITY OF WASHINGTON	150,040
5 P01AG04390-12	LIPSITZ, LEWIS A RESEARCH NURSING HOME	09-30-94/08-31-95	HEBREW REHABILITATION CENTER FOR AG	1,078,242
5 P01AG04393-10	WARREN, JOHN W COMPLICATIONS OF LONG TERM URINARY CATHETERS IN THE AGED	03-01-94/02-28-95	UNIVERSITY OF MARYLAND BALT PROF SC	762,411
5 P01AG04418-11	HOFFER, BARRY J AMINERGIC FUNCTION IN AGING AND ALZHEIMERS DISEASE	04-08-94/03-31-95	UNIVERSITY OF COLORADO HLTH SCIENCE	872,763
5 R37AG04517-11	WINGFIELD, ARTHUR AGE AND DECISION STRATEGIES IN RUNNING MEMORY FOR SPEECH	04-01-94/03-31-95	BRANDEIS UNIVERSITY	144,397
5 R01AG04518-11	HUI, SIU LUI LONGITUDINAL STUDIES OF OSTEOPOROSIS IN AGING	09-01-94/08-31-95	INDIANA UNIV-PURDUE UNIV AT INDIANA	106,773
5 R01AG04542-10	LANDFIELD, PHILIP W HIPPOCAMPAL SYNAPTIC STRUCTURE-PHYSIOLOGY DURING AGING	05-25-94/04-30-95	UNIVERSITY OF KENTUCKY	105,535
2 P30AG04590-10	ROCKWELL, RICHARD C FACTORS IN AGING--DEVELOPMENT RESEARCH RESOURCES	05-15-94/04-30-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	616,372
5 R01AG04594-11	STANSKI, DONALD R IV ANESTHETIC DISPOSITION IN THE AGED HEMODYNAMIC STATE	07-01-94/06-30-95	STANFORD UNIVERSITY	235,758
5 R01AG04736-11	THONAR, EUGENE J AGE RELATED DIFFERENCES IN CARTILAGE PROTEOGLYCANS	04-01-94/03-31-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	162,321
5 R37AG04791-11	NEBES, ROBERT D SEMANTIC MEMORY IN ALZHEIMERS DISEASE	04-01-94/03-31-95	UNIVERSITY OF PITTSBURGH AT PITTSBU	137,788

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5 R37AG04810-11	LU, JOHN K HORMONE SECRETION AND PREGNANCY DURING AGING	04-08-94/03-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	193,335
5 R01AG04821-12	OZER, HARVEY L IMMORTALIZATION OF SV40-TRANSFORMED HUMAN CELLS	09-01-94/07-31-95	UNIVERSITY OF MEDICINE & DENTISTRY	293,554
3 R01AG04821-12S1	OZER, HARVEY L IMMORTALIZATION OF SV40-TRANSFORMED HUMAN CELLS	09-15-94/07-31-95	UNIVERSITY OF MEDICINE & DENTISTRY	
3 P01AG04860-08S1	THORBECKE, GEERTRUIDA J AGING EFFECT ON THE IMMUNE RESPONSE	08-01-91/08-31-95	NEW YORK UNIVERSITY	60,508
2 P01AG04875-11	RIGGS, BYRON L PHYSIOLOGY OF BONE METABOLISM IN AN AGING POPULATION	07-15-94/06-30-95	MAYO FOUNDATION	1,229,372
5 P01AG04953-11	ALBERT, MARILYN S AGE-RELATED CHANGES OF COGNITION IN HEALTH AND DISEASE	08-15-94/07-31-95	MASSACHUSETTS GENERAL HOSPITAL	1,176,096
5 R01AG04980-31	THORBECKE, GEERTRUIDA J LYMPHOID CELLS IN PRODUCTION OF ANTIBODIES	04-01-94/02-28-95	NEW YORK UNIVERSITY	275,672
2 R01AG04984-08A1	RIKANS, LORA E AGING AND HEPATOTOXICITY	09-01-94/08-31-95	UNIVERSITY OF OKLAHOMA HLTH SCIENCE	126,728
5 P50AG05128-11	ROSES, ALLEN D ALZHEIMERS DISEASE	05-20-94/04-30-95	DUKE UNIVERSITY	1,409,307
2 P50AG05131-11	THAL, LEON J ALZHEIMERS DISEASE	05-20-94/03-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	2,500,000
3 P50AG05131-11S1	THAL, LEON J ALZHEIMERS DISEASE	07-01-94/03-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	4,012
5 P50AG05133-11	DEKOSKY, STEVEN ALZHEIMERS DISEASE RESEARCH	05-20-94/04-30-95	UNIVERSITY OF PITTSBURGH AT PITTSBU	1,329,118
2 P50AG05134-11	GROWDON, JOHN H ALZHEIMERS DISEASE	05-12-94/03-31-95	HARVARD UNIVERSITY	1,756,741
3 P50AG05134-11S1	GROWDON, JOHN H ALZHEIMERS DISEASE	07-01-94/03-31-95	HARVARD UNIVERSITY	66,520
5 P50AG05136-11	MARTIN, GEORGE M ALLZHEIMERS DISEASE	06-01-94/04-30-95	UNIVERSITY OF WASHINGTON	2,090,986

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2 P50AG05138-11	DAVIS, KENNETH L ALZHEIMERS DISEASE	05-01-94/03-31-95	MOUNT SINAI SCHOOL OF MEDICINE	1,922,187
2 P50AG05142-11	FINCH, CALEB E ADRC CONSORTIUM	05-01-94/03-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	2,796,000
3 P50AG05142-11S1	FINCH, CALEB E ADRC CONSORTIUM	08-15-94/03-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	91,890
5 P50AG05144-11	MARKESBERY, WILLIAM R ALZHEIMERS DISEASE RESEARCH CENTER	05-15-94/04-30-95	UNIVERSITY OF KENTUCKY	1,086,868
2 P50AG05146-12	PRICE, DONALD L AGING, NEURODEGENERATIVE DISEASE, AND ANIMAL MODELS	08-10-94/03-31-95	JOHNS HOPKINS UNIVERSITY	1,857,712
5 U01AG05170-10	FANTL, JOHN A URINARY INCONTINENCE IN COMMUNITY DWELLING WOMEN	07-01-94/06-30-95	VIRGINIA COMMONWEALTH UNIVERSITY	637,036
5 R01AG05213-09	FRIEDMAN, DAVID AGING EFFECTS ON COGNITIVE ERPD/CARDIAC WAVE EFFECT	05-01-94/04-30-95	NEW YORK STATE PSYCHIATRIC INSTITUT	200,713
5 R01AG05233-07	FREEDMAN, ROBERT R BEHAVIORAL TREATMENT OF MENOPAUSAL HOT FLASHES	04-01-94/03-31-95	WAYNE STATE UNIVERSITY	231,311
4 R37AG05284-09	DAVIS, MARADEE A LIVING ARRANGEMENTS HEALTH AND SURVIVAL--OLDER US ADULTS	02-01-94/01-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	200,000
5 R01AG05317-07	WOOLLACOTT, MARJORIE H AGE RELATED CHANGES IN POSTURE AND MOVEMENT	08-01-94/07-31-95	UNIVERSITY OF OREGON	110,666
5 R37AG05333-10	PEREIRA-SMITH, OLIVIA M MOLECULAR AND CYTOGENETIC STUDIES OF HUMAN CELL AGING	06-05-94/04-30-95	BAYLOR COLLEGE OF MEDICINE	221,113
3 U09AG05389-07S3	HAZZARD, WILLIAM R STUDY SECTION CHAIRMANS FUND (NIH)	09-30-92/12-30-94	U.S. PHS PUBLIC ADVISORY GROUPS	925,000
5 R01AG05394-09	ENSRUD, KRISTINE FRACTURES IN OLDER WOMEN	04-01-94/01-31-95	UNIVERSITY OF MINNESOTA TWIN CITIES	284,556
5 R01AG05407-09	CUMMINGS, STEVEN R FRACTURES IN OLDER WOMEN	05-01-94/04-30-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	836,624
3 R01AG05407-09S2	CUMMINGS, STEVEN R FRACTURES IN OLDER WOMEN	09-10-94/04-30-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	45,430

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5 R01AG05552-08	HESS, THOMAS M SCHEMATIC KNOWLEDGE INFLUENCES ON MEMORY IN ADULTHOOD	04-01-94/03-31-95	NORTH CAROLINA STATE UNIVERSITY RAL	110,181
5 P01AG05562-10	HOLLOSZY, JOHN O PHYSIOLOGICAL ADAPTATIONS TO EXERCISE IN THE ELDERLY	06-01-94/04-30-95	WASHINGTON UNIVERSITY	1,217,097
5 F32AG05569-03	ROOKS, DANIEL S NEUROMOTOR CHANGES WITH EXERCISE IN ELDERLY WOMEN	11-01-93/10-31-94	BETH ISRAEL HOSP (BOSTON)	31,200
5 F32AG05571-03	JENNINGS, PEGGY J COGNITION AND THE BASAL GANGLIA IN AGING AND DISEASE	05-15-94/03-23-95	MASSACHUSETTS INSTITUTE OF TECHNOLO	28,600
5 F31AG05576-03	JASPER, JARROD E MINORITY PREDOCTORAL FELLOWSHIP	02-10-94/01-12-95	WAYNE STATE UNIVERSITY	14,453
5 F32AG05579-03	GOODMAN, LAURIE E EXPRESSION OF INTERLEUKIN-6 IN SENESCENT CELLS	05-01-94/03-31-95	UNIVERSITY OF COLORADO AT BOULDER	28,600
7 F32AG05600-02	BUNSEY, MICHAEL D MEMORY AND HIPPOCAMPAL ACTIVITY IN AGING	01-01-94/12-31-94	STATE UNIVERSITY NEW YORK STONY BRO	28,600
5 R01AG05601-10	MONNIER, VINCENT M BROWNING OF HUMAN COLLAGEN IN DIABETES AND AGING	04-01-94/03-31-95	CASE WESTERN RESERVE UNIVERSITY	158,160
5 R37AG05604-09	NIXON, RALPH DYNAMICS OF THE NEURONAL CYTOSKELETON IN AGING BRAIN	01-01-94/12-31-94	MC LEAN HOSPITAL (BELMONT, MA)	300,766
5 F32AG05605-02	SCOTT, SAMUEL A INCREASED NGF-LIKE ACTIVITY IN ALZHEIMERS DISEASE	03-01-94/01-31-95	UNIVERSITY OF CINCINNATI	29,900
5 F32AG05608-02	BENLOUCIF, SUSAN J MELATONIN AND AGING	09-01-94/08-31-95	NORTHWESTERN UNIVERSITY	32,500
5 F32AG05612-02	LADERMAN, KENNETH A CONTRIBUTION OF MITOCHONDRIAL DNA MUTATIONS OF AGING	05-05-94/04-30-95	CALIFORNIA INSTITUTE OF TECHNOLOGY	23,700
5 F31AG05613-02	BROWN, MICHAEL D MINORITY PREDOCTORAL FELLOWSHIP PROGRAM	08-17-94/08-16-95	UNIVERSITY OF MARYLAND COLLEGE PK C	20,403
5 F31AG05615-02	HAMBLET, NATASHA S MITOCHONDRIAL DNA MUTATIONS IN ALZHEIMER'S DISEASE	11-01-93/10-31-94	EASTERN VIRGINIA MED SCH/MED COL HA	14,633
5 F32AG05616-02	STONE, MARIA V ATTENTIVE AND PREATTENTIVE PROCESSING IN ALZHEIMERS	06-15-94/06-14-95	STANFORD UNIVERSITY	23,700

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5 F32AG05619-02	SHIARELLA, KENNETH T DIET RESTRICTION EFFECT ON GLUTAMATE RECEPTOR AGING	05-15-94/05-02-95	COLORADO STATE UNIVERSITY	29,900
5 F33AG05620-02	MORGAN, LESLIE A JOB MOTIVATIONS OF DIRECT CARE WORKERS TO FRAIL ELDERLY	07-01-94/06-30-95	UNIVERSITY OF MARYLAND BALT PROF SC	17,650
5 F32AG05624-02	SCHUSTER, TONYA L NETWORK RELATIONSHIPS--SURVIVAL AND HEALTH IN LATER LIFE	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA IRVINE	33,800
5 R01AG05627-10	BLASCHKE, TERRENCE F AGING AND IN VIVO VASCULAR RESPONSIVENESS	08-01-94/07-31-95	STANFORD UNIVERSITY	224,665
5 R37AG05628-10	GOOD, ROBERT A CELLULAR ENGINEERING TO TREAT/PREVENT DISEASES OF AGING	06-01-94/03-31-95	UNIVERSITY OF SOUTH FLORIDA	149,984
5 F32AG05629-02	DIEDRICH, JANE F NEURODEGENERATION IN PRION DISEASE	07-23-94/07-21-95	UNIVERSITY OF MINNESOTA TWIN CITIES	29,900
5 R01AG05633-10	GOOD, ROBERT A REDUCED CALORIES, PROLIFERATION, IMMUNITY, CANCER, AGING	05-01-94/04-30-95	UNIVERSITY OF SOUTH FLORIDA	193,470
1 F32AG05635-01	LEVY-LAMAD, EPHRAT GENETICS OF FAMILIAL ALZHEIMER DISEASE IN VOLGA GERMANS	08-01-94/07-31-95	UNIVERSITY OF WASHINGTON	33,800
1 F32AG05636-01	TAYLOR, J ANDREW AGE EFFECT ON BAROREFLEX CONTROL OF AUTONOMIC OUTFLOW	06-01-94/05-31-95	VIRGINIA COMMONWEALTH UNIVERSITY	29,900
1 F32AG05638-01	THOMPSON, JANICE L GH/IGF-I-INDUCED STRENGTH AUGMENTATION IN ELDERLY WOMEN	01-01-94/12-31-94	STANFORD UNIVERSITY	28,600
1 F32AG05639-01	VIRTA-PEARLMAN, VALERIE J YEAST TELOMERE REPLICATION	02-07-94/02-06-95	BAYLOR COLLEGE OF MEDICINE	23,700
1 F32AG05641-01	MUSIOL, INES M VITAMIN D AND NERVE GROWTH FACTOR--EFFECTS OF AGING	12-01-93/11-30-94	STANFORD UNIVERSITY	29,900
1 F32AG05642-01	DALY, MARY C WORK DISABILITY AND POSTRETIREMENT ECONOMIC WELLBEING	06-30-94/06-29-95	SYRACUSE UNIVERSITY AT SYRACUSE	22,608
1 F32AG05643-01	FLEMING, LYNNE M METABOLISM & EXPRESSION OF TAU & MAP2--ROLE OF STEROIDS	12-15-93/12-14-94	UNIVERSITY OF ALABAMA AT BIRMINGHAM	23,700
1 F32AG05652-01	ROBLES, STEVEN J SCREENING FOR GENES INVOLVED IN CELLULAR SENESCENCE	03-23-94/03-22-95	BAYLOR COLLEGE OF MEDICINE	23,700

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1 F33AG05654-01	SOKOLOVSKY, JAY H SOCIAL SUPPORT OF CAREGIVERS FOR DEMENTIA PATIENTS	07-27-94/07-26-95	UNIVERSITY OF SOUTH FLORIDA	35,300
1 F32AG05664-01	HARNEY, JACOB P AGING, THE SUPRACHIASMATIC NUCLEUS AND ENDOCRINE RHYTHMS	09-02-94/09-01-95	UNIVERSITY OF KENTUCKY	28,600
1 F32AG05666-01	CLANCY, KEVIN P ISOLATION OF D14Q23 FAMILIAL ALZHEIMER DISEASE LOCUS	09-01-94/08-31-95	ELEANOR ROOSEVELT INST FOR CANCER R	23,700
1 F32AG05670-01	BRADBURY, MARGARET J HORMONAL CONTRIBUTIONS TO SLEEP DETERIORATION WITH AGE	09-01-94/08-31-95	STANFORD UNIVERSITY	23,700
5 P50AG05681-11	BERG, LEONARD WASHINGTON UNIVERSITY ALZHEIMERS DISEASE RESEARCH CENTER	07-01-94/04-30-95	WASHINGTON UNIVERSITY	1,867,504
5 R37AG05683-10	GLENNER, GEORGE G CEREBROVASCULAR AMYLOID PROTEIN IN ALZHEIMER'S DISEASE	09-10-94/08-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	276,427
3 R01AG05739-08S1	BALL, KARLENE K IMPROVEMENT OF VISUAL PROCESSING IN OLDER ADULTS	05-15-94/03-31-95	WESTERN KENTUCKY UNIVERSITY	14,619
5 P01AG05793-09	JOHNSTON, C CONRAD, JR SOME DETERMINANTS OF BONE MASS IN THE ELDERLY	12-01-93/11-30-94	INDIANA UNIV-PURDUE UNIV AT INDIANA	1,471,463
2 P01AG05842-09	WISE, DAVID A ECONOMICS OF AGING	02-15-94/12-31-94	NATIONAL BUREAU OF ECONOMIC RESEARC	785,280
3 P01AG05842-09S1	WISE, DAVID A ECONOMICS OF AGING	09-30-94/12-31-94	NATIONAL BUREAU OF ECONOMIC RESEARC	40,000
5 R01AG05885-06	MODAN, BARUCH NATIONAL EPIDEMIOLOGICAL STUDY OF THE OLDEST OLD	09-01-94/08-31-95	CHAIM SHEBA MEDICAL CENTER	94,125
4 R37AG05890-10	BUDINGER, THOMAS F CEREBRAL CHEMICAL PATTERNS IN ALZHEIMERS DISEASE	09-01-94/06-30-95	UNIVERSITY OF CALIF-LAWRENC BERKELE	248,012
5 R01AG05891-10	FRANGIONE, BLAS AMYLOIDOSIS AND ALZHEIMERS DISEASE	07-05-94/06-30-95	NEW YORK UNIVERSITY	349,835
2 R01AG05892-12A1	IQBAL, KHALID ALZHEIMER'S NEUROFIBRILLARY TANGLES--BIOCHEMICAL STUDIES	01-01-94/11-30-94	NEW YORK STATE OFFICE OF MENTAL HEA	226,806
2 R01AG05893-14	HERSH, LOUIS B CHOLINE ACETYLTRANSFERASE	04-08-94/03-31-95	UNIVERSITY OF KENTUCKY	225,853

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5 R37AG05894-22	FINE, RICHARD E NEURONAL CA++ SEQUESTERING COMPARTMENTS PROTECTING ROLE	07-20-94/04-30-95	BOSTON UNIVERSITY	286,678
2 R01AG05917-09A2	ROTUNDO, RICHARD L REGULATION OF ACETYLCHOLINESTERASE SYNTHESIS & ASSEMBLY	09-01-94/06-30-95	UNIVERSITY OF MIAMI	240,334
3 R01AG05917-09A2S1	ROTUNDO, RICHARD L REGULATION OF ACETYLCHOLINESTERASE SYNTHESIS & ASSEMBLY	09-10-94/06-30-95	UNIVERSITY OF MIAMI	45,114
5 R01AG05972-09	BOWLES, NANCY L WORD RETRIEVAL DEFICITS	05-01-94/08-31-94	BOSTON UNIVERSITY	34,928
5 R01AG05977-06	EVANS, WILLIAM S REGULATION OF GONADOTROPIN SECRETION IN AGING WOMEN	01-01-94/12-31-94	UNIVERSITY OF VIRGINIA CHARLOTTESVI	156,072
5 R01AG06036-09	ARNSTEN, AMY F COGNITIVE LOSS WITH AGE--ROLE OF CORTICAL CATECHOLAMINES	07-01-94/06-30-95	YALE UNIVERSITY	190,680
5 R37AG06060-09	FELTEN, DAVID L MPTP DEGENERATION OF MONOAMINE SYSTEMS AND AGING	08-01-94/07-31-95	UNIVERSITY OF ROCHESTER	171,767
5 R01AG06072-10	CZEISLER, CHARLES A DISRUPTED SLEEP IN THE ELDERLY--RESPONSE TO PHOTOTHERAPY	07-01-94/06-30-95	BRIGHAM AND WOMEN'S HOSPITAL	432,188
5 R01AG06088-08	GAGE, FRED H EMBRYONIC NERVE CELL TRANSPLANTATION IN AGED RAT BRAIN	02-15-94/01-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	276,145
5 R01AG06093-22	NAKAJIMA, YASUKO ULTRASTRUCTURE AND FUNCTION OF NERVE AND MUSCLE	02-15-94/01-31-95	UNIVERSITY OF ILLINOIS AT CHICAGO	192,844
5 R37AG06108-11	HORNSBY, PETER J AGING OF ENDOCRINE CELLS IN CULTURE	04-01-94/03-31-95	BAYLOR COLLEGE OF MEDICINE	256,045
3 R37AG06108-11S1	HORNSBY, PETER J AGING OF ENDOCRINE CELLS IN CULTURE	09-01-94/03-31-95	BAYLOR COLLEGE OF MEDICINE	74,000
5 R37AG06116-10	DICE, JAMES F, JR PROTEIN DEGRADATION IN AGING FIBROBLASTS	04-01-94/03-31-95	TUFTS UNIVERSITY BOSTON	267,274
5 R01AG06127-08	GILDEN, DONALD H NEUROBIOLOGY OF VARICELLA-ZOSTER VIRUS	07-01-94/06-30-95	UNIVERSITY OF COLORADO HLTH SCIENCE	291,639
5 R01AG06157-08	FAULKNER, JOHN A EXERCISE INJURY AND REPAIR OF MUSCLE FIBERS IN AGED MICE	01-01-94/12-31-94	UNIVERSITY OF MICHIGAN AT ANN ARBOR	135,910

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3 R01AG06168-08S1	JAZWINSKI, S MICHAL CELLULAR AGING IN A YEAST MODEL SYSTEM	06-01-94/04-30-95	LOUISIANA STATE UNIV MED CTR NEW OR	71,000
2 R01AG06168-09A1	JAZWINSKI, S MICHAL CELLULAR AGING IN A YEAST MODEL SYSTEM	09-30-94/08-31-95	LOUISIANA STATE UNIV MED CTR NEW OR	228,243
3 R01AG06170-08S1	POTTER, LINCOLN T CHOLINERGIC MECHANISMS IN AGING AND ALZHEIMERS DISEASE	02-15-94/04-30-94	UNIVERSITY OF MIAMI	16,534
5 R01AG06170-09	POTTER, LINCOLN T CHOLINERGIC MECHANISMS IN AGING AND ALZHEIMERS DISEASE	05-12-94/04-30-95	UNIVERSITY OF MIAMI	267,647
5 R37AG06173-09	SELKOE, DENNIS J AGING IN THE BRAIN--ROLE OF THE FIBROUS PROTEINS	02-15-94/01-31-95	BRIGHAM AND WOMEN'S HOSPITAL	299,768
5 R01AG06221-09	TATE, CHARLOTTE A MYOCARDIAL RESPONSE TO EXERCISE DURING SENESCENCE	04-01-94/03-31-95	UNIVERSITY OF HOUSTON-UNIVERSITY PA	175,019
2 R01AG06246-09	KELLEY, KEITH W HORMONAL RESTORATION OF A FUNCTIONAL THYMUS DURING AGING	09-01-94/08-31-95	UNIVERSITY OF ILLINOIS URBANA-CHAMP	278,840
5 R01AG06265-09	PARK, DENISE C CONTEXT EFFECTS ON THE AGING MEMORY	07-01-94/06-30-95	UNIVERSITY OF GEORGIA	175,115
5 R01AG06268-05	ERBER, JOAN T AGE AND MEMORY IN PERCEPTIONS OF COGNITIVE CAPABILITY	06-01-94/05-31-95	FLORIDA INTERNATIONAL UNIVERSITY	110,777
5 R01AG06432-08	DEUTSCH, GEORG PARIETAL AND ROLANDIC RCBF ACTIVATION IN DEMENTIA	08-01-94/07-31-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	192,012
5 R01AG06434-08	GERHARDT, GREG A AGE-INDUCED CHANGES IN MONOAMINE PRESYNAPTIC FUNCTION	04-01-94/03-31-95	UNIVERSITY OF COLORADO HLTH SCIENCE	179,158
5 R01AG06442-09	PAIGE, GARY D SENSORY-MOTOR ADAPTIVE MECHANISMS IN EQUILIBRIUM CONTROL	06-01-94/05-31-95	UNIVERSITY OF ROCHESTER	227,443
3 R01AG06457-08S1	HORAK, FAY B PERIPHERAL AND CENTRAL POSTURAL DISORDERS IN THE ELDERLY	01-01-94/08-31-94	GOOD SAMARITAN HOSP & MED CTR(PRTLN	36,000
2 R01AG06457-09	HORAK, FAY B PERIPHERAL AND CENTRAL POSTURAL DISORDERS IN THE ELDERLY	09-01-94/08-31-95	GOOD SAMARITAN HOSP & MED CTR(PRTLN	297,048
5 R37AG06490-09	DEMENT, WILLIAM C SLEEP, EXERCISE, AGING AND THE CIRCADIAN SYSTEM	09-01-94/08-31-95	STANFORD UNIVERSITY	180,056

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5 R01AG06528-09	DAVIDSON, JEFFREY M ELASTIN AND COLLAGEN IN THE AGING PROCESS	08-01-94/07-31-95	VANDERBILT UNIVERSITY	182,793
5 R01AG06537-09	SEALS, DOUGLAS R SYMPATHETIC NERVOUS SYSTEM ACTIVITY AND HUMAN AGING	08-10-94/07-31-95	UNIVERSITY OF COLORADO AT BOULDER	156,208
5 R37AG06559-07	JOHNSON, COLLEEN L SOCIAL WORLD OF THE OLDEST OLD	03-01-94/02-28-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	213,031
5 P01AG06569-08	HARRELL, LINDY E ALZHEIMERS DISEASE--A MULTIDISCIPLINARY APPROACH	05-25-94/04-30-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	1,167,240
5 R01AG06601-08	KOSIK, KENNETH S PATHOBIOLOGY OF TAU PROTEIN	01-01-94/12-31-95	BRIGHAM AND WOMEN'S HOSPITAL	182,002
5 R37AG06605-08	CORKIN, SUZANNE H THEORETICAL ANALYSIS OF LEARNING IN AGE-RELATED DISEASE	02-15-94/01-31-95	MASSACHUSETTS INSTITUTE OF TECHNOLO	273,769
5 R01AG06621-07	SCHULTZ, ALBERT B BIOMECHANICS OF FALLS AND BALANCE IN OLD ADULTS	04-01-94/03-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	215,078
5 R01AG06633-08	SAPOLSKY, ROBERT M AGING AND HIPPOCAMPAL NEURON LOSS: ROLE OF GLUCOCORTICOI	01-01-94/12-31-94	STANFORD UNIVERSITY	202,390
5 R01AG06641-08	ROBBINS, NORMAN PLASTICITY OF MOTOR NERVE TERMINALS	04-01-94/03-31-95	CASE WESTERN RESERVE UNIVERSITY	131,651
5 R37AG06643-08	LIANG, JERSEY WELL BEING AMONG THE ELDERLY	05-01-94/04-30-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	187,674
5 R01AG06647-07	MORRISON, JOHN H CORTICO-CORTICAL LOSS IN ALZHEIMERS DISEASE	04-20-94/03-31-95	MOUNT SINAI SCHOOL OF MEDICINE	226,225
5 R01AG06656-08	YOUNKIN, STEVEN G ACHE, CHAT, & CHOLINERGIC NEURONS IN AGING & ALZHEIMER'S	12-01-93/11-30-94	CASE WESTERN RESERVE UNIVERSITY	220,724
5 R37AG06665-07	HORWITZ, BARBARA A AGING AND GENDER EFFECTS ON RESPONSES TO COLD	08-01-94/07-31-95	UNIVERSITY OF CALIFORNIA DAVIS	231,371
2 R01AG06766-06A2	WALKER, ALEXIS J PARENT CARING AND THE MOTHER-DAUGHTER RELATIONSHIP	08-01-94/07-31-95	OREGON STATE UNIVERSITY	111,587
3 R01AG06766-06A2S1	WALKER, ALEXIS J PARENT CARING AND THE MOTHER/DAUGHTER RELATIONSHIP	08-01-94/07-31-95	OREGON STATE UNIVERSITY	27,027

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5 U01AG06781-08	LARSON, ERIC B ALZHEIMER'S DISEASE PATIENT REGISTRY	07-01-94/06-30-95	UNIVERSITY OF WASHINGTON	708,608
2 U01AG06786-09	KOKMEN, EMRE ALZHEIMERS DISEASE PATIENT REGISTRY	09-30-94/08-31-95	MAYO FOUNDATION	748,723
3 U01AG06790-08S1	HEYMAN, ALBERT CONSORTIUM--ESTABLISHING AN ALZHEIMERS DISEASE REGISTER	08-10-94/08-31-95	DUKE UNIVERSITY	250,000
5 P01AG06803-08	DAVIES, PETER FUNDAMENTAL STUDIES ON ALZHEIMERS DISEASE	06-01-94/05-31-95	YESHIVA UNIVERSITY	1,140,937
4 R37AG06826-09	SALTHOUSE, TIMOTHY A ADULT AGE DIFFERENCES IN REASONING AND SPATIAL ABILITIES	09-01-94/08-31-95	GEORGIA STATE UNIVERSITY	194,668
5 R01AG06849-07	OSTERGAARD, ARNE L PRIMING DEFICITS & BRAIN SYSTEMS IN DEMENTIA & AMNESIA	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	88,386
5 R01AG06860-08	CATHCART, EDGAR S AMYLOID, AGING, AND DIET	09-01-94/08-31-95	BOSTON UNIVERSITY	202,083
5 P01AG06872-08	BOWMAN, BARBARA H MOLECULAR GENETIC MECHANISMS OF AGING	05-20-94/04-30-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	964,991
5 R01AG06886-08	MC GUE, MATTHEW K TWIN STUDY OF NORMAL AGING	09-15-94/08-31-95	UNIVERSITY OF MINNESOTA TWIN CITIES	212,853
5 R01AG06895-15	SCHIAVI, RAUL C PSYCHOPHYSIOLOGY OF SEXUAL FUNCTION AND DYSFUNCTION	05-01-94/04-30-95	MOUNT SINAI SCHOOL OF MEDICINE	232,088
5 R01AG06943-08	VLASSARA, HELEN GLYCATION IN DIABETES AND AGING	07-01-94/06-30-95	PICOWER INSTITUTE FOR MEDICAL RESEA	270,516
2 R01AG06945-08	BLAIR, STEVEN N IMPACT OF PHYSICAL FITNESS AND EXERCISE ON HEALTH	04-08-94/03-31-95	COOPER INSTITUTE FOR AEROBICS RESEA	580,332
5 R01AG06946-08	ORME, IAN M AGING AND IMMUNITY TO TUBERCULOSIS	08-01-94/07-31-95	COLORADO STATE UNIVERSITY	220,292
5 R01AG06969-08	BINDER, LESTER I MAPS--SEGREGATION AND FUNCTION	04-15-94/03-31-95	MOLECULAR GERIATRICS CORPORATION	174,981
3 R37AG07001-07S1	LAWTON, M POWELL AFFECT NORMAL AGING AND PERSONAL COMPETENCE	03-21-94/06-30-94	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	5,000

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5 R37AG07001-08	LAWTON, M POWELL AFFECT NORMAL AGING AND PERSONAL COMPETENCE	07-01-94/06-30-95	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	189,195
2 R01AG07004-06A3	KENNEY, WILLIAM L, JR AGE AND CONTROL OF HUMAN SKIN BLOOD FLOW	08-20-94/07-31-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	293,652
5 R37AG07025-08	MANTON, KENNETH G FORECASTING LIFE AND ACTIVE LIFE EXPECTANCY	08-01-94/07-31-95	DUKE UNIVERSITY	216,464
5 R01AG07114-08	GILCHREST, BARBARA A AGING--CELL GROWTH AND DIFFERENTIATION	08-01-94/07-31-95	BOSTON UNIVERSITY	221,343
5 P01AG07123-07	SMITH, JAMES R MOLECULAR APPROACHES TO CELLULAR AGING	12-01-93/11-30-94	BAYLOR COLLEGE OF MEDICINE	805,860
5 R01AG07137-08	MC ARDLE, J JACK GROWTH CURVES OF ADULT INTELLIGENCE BY TIME LAG TESTING	07-01-94/05-31-95	UNIVERSITY OF VIRGINIA CHARLOTTESVI	130,945
5 R01AG07146-06	BARON, JOHN A FRACTURE EPIDEMIOLOGY AND OUTCOMES IN THE ELDERLY	04-01-94/09-30-95	DARTMOUTH COLLEGE	122,938
5 R37AG07181-08	BARRETT-CONNOR, ELIZABETH L RISK FACTORS FOR OSTEOPOROSIS IN ELDERLY	09-01-94/07-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	367,326
5 R37AG07182-08	MC KINLAY, JOHN B PATHWAYS TO SUCCESSFUL CAREGIVING FOR FRAIL OLDER PERSON	07-01-94/06-30-95	NEW ENGLAND RESEARCH INSTITUTE, INC	383,012
5 R01AG07195-06	FORD, AMASA B SERVICES BY BLACK AND WHITE ELDERLY	07-01-94/06-30-95	CASE WESTERN RESERVE UNIVERSITY	279,273
5 R37AG07198-08	MANTON, KENNETH G FUNCTIONAL AND HEALTH CHANGES OF THE ELDERLY	02-10-94/12-31-94	DUKE UNIVERSITY	1,057,007
3 R37AG07198-08S1	MANTON, KENNETH G FUNCTIONAL AND HEALTH CHANGES OF THE ELDERLY	03-18-94/12-31-94	DUKE UNIVERSITY	29,650
3 R37AG07198-08S2	MANTON, KENNETH G FUNCTIONAL AND HEALTH CHANGES OF THE ELDERLY	09-30-94/12-31-94	DUKE UNIVERSITY	75,000
2 R37AG07218-08	HERMAN, BRIAN A MECHANISMS OF CELL DEATH IN LIVER CELLS	08-01-94/06-30-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	298,645
2 P01AG07232-06	MAYEUX, RICHARD P EPIDEMIOLOGY OF DEMENTIA	04-10-94/01-31-95	COLUMBIA UNIVERSITY NEW YORK	1,359,287

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3 P01AG07232-06S1	MAYEUX, RICHARD P EPIDEMIOLOGY OF DEMENTIA	09-30-94/01-31-95	COLUMBIA UNIVERSITY NEW YORK	45,448
2 R01AG07367-07	ROGERS, JOSEPH COMPLEMENT MEDIATED MECHANISMS IN ALZHEIMERS DISEASE	09-01-94/08-31-95	SUN HEALTH RESEARCH INSTITUTE	439,466
2 R01AG07369-04A1	SCHIRCH, LAVERNE G PROTEIN DEAMIDATION IN PROTEIN TURNOVER AND AGING	12-01-93/11-30-94	VIRGINIA COMMONWEALTH UNIVERSITY	143,744
2 R01AG07370-06A1	STERN, YAAKOV PREDICTORS OF SEVERITY IN ALZHEIMERS DISEASE	09-15-94/06-30-95	COLUMBIA UNIVERSITY NEW YORK	582,359
5 R01AG07410-04	REITZES, DONALD C ROLES AND SELF--FACTORS IN DEVELOPMENT AND RETIREMENT	09-01-94/08-31-95	GEORGIA STATE UNIVERSITY	252,214
5 R01AG07424-07	ECKENSTEIN, FELIX P NEUROTROPHIC SUPPORT IN AGING AND ALZHEIMER'S DISEASE	07-10-94/06-30-95	OREGON HEALTH SCIENCES UNIVERSITY	169,121
3 R01AG07424-07S1	ECKENSTEIN, FELIX P NEUROTROPHIC SUPPORT IN AGING AND ALZHEIMERS DISEASE	09-30-94/06-30-95	OREGON HEALTH SCIENCES UNIVERSITY	6,500
5 R37AG07444-07	WANG, EUGENIA GROWTH CONTROL IN AGING FIBROBLASTS	05-01-94/04-30-95	MC GILL UNIVERSITY	136,344
2 R01AG07449-06	TINETTI, MARY E INJURY AND FUNCTIONAL DECLINE IN ELDERLY FALLERS	08-15-94/06-30-95	YALE UNIVERSITY	352,821
5 R01AG07450-06	MACIAG, THOMAS ENDOTHELIAL CELL SENESCENCE GENES	06-05-94/04-30-95	AMERICAN NATIONAL RED CROSS	249,986
5 R01AG07469-07	MANTON, KENNETH G ACTIVE LIFE EXPECTANCY IN OLD AND OLDEST-OLD POPULATIONS	09-01-94/08-31-95	DUKE UNIVERSITY	152,253
3 R01AG07552-06S1	PERRY, GEORGE AMYLOID PRECURSOR IN ALZHEIMERS DISEASE	06-15-94/12-31-94	CASE WESTERN RESERVE UNIVERSITY	28,992
5 R37AG07554-07	WILLOTT, JAMES F AGING AND CENTRAL AUDITORY SYSTEM MORPHOLOGY	05-01-94/04-30-95	NORTHERN ILLINOIS UNIVERSITY	85,676
3 R01AG07562-06S1	GANGULI, MARY EPIDEMIOLOGY OF DEMENTIA--A PROSPECTIVE COMMUNITY STUDY	07-01-94/07-31-94	UNIVERSITY OF PITTSBURGH AT PITTSBU	25,821
5 R01AG07562-07	GANGULI, MARY EPIDEMIOLOGY OF DEMENTIA--A PROSPECTIVE COMMUNITY STUDY	08-01-94/07-31-95	UNIVERSITY OF PITTSBURGH AT PITTSBU	658,520

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GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
5 R01AG07569-06	PARASURAMAN, RAJA ATTENTION IN AGING AND EARLY ALZHEIMERS DEMENTIA	04-01-94/03-31-95	CATHOLIC UNIVERSITY OF AMERICA	100,135
5 R01AG07584-07	KUKULL, WALTER A GENETIC DIFFERENCES IN ALZHEIMERS CASES AND CONTROLS	04-01-94/03-31-95	UNIVERSITY OF WASHINGTON	288,419
2 R01AG07592-06	BARNARD, ROY J MECHANISM OF AGING INDUCED INSULIN RESISTANCE	04-08-94/02-28-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	155,894
2 R01AG07607-04A1	BLANCHARD-FIELDS, FREDDA H ATTRIBUTIONAL PROCESSES IN ADULTHOOD AND AGING	09-30-94/06-30-95	GEORGIA INSTITUTE OF TECHNOLOGY	151,202
4 R37AG07637-06	HERMALIN, ALBERT I RAPID DEMOGRAPHIC CHANGE AND WELFARE	04-21-94/03-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	382,647
5 R01AG07648-05	GOLD, PAUL E AGING AND MEMORY	05-12-94/04-30-95	UNIVERSITY OF VIRGINIA CHARLOTTESVI	125,682
5 R01AG07657-06	SOHAL, RAJINDAR S CELLULAR AGING AND OXYGEN FREE RADICALS	04-01-94/03-31-95	SOUTHERN METHODIST UNIVERSITY	128,833
5 R01AG07695-07	LAL, HARBANS NEUROBEHAVIORAL AND IMMUNOLOGICAL MARKERS OF AGING	04-01-94/03-31-95	UNIVERSITY OF NORTH TEXAS HLTH SCI	218,684
3 R01AG07695-07S1	LAL, HARBANS NEUROBEHAVIORAL AND IMMUNOLOGICAL MARKERS OF AGING	09-20-94/03-31-95	UNIVERSITY OF NORTH TEXAS HLTH SCI	4,213
5 R01AG07700-07	FRIEDMAN, EITAN AGING, PROTEIN KINASE C, AND SEROTONIN RELEASE	04-01-94/03-31-95	MEDICAL COLLEGE OF PENNSYLVANIA	220,075
5 R01AG07719-07	MURASKO, DONNA M IMMUNE PARAMETERS AS BIOMARKERS OF AGING	04-01-94/03-31-95	MEDICAL COLLEGE OF PENNSYLVANIA	234,056
3 R01AG07719-07S1	MURASKO, DONNA M IMMUNE PARAMETERS AS BIOMARKERS OF AGING	09-30-94/03-31-95	MEDICAL COLLEGE OF PENNSYLVANIA	97,654
5 R01AG07724-07	WOLF, NORMAN S BIOMARKERS OF AGING--CELLULAR PROLIFERATION AND TURNOVER	04-01-94/03-31-95	UNIVERSITY OF WASHINGTON	190,322
3 R01AG07724-07S1	WOLF, NORMAN S BIOMARKERS OF AGING--CELLULAR PROLIFERATION AND TURNOVER	09-10-94/03-31-95	UNIVERSITY OF WASHINGTON	48,481
5 R01AG07735-07	MARKOWSKA, ALICJA L BEHAVIORAL AND PHYSIOLOGICAL BIOMAKERS OF AGING	04-01-94/03-31-95	JOHNS HOPKINS UNIVERSITY	178,809

GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
5 R01AG07747-07	BRONSON, RODERICK T AGE-RELATED LESIONS AS BIOMARKERS OF AGING	04-01-94/03-31-95	TUFTS UNIVERSITY BOSTON	221,153
5 R01AG07752-07	SONNTAG, WILLIAM E GROWTH HORMONE (GH) AND GH-DEPENDENT BIOMARKERS OF AGING	04-01-94/03-31-95	WAKE FOREST UNIVERSITY	166,256
5 R01AG07767-07	LANDFIELD, PHILIP W BIOMARKERS OF BRAIN AGING	04-01-94/03-31-95	UNIVERSITY OF KENTUCKY	225,627
2 R01AG07793-06A1	JAGUST, WILLIAM J LONGITUDINAL SPECT AND PET STUDIES OF DEMENTIA	04-10-94/03-31-95	UNIVERSITY OF CALIF-LAWRENC BERKELE	281,088
5 R01AG07800-03	GUSTMAN, ALAN L PROJECTING PENSION INCOMES OF THE OLD AND OLDEST OLD	07-01-94/06-30-95	NATIONAL BUREAU OF ECONOMIC RESEARC	33,837
5 R01AG07805-06	GRIFFITH, WILLIAM H, III PHYSIOLOGY OF CHOLINERGIC BASAL FOREBRAIN NEURONS	05-20-94/04-30-95	TEXAS A&M UNIVERSITY HEALTH SCIENCE	134,354
4 R37AG07823-06	KAHANA, EVA F ADAPTATION TO FRAILTY AMONG DISPERSED ELDERLY	09-01-94/06-30-95	CASE WESTERN RESERVE UNIVERSITY	187,063
5 R01AG07857-08	POEHLMAN, ERIC T ENERGY METABOLISM IN ALEHEIMER'S DISEASE	08-01-94/07-31-95	UNIVERSITY OF MARYLAND BALT PROF SC	120,308
3 R01AG07857-08S1	POEHLMAN, ERIC T ENERGY METABOLISM IN ALEHEIMERS DISEASE	08-10-94/07-31-95	UNIVERSITY OF MARYLAND BALT PROF SC	61,154
5 R01AG07886-07	HOLLAND, AUDREY L DISCOURSE AND EVERYDAY REMEMBERING IN ALZHEIMER DISEASES	07-01-94/06-30-95	UNIVERSITY OF ARIZONA	64,953
5 R29AG07904-06	WILLIAMS, DAVID R SEX DIFFERENCES IN MORBIDITY/MORTALITY IN MID/LATE LIFE	01-01-94/12-31-94	UNIVERSITY OF MICHIGAN AT ANN ARBOR	109,717
5 R35AG07909-06	FINCH, CALEB E ALZHEIMERS DISEASE	03-01-94/12-31-94	UNIVERSITY OF SOUTHERN CALIFORNIA	741,808
5 R35AG07911-07	SELKOE, DENNIS J LEADERSHIP AND EXCELLENCE IN ALZHEIMERS DISEASE	08-05-94/07-31-95	BRIGHAM AND WOMEN'S HOSPITAL	758,695
5 R35AG07914-06	PRICE, DONALD L MOLECULAR NEUROPATHOLOGY OF AGING AND DEMENTIA	08-05-94/12-31-94	JOHNS HOPKINS UNIVERSITY	280,880
5 R35AG07918-06	COTMAN, CARL W NEURONAL PLASTICITY/PATHOLOGY IN ALZHEIMERS DISEASE	02-25-94/12-31-94	UNIVERSITY OF CALIFORNIA IRVINE	562,352

GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
5 R35AG07922-07	ROSES, ALLEN D GENETICS OF LATE AND EARLY ONSET ALZHEIMERS DISEASE	09-30-94/07-31-95	DUKE UNIVERSITY	760,181
5 U01AG07929-06	DEFRIESE, GORDON H NATIONAL FOLLOW UP STUDY OF SELF CARE AMONG OLDER ADULTS	08-01-94/01-31-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	129,660
5 R37AG07977-12	BENGTSON, VERN L LONGITUDINAL STUDY OF GENERATIONS AND MENTAL HEALTH	03-01-94/02-28-95	UNIVERSITY OF SOUTHERN CALIFORNIA	618,868
3 R37AG07977-12S1	BENGTSON, VERN L LONGITUDINAL STUDY OF GENERATIONS AND MENTAL HEALTH	07-01-94/02-28-95	UNIVERSITY OF SOUTHERN CALIFORNIA	5,000
3 R37AG07977-12S2	BENGTSON, VERN L LONGITUDINAL STUDY OF GENERATIONS AND MENTAL HEALTH	07-25-94/02-28-95	UNIVERSITY OF SOUTHERN CALIFORNIA	28,769
5 R01AG07988-05	BODEN, GUENTHER NUTRITIONAL EFFECTS OF ETHANOL IN THE ELDERLY	01-01-94/12-31-95	TEMPLE UNIVERSITY	178,936
7 R29AG07991-05	MC DOWD, JOAN M INHIBITORY PROCESS IN SELECTIVE ATTENTION AND AGING	09-01-94/08-31-95	UNIVERSITY OF KANSAS MEDICAL CENTER	98,689
5 P01AG07996-06	LOTZ, MARTIN K JOINT AGING AND OSTEOARTHRITIS	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	499,559
2 R01AG07998-05A1	DIVENYI, PIERRE L SPEECH PERCEPTION UNDER NONOPTIMAL CONDITIONS IN AGING	01-01-94/12-31-94	EAST BAY INSTITUTE FOR RESEARCH AND	139,939
3 R01AG07998-05A1S1	DIVENYI, PIERRE L SPEECH PERCEPTION UNDER NONOPTIMAL CONDITIONS IN AGING	03-10-94/12-31-94	EAST BAY INSTITUTE FOR RESEARCH AND	5,120
5 P50AG08012-07	WHITEHOUSE, PETER J UHC/CWRU ADRC COMPETITIVE RENEWAL	07-01-94/05-31-95	CASE WESTERN RESERVE UNIVERSITY	2,062,765
3 P50AG08012-07S1	WHITEHOUSE, PETER J UHC/CWRU ADRC COMPETITIVE RENEWAL	07-05-94/05-31-95	CASE WESTERN RESERVE UNIVERSITY	5,074
5 P30AG08014-05	BECKER, ROBERT E ALZHEIMERS DISEASE CENTER CORE GRANT	07-01-94/04-30-95	SOUTHERN ILLINOIS UNIVERSITY SCH OF	705,833
5 P30AG08017-05	ZIMMERMAN, EARL A ALZHEIMERS DISEASE	04-15-94/03-31-95	OREGON HEALTH SCIENCES UNIVERSITY	619,959
5 P30AG08031-05	PETERSEN, RONALD C ALZHEIMERS DISEASE CENTER CORE GRANT	06-25-94/04-30-95	MAYO FOUNDATION	723,105

GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
5 R29AG08047-05	NEWMAN, ANNE B EPIDEMIOLOGY OF ARTERIAL DISEASE IN THE ELDERLY	02-01-94/06-30-95	ALLEGHENY-SINGER RESEARCH INSTITUTE	75,019
5 P30AG08051-05	FERRIS, STEVEN H ALZHEIMERS DISEASE CENTER CORE GRANT	08-10-94/04-30-95	NEW YORK UNIVERSITY	1,106,864
4 R37AG08055-06	SCHAIE, K WARNER LONGITUDINAL STUDIES OF ADULT COGNITIVE DEVELOPMENT	12-30-93/11-30-94	PENNSYLVANIA STATE UNIVERSITY-UNIV	409,215
3 R37AG08055-06S1	SCHAIE, K WARNER LONGITUDINAL STUDIES OF COGNITIVE DEVELOPMENT	04-08-94/11-30-94	PENNSYLVANIA STATE UNIVERSITY-UNIV	5,000
5 R01AG08076-04	IQBAL, KHALID NEURONAL CYTOSKELETAL ALTERATIONS IN ALZHEIMERS DISEASE	02-15-94/01-31-95	INSTITUTE FOR BASIC RES IN DEV DISA	179,561
5 R01AG08084-06	POTTER, HUNTINGTON AMYLOID DEPOSITION IN AGING AND ALZHEIMER'S DISEASE	02-15-94/01-31-95	HARVARD UNIVERSITY	195,168
3 R01AG08099-05S1	TORAN-ALLERAND, C DOMINIQUE INTERACTIONS OF NGF/ESTROGEN IN CNS DEVELOPMENT & AGING	03-18-94/09-29-94	COLUMBIA UNIVERSITY NEW YORK	83,500
2 R01AG08099-06A1	TORAN-ALLERAND, C DOMINIQUE INTERACTIONS OF NGF/ESTROGEN IN CNS DEVELOPMENT AND AGIN	09-30-94/08-31-95	COLUMBIA UNIVERSITY NEW YORK	200,621
5 R01AG08117-06	CORKIN, SUZANNE H AD EFFECTS ON BASIC AND HIGH ORDER SENSORY CAPACITIES	08-01-94/07-31-95	MASSACHUSETTS INSTITUTE OF TECHNOLO	221,766
2 R01AG08122-06A1	WOLF, PHILIP A EPIDEMIOLOGY OF DEMENTIA IN THE FRAMINGHAM STUDY	09-15-94/06-30-95	BOSTON UNIVERSITY	240,738
4 R37AG08146-06	WISE, DAVID A PENSION PLAN PROVISIONS AND EARLY RETIREMENT EXTENSION	02-01-94/12-31-94	NATIONAL BUREAU OF ECONOMIC RESEARC	146,595
4 R37AG08155-06	GAMBETTI, PIERLUIGI PRION DISEASES	05-20-94/03-31-95	CASE WESTERN RESERVE UNIVERSITY	319,693
5 R37AG08174-07	SIMPSON, EVAN R AROMATASE IN ADIPOSE--RELATIONSHIP TO AGING AND CANCER	07-01-94/06-30-95	UNIVERSITY OF TEXAS SW MED CTR/DALL	213,123
3 R37AG08174-07S1	SIMPSON, EVAN R AROMATASE IN ADIPOSE--RELATIONSHIP TO AGING AND CANCER	09-01-94/06-30-95	UNIVERSITY OF TEXAS SW MED CTR/DALL	49,730
5 R01AG08193-06	CERNY, JAN REPERTOIRE OF BACTERIAL ANTIBODY IN AGING	02-10-94/12-31-94	UNIVERSITY OF MARYLAND BALT PROF SC	185,805

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GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
5 R44AG08195-03	LEHTINET, JO ANN SMART PHARMACY CARDS TO AUTOMATE PATIENT RECORDS	07-25-94/03-31-95	APPLIED SYSTEMS INSTITUTE, INC.	72,152
5 R01AG08200-07	ROBAKIS, NIKOLAOS K CYTOSKELETAL ASSOCIATION OF FULL LENGTH & TRUNCATED APP	08-01-94/07-31-95	MOUNT SINAI SCHOOL OF MEDICINE	203,567
5 R01AG08203-07	MURPHY, CLAIRE L OLFACTORY DYSFUNCTION IN ALZHEIMER'S DISEASE	08-01-94/07-31-95	SAN DIEGO STATE UNIVERSITY	178,544
5 R01AG08205-07	SAITOH, TSUNAO ALTERED PROTEIN KINASES IN ALZHEIMERS DISEASE	08-01-94/07-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	194,339
2 R01AG08206-07A1	ARMSTRONG, DAVID M TRANSMITTER NEUROANATOMY IN ALZHEIMERS DISEASE	09-30-94/06-30-95	ALLEGHENY-SINGER RESEARCH INSTITUTE	180,068
5 R01AG08211-04	MAGAZINER, JAY S EPIDEMIOLOGY OF DEMENTIA IN AGED NURSING HOME ADMISSIONS	08-01-94/07-31-95	UNIVERSITY OF MARYLAND BALT PROF SC	356,685
5 R01AG08235-04	HULTSCH, DAVID F INDIVIDUAL DIFFERENCES IN MEMORY CHANGE IN THE AGED	02-10-94/11-30-94	UNIVERSITY OF VICTORIA	111,982
5 R29AG08256-04	CUSHMAN, LAURA A COGNITIVE FACTORS IN THE SAFETY OF OLDER DRIVERS	09-01-94/08-31-95	UNIVERSITY OF ROCHESTER	100,976
5 P01AG08291-05	LILLARD, LEE A SOCIAL AND ECONOMIC FUNCTIONING IN OLDER POPULATIONS	02-16-94/12-31-94	RAND CORPORATION	462,557
5 R01AG08293-05	HUMES, LARRY E SPEECH RECOGNITION BY THE HEARING IMPAIRED ELDERLY	05-01-94/04-30-95	INDIANA UNIVERSITY BLOOMINGTON	144,203
4 R37AG08303-06	MARTIN, GEORGE M HOMOZYGOSITY MAPPING OF THE WERNER SYNDROME LOCUS	05-01-94/04-30-95	UNIVERSITY OF WASHINGTON	188,209
5 R01AG08313-05	KUTAS, MARTA BRAIN POTENTIALS--LANGUAGE, MEMORY, AND AGING	05-01-94/04-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	166,011
3 P01AG08321-03S2	ZIRKIN, BARRY R AGING AND MALE REPRODUCTIVE TRACT STRUCTURE AND FUNCTION	01-01-94/03-31-94	JOHNS HOPKINS UNIVERSITY	83,238
2 P01AG08321-04A1	ZIRKIN, BARRY R AGING AND MALE REPRODUCTIVE TRACT STRUCTURE AND FUNCTION	05-12-94/04-30-95	JOHNS HOPKINS UNIVERSITY	797,081
5 R01AG08322-06	JOHNSON, THOMAS E MOLECULAR GENETIC SPECIFICATION OF AGING PROCESSES	08-01-94/07-31-95	UNIVERSITY OF COLORADO AT BOULDER	209,405

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GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
2 R01AG08324-04A1	STRUMPF, NEVILLE E MAINTAINING RESTRAINT REDUCTION IN NURSING HOMES	07-25-94/03-31-95	UNIVERSITY OF PENNSYLVANIA	425,403
5 R01AG08325-05	KAWAS, CLAUDIA H RISK FACTORS AND EARLY SIGNS IN ALZHEIMERS DISEASE/BLSA	05-25-94/04-30-95	JOHNS HOPKINS UNIVERSITY	258,890
5 R37AG08346-04	LILLARD, LEE A INTERGENERATIONAL TRANSFERS IN MALAYSIA	04-05-94/01-31-95	RAND CORPORATION	114,969
5 R01AG08419-06	RASKIND, MURRAY A PSYCHOPATHOLOGY OF ALZHEIMERS--PSYCHONEUROENDOCRINOLOGY	09-01-94/08-31-95	UNIVERSITY OF WASHINGTON	340,407
2 R01AG08436-03A1	EINSTEIN, GILLES O COMPONENTIAL ANALYSIS OF PROSPECTIVE MEMORY AND AGING	04-08-94/03-31-95	FURMAN UNIVERSITY	135,717
5 R01AG08438-04	MAJUMDAR, ADHIP N GASTRIC MUCOSAL INJURY AND AGING	07-01-94/06-30-95	WAYNE STATE UNIVERSITY	105,113
5 R01AG08444-07	KAY, MARGUERITE M B MEMBRANE CHANGES IN NEUROLOGIC AND AGING DISEASES	07-01-94/06-30-95	UNIVERSITY OF ARIZONA	200,395
2 R01AG08459-06	SOHAL, RAJINDAR S ANTIOXIDANT ENZYMES AND AGING IN TRANSGENIC DROSOPHILA	07-20-94/06-30-95	SOUTHERN METHODIST UNIVERSITY	202,584
5 R01AG08470-06	LANSBURY, PETER T, JR AMYLOID DEPOSITION IN ALZHEIMERS DISEASE	07-01-94/06-30-95	MASSACHUSETTS INSTITUTE OF TECHNOLO	224,246
5 R01AG08496-02	VOM SAAL, FREDERICK S EFFECTS OF ESTROGEN ON PROSTATE FUNCTION DURING AGING	05-10-94/04-30-95	UNIVERSITY OF MISSOURI COLUMBIA	159,631
5 R01AG08505-03	FELDMAN, MARTIN L HEARING LOSS AND AGING IN THE AUDITORY SYSTEM	06-20-94/05-31-95	BOSTON UNIVERSITY	141,258
5 R01AG08510-06	BAUMGARTNER, RICHARD N BODY COMPOSITION METHOD FOR THE ELDERLY	06-01-94/05-31-95	UNIVERSITY OF NEW MEXICO ALBUQUERQU	53,125
5 R37AG08514-06	GAGE, FRED H GRAFTING GENETICALLY MODIFIED CELLS	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	245,155
5 R01AG08523-04	MYERS, GEORGE C COLLABORATIVE STUDY OF AGING IN THE US AND AUSTRALIA	08-01-94/07-31-95	DUKE UNIVERSITY	274,343
5 R01AG08537-04	ESIRI, MARGARET M PLAQUE AND TANGLE PATHOGENESIS IN ALZHEIMERS DISEASE	05-15-94/12-31-94	UNIVERSITY OF OXFORD	80,870

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3 R01AG08538-02S1	BLUM, MARIANN GROWTH FACTORS IN THE ADULT AND AGING BRAIN	02-15-94/04-30-94	MOUNT SINAI SCHOOL OF MEDICINE	17,990
5 R01AG08538-03	BLUM, MARIANN GROWTH FACTORS IN THE ADULT AND AGING BRAIN	05-25-94/04-30-95	MOUNT SINAI SCHOOL OF MEDICINE	189,021
5 R01AG08545-07	DALE, GEORGE L ERYTHROCYTE SENESCENCE	07-01-94/06-30-95	UNIVERSITY OF OKLAHOMA HLTH SCIENCE	141,540
5 R29AG08554-05	UMBERSON, DEBRA DEATH OF A PARENT--IMPACT ON ADULT CHILDREN AND FAMILIES	06-10-94/05-31-95	UNIVERSITY OF TEXAS AUSTIN	101,826
5 R37AG08557-04	HAUG, MARIE R STRESSES, STRAINS AND ELDERLY PHYSICAL HEALTH	03-01-94/02-28-95	CASE WESTERN RESERVE UNIVERSITY	153,501
3 R37AG08557-04S1	HAUG, MARIE R STRESSES, STRAINS AND ELDERLY PHYSICAL HEALTH	03-15-94/02-28-95	CASE WESTERN RESERVE UNIVERSITY	34,075
5 R01AG08562-06	WILLIAMS-RUSSO, PAMELA G TRIAL OF HYPOTENSIVE VS NORMOTENSIVE ANESTHESIA	07-01-94/06-30-96	HOSPITAL FOR SPECIAL SURGERY	201,566
5 R01AG08572-06	KIRSCHNER, DANIEL A ABNORMAL FIBROUS ASSEMBLIES OF ALZHEIMERS DISEASE	08-01-94/07-31-95	CHILDREN'S HOSPITAL (BOSTON)	151,619
2 R01AG08573-12A1	BANDMAN, EVERETT IMMUNOBIOCHEMICAL STUDY OF MUSCLE MYOSIN ISOFORMS	07-10-94/06-30-95	UNIVERSITY OF CALIFORNIA DAVIS	214,684
5 R29AG08589-05	TSANG, PAMELA AGING AND PILOT TIME SHARING PERFORMANCE	06-10-94/05-31-95	WRIGHT STATE UNIVERSITY	92,975
2 R01AG08617-04A1	BRENNAN, PATRICIA F SUPPORTING HOME CARE VIA A COMMUNITY COMPUTER NETWORK	04-10-94/03-31-95	CASE WESTERN RESERVE UNIVERSITY	179,304
5 R01AG08659-05	MURASKO, DONNA M AGE EFFECT ON RETROVIRAL DISEASE AND IMMUNOSUPPRESSION	12-01-93/11-30-95	MEDICAL COLLEGE OF PENNSYLVANIA	203,445
3 P50AG08664-05S1	APPEL, STANLEY H ALZHEIMERS DISEASE RESEARCH CENTER	06-20-94/05-31-95	BAYLOR COLLEGE OF MEDICINE	296,653
5 P30AG08665-05	COLEMAN, PAUL D ALZHEIMERS DISEASE CENTER	05-15-94/04-30-95	UNIVERSITY OF ROCHESTER	804,676
2 P50AG08671-06	GILMAN, SID MICHIGAN ALZHEIMERS DISEASE RESEARCH CENTER	08-15-94/05-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	1,751,088

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5 R37AG08678-05	OUSLANDER, JOSEPH G ASSESSMENT & TREATMENT OF INCONTINENCE IN NURSING HOMES	01-01-94/12-31-94	UNIVERSITY OF CALIFORNIA LOS ANGELE	241,087
2 P50AG08702-06	SHELANSKI, MICHAEL L ALZHEIMERS DISEASE RESEARCH CENTER	06-15-94/05-31-95	COLUMBIA UNIVERSITY NEW YORK	1,079,718
5 R37AG08707-05	WEKSLER, MARC E AUTOIMMUNE REACTIONS IN AGING	03-01-94/12-31-94	CORNELL UNIVERSITY MEDICAL CENTER	153,175
5 R01AG08708-05	GOLDSTEIN, SAMUEL MOLECULAR GENETICS OF WERNER SYNDROME & BIOLOGICAL AGING	12-01-93/11-30-94	UNIVERSITY OF ARKANSAS MED SCIS LTL	172,312
5 R29AG08710-05	ROBERTS, EUGENE L, JR AGE RELATED CHANGES IN BRAIN METABOLIC NEUROPHYSIOLOGY	08-01-94/07-31-95	UNIVERSITY OF MIAMI	97,739
5 R29AG08713-05	BECK, THOMAS J STRUCTURAL ANALYSIS OF HIP BONE MINERAL IMAGE DATA	01-01-94/12-31-94	JOHNS HOPKINS UNIVERSITY	120,326
5 R01AG08714-04	OKEN, BARRY S AGE RELATED CHANGES IN ALERTNESS AND VISUAL PROCESSING	05-01-94/04-30-95	OREGON HEALTH SCIENCES UNIVERSITY	102,404
5 R29AG08718-05	SWARTZ, KENNETH P NEUROPSYCHOLOGY OF MUSIC IN AGING & ALZHEIMERS DEMENTIA	03-01-94/02-28-96	UNIVERSITY OF ROCHESTER	109,225
5 R01AG08721-05	FRANGIONE, BLAS AMYLOID ANGIOPATHY, EARLY PLAQUES, AND AGING	01-01-94/12-31-94	NEW YORK UNIVERSITY	230,118
5 R01AG08724-05	GATZ, MARGARET J DEMENTIA IN SWEDISH TWINS	08-01-94/07-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	305,000
5 R29AG08729-05	LEIBSON, CYNTHIA TRENDS IN ELDERLY MORTALITY MORBIDITY AND HOSPITAL USE	08-01-94/07-31-95	MAYO FOUNDATION	113,843
5 R01AG08740-05	FROST, J JAMES OPIATE RECEPTOR QUANTIFICATION IN ALZHEIMERS DISEASE	04-08-94/03-31-95	JOHNS HOPKINS UNIVERSITY	416,911
2 P01AG08761-05	VAUPEL, JAMES W OLDEST-OLD MORTALITY--DEMOGRAPHIC MODELS AND ANALYSIS	03-21-94/12-31-94	DUKE UNIVERSITY	730,212
5 R01AG08768-05	SELTZER, MARSHA M AGING MOTHERS OF DISABLED ADULTS--IMPACTS OF CAREGIVING	02-01-94/01-31-96	UNIVERSITY OF WISCONSIN MADISON	186,383
3 R01AG08768-05S1	SELTZER, MARSHA M AGING MOTHERS OF RETARDED ADULTS--IMPACTS OF CAREGIVING	09-01-94/01-31-95	UNIVERSITY OF WISCONSIN MADISON	133,788

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GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
5 R29AG08776-05	CODY, DIANNA D STRENGTH DENSITY & MICROSTRUCTURE IN THE PROXIMAL FEMUR	02-15-94/01-31-96	CASE WESTERN RESERVE UNIV-HENRY FOR	79,259
5 P01AG08777-04	MANN, KENNETH G REGULATION OF BONE FORMATION	06-01-94/05-31-95	UNIVERSITY OF VERMONT & ST AGRIC CO	448,181
3 P01AG08777-04S1	MANN, KENNETH G REGULATION OF BONE FORMATION	09-30-94/05-31-95	UNIVERSITY OF VERMONT & ST AGRIC CO	76,000
5 R01AG08796-05	DISTERHOFT, JOHN F MECHANISMS OF NIMODIPINE LEARNING ENHANCEMENT IN AGING	03-01-94/02-28-95	NORTHWESTERN UNIVERSITY	197,651
3 R01AG08796-05S1	DISTERHOFT, JOHN F MECHANISMS OF NIMODIPINE LEARNING ENHANCEMENT IN AGING	09-30-94/02-28-95	NORTHWESTERN UNIVERSITY	6,500
5 P01AG08802-05	KURLAND, LEONARD T EPIDEMIOLOGY OF DEMENTIA	03-01-94/11-30-95	MAYO FOUNDATION	1,048,885
2 P60AG08808-06	HALTER, JEFFREY B CLAUDE D PEPPER OLDER AMERICANS INDEPENDENCE CENTER	09-01-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	1,033,709
5 P30AG08812-05	WEI, JEANNE Y GERIATRIC RESEARCH AND TRAINING	03-15-94/02-28-95	HARVARD UNIVERSITY	1,170,280
3 R01AG08816-04S1	CARSTENSEN, LAURA L SOCIAL INTERACTION IN OLD AGE	09-30-94/02-28-95	STANFORD UNIVERSITY	45,216
5 R29AG08820-05	SMITH, STANLEY D ALZHEIMER'S DISEASE--LEXICAL/SEMANTIC & EVENT KNOWLEDGE	01-01-94/12-31-94	GOOD SAMARITAN HOSP & MED CTR(PRTLN	103,212
2 R01AG08825-04A1	FRIEDMAN, HOWARD S PREDICTORS OF HEALTH AND LONGEVITY	09-15-94/06-30-95	UNIVERSITY OF CALIFORNIA RIVERSIDE	141,396
1 R01AG08834-01A4	ARKING, ROBERT MUTATIONAL ANALYSIS OF LONGEVITY ASSURANCE GENES	05-01-94/04-30-95	WAYNE STATE UNIVERSITY	200,798
5 R01AG08835-05	BURKE, DEBORAH M MEMORY AND LANGUAGE IN OLD AGE	12-01-93/11-30-94	POMONA COLLEGE	97,201
5 R29AG08843-04	ANDERSON, KEVIN J EXCITATORY AMINO ACID SYSTEMS IN THE AGED BRAIN	02-15-94/01-31-95	UNIVERSITY OF FLORIDA	87,921
5 R01AG08849-04	DALTON, ARTHUR J DEMENTIA IN DOWN SYNDROME--LONGITUDINAL EVALUATION	02-16-94/01-31-95	NEW YORK STATE OFFICE OF MENTAL HEA	84,073

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GRANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
5 R37AG08861-05	MC CLEARN, GERALD E ORIGINS OF VARIANCE IN THE OLD-OLD--OCTOGENARIAN TWINS	09-01-94/08-31-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	348,598
5 R01AG08885-05	ALTSCHULER, RICHARD A MECHANISMS OF AGE-RELATED AUDITORY SENSORY DEFICITS	03-01-94/02-28-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	332,198
5 R44AG08915-03	GANGULY, DIPANKAR AMBULATORY NON-INVASIVE URINARY INCONTINENCE MONITOR	06-15-94/05-31-95	DIAGNOSTIC DEVICES GROUP	226,609
5 R37AG08937-04	HEYMAN, ALBERT DIFFERENCES IN PREVALENCE AND INCIDENCE OF DEMENTIA	02-01-94/01-31-95	DUKE UNIVERSITY	175,730
3 R37AG08937-04S1	HEYMAN, ALBERT DIFFERENCES IN PREVALENCE AND INCIDENCE OF DEMENTIA	03-18-94/01-31-95	DUKE UNIVERSITY	
5 P01AG08938-10	EPSTEIN, CHARLES J BIOLOGY OF DOWN SYNDROME	08-01-94/07-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	836,312
1 R01AG08947-01A3	ROGERS, JOAN C ASSESSING ELDERS ADL/IADL--EQUALITY OF METHODS AND COSTS	08-10-94/06-30-95	UNIVERSITY OF PITTSBURGH AT PITTSBU	350,000
3 R01AG08948-03S1	TERESI, JEANNE A IMPACT OF SPECIAL CARE UNITS IN NURSING HOMES	04-05-94/08-31-94	HEBREW HOME FOR THE AGED AT RIVERDA	30,000
2 R01AG08948-04	TERESI, JEANNE A IMPACT OF SPECIAL CARE UNITS IN NURSING HOMES	09-20-94/08-31-95	HEBREW HOME FOR THE AGED AT RIVERDA	331,382
5 R01AG08958-04	JERGER, JAMES F AUDITORY REHABILITATION OF THE ELDERLY	04-01-94/03-31-95	BAYLOR COLLEGE OF MEDICINE	141,834
5 R29AG08959-04	BELL, THEODORE S RECEPTIVE COMMUNICATION PROBLEMS OF THE ELDERLY	03-01-94/02-28-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	102,816
5 R01AG08961-04	FRASER, GARY E HEALTH HABITS EFFECT ON SURVIVAL	09-01-94/08-31-95	LOMA LINDA UNIVERSITY	224,482
5 R35AG08967-05	PRUSINER, STANLEY B LEADERSHIP AND EXCELLENCE IN ALZHEIMERS DISEASE	07-20-94/04-30-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	818,620
5 R35AG08974-04	PETTEGREW, JAY W MOLECULAR STUDIES IN ALZHEIMERS DISEASE	04-01-94/03-31-95	UNIVERSITY OF PITTSBURGH AT PITTSBU	633,769
5 R01AG08979-03	RYFF, CAROL D COMMUNITY RELOCATION AND HEALTH--PSYCHOSOCIAL LINKAGES	04-01-94/03-31-95	UNIVERSITY OF WISCONSIN MADISON	270,568

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ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG08991-06	VARSHAVSKY, ALEXANDER J STRESS, REPAIR, AND AGING	05-01-94/04-30-95	CALIFORNIA INSTITUTE OF TECHNOLOGY	250,988
R35AG08992-04	GAMBETTI, PIERLUIGI CELLULAR AND MOLECULAR PATHOLOGY OF ALZHEIMER DISEASE	08-01-94/06-30-95	CASE WESTERN RESERVE UNIVERSITY	730,636
R01AG09009-06	COLE, GREGORY M AMYLOID PRECURSOR IN ALZHEIMER'S DISEASE BRAIN	05-20-94/04-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	106,767
R35AG09014-04	BLASS, JOHN P CELL BIOLOGICAL STUDIES IN ALZHEIMERS DISEASE	05-12-94/04-30-95	WINIFRED MASTERSON BURKE MED RES IN	483,868
R35AG09016-05	COLEMAN, PAUL D LEADERSHIP AND EXCELLENCE IN ALZHEIMERS DISEASE	05-09-94/04-30-95	UNIVERSITY OF ROCHESTER	602,793
P01AG09017-05	CARP, RICHARD I SEARCH FOR A TRANSMISSIBLE AGENT IN ALZHEIMERS DISEASE	05-01-94/04-30-95	INSTITUTE FOR BASIC RES IN DEV DISA	579,527
R01AG09029-04	FARRER, LINDSAY A GENETIC EPIDEMIOLOGICAL STUDIES OF ALZHEIMERS DISEASE	05-20-94/04-30-95	BOSTON UNIVERSITY	311,151
R01AG09031-06	BINDER, LESTER I MICROTUBULE PROTEINS IN ALZHEIMERS DISEASE	09-10-94/04-30-95	MOLECULAR GERIATRICS CORPORATION	207,168
R29AG09055-05	SHIMAMURA, ARTHUR P AGING AND MEMORY--A NEUROPSYCHOLOGICAL ANALYSIS	05-01-94/04-30-95	UNIVERSITY OF CALIFORNIA BERKELEY	97,826
U01AG09087-04	TINETTI, MARY E COMMUNITY BASED MULTIPLE FALL RISK FACTOR INTERVENTION	07-01-94/06-30-95	YALE UNIVERSITY	115,620
U01AG09095-03S3	BUCHNER, DAVID M HEALTH STATUS EFFECTS OF ENDURANCE AND STRENGTH TRAINING	03-11-94/06-30-95	UNIVERSITY OF WASHINGTON	1,340
U01AG09098-03S3	MILLER, J PHILIP REDUCING FRAILTY AND INJURIES IN OLDER PERSONS	06-15-94/06-30-95	WASHINGTON UNIVERSITY	10,045
U01AG09098-03S4	MILLER, J PHILIP REDUCING FRAILTY AND INJURIES IN OLDER PERSONS	08-10-94/06-30-95	WASHINGTON UNIVERSITY	108,929
R01AG09121-05	LANGSTON, J WILLIAM AGING AND ENVIRONMENTAL TOXINS	04-01-94/03-31-95	PARKINSON'S INSTITUTE	417,272
R01AG09127-05	REISBERG, BARRY BEHAVIORAL AND PSYCHOTIC SYMPTOMS IN ALZHEIMERS DISEASE	05-25-94/04-30-95	NEW YORK UNIVERSITY	207,921

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ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG09186-04	MALMGREN, LESLIE T AGING LARYNGEAL PROTECTIVE MECHANISM	08-01-94/07-31-95	HEALTH SCIENCE CENTER AT SYRACUSE	148,233
R01AG09191-04	GORDON-SALANT, SANDRA M AUDITORY TEMPORAL PROCESSES, SPEECH PERCEPTION AND AGING	03-01-94/02-28-95	UNIVERSITY OF MARYLAND COLLEGE PK C	173,539
R01AG09203-04	LABOUVIE-VIEF, GISELA COGNITIVE EMOTIONAL MATURITY IN ADULTHOOD AND AGING	07-01-94/06-30-95	WAYNE STATE UNIVERSITY	243,477
R29AG09208-04	ZABRUCKY, KAREN M AGING AND EVALUATION AND REGULATION OF UNDERSTANDING	07-01-94/06-30-95	GEORGIA STATE UNIVERSITY	84,411
R01AG09210-03	RUBINSTEIN, ROBERT L CAREGIVING FROM THE CARE RECEIVER'S PERSPECTIVE	09-01-94/08-31-95	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	94,573
R29AG09214-04	RANCE, NAOMI E REPRODUCTIVE AGING AND THE HYPOTHALAMUS	06-05-94/05-31-95	UNIVERSITY OF ARIZONA	104,561
R29AG09214-04S1	RANCE, NAOMI E REPRODUCTIVE AGING AND THE HYPOTHALAMUS	09-25-94/05-31-95	UNIVERSITY OF ARIZONA	99,853
P01AG09215-05	TROJANOWSKI, JOHN Q MOLECULAR SUBSTRATES OF AGING AND NEURON DEATH	05-10-94/04-30-95	UNIVERSITY OF PENNSYLVANIA	1,011,147
R01AG09216-05	CRAIN, BARBARA J PATHOLOGY OF FASCIA DENTATA IN ALZHEIMERS DISEASE	07-01-94/06-30-95	JOHNS HOPKINS UNIVERSITY	116,317
R01AG09219-04	BARNES, CAROL A TRANSCRIPTION FACTOR GENES, NEURONAL PLASTICITY, & AGING	06-01-94/05-31-95	UNIVERSITY OF ARIZONA	197,494
R01AG09220-04	NELSON, JAMES F AGING AND THE REGULATION OF ESTROGEN ACTION IN THE BRAIN	02-01-94/01-31-96	UNIVERSITY OF TEXAS HLTH SCI CTR SA	174,668
R29AG09229-05	YANKNER, BRUCE A AMYLOID NEUROTOXICITY AND BIOLOGICAL FUNCTION	08-01-94/07-31-95	CHILDREN'S HOSPITAL (BOSTON)	97,800
R01AG09235-05	NEBERT, DANIEL W OXIDATIVE STRESS CELL DEATH AND THE AH GENE BATTERY	09-01-94/08-31-95	UNIVERSITY OF CINCINNATI	258,262
R01AG09238-03	MORTIMER, JAMES A EPIDEMIOLOGY OF ALZHEIMER DISEASE IN A TOTAL POPULATION	09-01-94/08-31-95	UNIVERSITY OF MINNESOTA TWIN CITIES	448,130
R01AG09241-04	WRONSKI, THOMAS J RESTORATION OF LOST BONE MASS AFTER OVARIECTOMY	07-01-94/06-30-95	UNIVERSITY OF FLORIDA	76,726

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ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG09253-04	JOHNSON, MARCIA K AGING EFFECTS ON MEMORY FOR SOURCE OF INFORMATION	09-30-94/08-31-95	PRINCETON UNIVERSITY	216,330
R01AG09254-03	MORROW, DANIEL G IMPROVING MEDICATION INSTRUCTIONS FOR THE ELDERLY	09-01-94/07-31-95	UNIVERSITY OF NEW HAMPSHIRE	120,496
R01AG09258-03	KAY, MARGUERITE M B IMMUNOCHEMISTRY OF AN AGING ANTIGEN	06-01-94/05-31-95	UNIVERSITY OF ARIZONA	162,709
R01AG09276-05	BAREFOOT, JOHN C GENDER AND AGE DIFFERENCES IN HOSTILITY	08-01-94/07-31-95	DUKE UNIVERSITY	168,974
R01AG09278-04	WANG, EUGENIA FIBROBLAST AGING AND PROGRAMMED CELL DEATH	09-30-94/08-31-95	MC GILL UNIVERSITY	131,240
R29AG09282-04	ALLEN, PHILIP A ADULT AGE DIFFERENCES IN COGNITIVE NOISE	08-01-94/07-31-95	CLEVELAND STATE UNIVERSITY	88,877
R01AG09287-05	PERRY, GEORGE NEUROFIBRILLARY PATHOLOGY IN ALZHEIMERS DISEASE	09-01-94/08-31-95	CASE WESTERN RESERVE UNIVERSITY	174,129
R01AG09291-04	BOURGEOIS, MICHELLE S INTERVENTIONS TO CHANGE CAREGIVING AND AD PATIENT OUTCOM	09-01-94/08-31-95	UNIVERSITY OF PITTSBURGH AT PITTSBU	190,327
R01AG09297-04	TUREK, FRED W AGE EFFECTS ON CIRCADIAN CLOCKS	05-12-94/04-30-95	NORTHWESTERN UNIVERSITY	148,331
R01AG09299-03	MIZUMORI, SHERI J HIPPOCAMPAL SPATIAL REPRESENTATIONS	05-20-94/04-30-95	UNIVERSITY OF UTAH	73,106
R01AG09300-04	FELSON, DAVID T LONGITUDINAL OSTEOARTHRITIS STUDY IN AN ELDERLY COHORT	05-20-94/04-30-95	BOSTON UNIVERSITY	264,801
R01AG09309-05	SENGELAUB, DALE R STEROIDS AS TROPHIC FACTORS--AGING NEUROMUSCULAR SYSTEM	08-01-94/07-31-95	INDIANA UNIVERSITY BLOOMINGTON	129,248
R01AG09320-05	GOLDGABER, DMITRY Y REGULATION OF ALZHEIMER AMYLOID PRECURSOR GENE	09-01-94/08-31-95	STATE UNIVERSITY NEW YORK STONY BRO	176,837
R01AG09321-04	FLOOD, JAMES F MODEL OF DEMENTIA--SENESCENCE ACCELERATED	06-10-94/05-31-95	ST. LOUIS UNIVERSITY	135,915
R37AG09326-05	EDELMAN, GERALD M CONTROL OF CAM EXPRESSION IN TRANSGENIC MICE	07-01-94/06-30-95	SCRIPPS RESEARCH INSTITUTE	338,592

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R29AG09344-05	LAWRENCE, RENEE H PHYSICAL AND EMOTIONAL HEALTH AMONG THE ELDERLY	02-10-94/07-31-94	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	
R29009 344-06	LAWRENCE, RENEE H PHYSICAL AND EMOTIONAL HEALTH AMONG THE ELDERLY	08-01-94/01-31-96	NEW ENGLAND RESEARCH INSTITUTE, INC	112,216
R01AG09345-01A3	CAVANAGH, PETER R POSTURE IN THE NEUROPATHIC DIABETIC ELDERLY	09-10-94/08-31-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	235,643
R01AG09375-05	MC GARVEY, STEPHEN T ADIPOSITY INSULIN ELECTROLYTES AND BLOOD PRESSURE	02-16-94/01-31-95	MIRIAM HOSPITAL	323,826
R01AG09383-04	GREIDER, CAROL W STRUCTURE AND FUNCTION OF TELOMERES IN MAMMALIAN AGING	08-01-94/07-31-95	COLD SPRING HARBOR LABORATORY	260,870
R01AG09388-02	SELTZER, MARSHA M CAREGIVING IMPACT--DURATION AND RELATIONSHIP EFFECTS	03-01-94/02-28-95	UNIVERSITY OF WISCONSIN MADISON	157,536
R01AG09389-03	TAGER, IRA B EPIDEMIOLOGY OF AGING AND PHYSICAL PERFORMANCE	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA BERKELEY	503,037
R01AG09399-04	GROSSMAN, MURRAY CONGNITIVE PROFILES IN ALZHEIMERS DISEASE AND AGING	03-01-94/02-28-95	UNIVERSITY OF PENNSYLVANIA	222,177
R01AG09400-03	SCHUPF, NICOLE DOWN SYNDROME & ALZHEIMER DISEASE--FAMILIAL AGGREGATION	06-01-94/05-31-95	INSTITUTE FOR BASIC RES IN DEV DISA	335,481
R01AG09411-04	GLENNER, GEORGE G PAIRED HELICAL FILAMENTS AND PLAQUE AMYLOID PROTEINS	05-01-94/04-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	177,676
R01AG09413-04	SHMOOKLER-REIS, ROBERT J POLYMORPHIC GENES MODULATING LIFESPAN IN C ELEGANS	08-10-94/07-31-95	UNIVERSITY OF ARKANSAS MED SCIS LTL	153,981
R29AG09425-03	MASTERS, JEFFREY N NEUROENDOCRINE MECHANISMS OF BRAIN AGING	06-15-94/05-31-95	OHIO STATE UNIVERSITY	91,129
R29AG09433-04	HUMMERT, MARY L STEREOTYPES OF THE ELDERLY AND COMMUNICATION	08-01-94/07-31-95	UNIVERSITY OF KANSAS LAWRENCE	99,998
R01AG09439-04	SILVERMAN, WAYNE P AGING AND MENTAL RETARDATION--CHANGES IN PROCESSING RATE	03-01-94/02-28-95	NEW YORK STATE OFFICE OF MENTAL HEA	278,023
R01AG09440-03	ZINSMEISTER, ALAN R IMPACT OF FUNCTIONAL BOWEL DISEASE IN THE ELDERLY	06-01-94/05-31-95	MAYO FOUNDATION	228,922

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG09453-04	VLASSARA, HELEN AGING AND VASCULAR DISEASE--ROLE OF GLYCATION	01-01-94/12-31-94	PICOWER INSTITUTE FOR MEDICAL RESEA	196,883
R01AG09458-04	LIPSCHITZ, DAVID A NEUTROPHIL FUNCTION AND AGING	09-01-94/08-31-95	UNIVERSITY OF ARKANSAS MED SCIS LTL	185,284
R01AG09461-03	PRINEAS, RONALD J EPIDEMIOLOGY OF ALZHEIMERS DISEASE	06-05-94/05-31-95	UNIVERSITY OF MIAMI	1,560,728
R29AG09462-04	LEVIN, JEFFREY S RELIGION, HEALTH & PSYCHOLOGICAL WELL-BEING IN THE AGED	01-10-94/12-31-94	EASTERN VIRGINIA MED SCH/MED COL HA	105,228
P01AG09464-04	GREENGARD, PAUL SIGNAL TRANSDUCTION AND ALZHEIMERS DISEASE	02-15-94/01-31-95	ROCKEFELLER UNIVERSITY	1,147,976
P01AG09466-04	DETOLEDO-MORRELL, LEYLA ANATOMIC, PHYSIOLOGIC AND COGNITIVE PATHOLOGY OF AD	04-20-94/03-31-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	437,050
R01AG09470-04	GLORIOSO, JOSEPH C ALZHEIMERS DISEASE STUDIES USING HSV GENE TRANSFER	03-03-94/12-31-95	UNIVERSITY OF PITTSBURGH AT PITTSBU	169,276
P01AG09480-04	LLINAS, RODOLFO R AGING AND NEURONAL DEATH--ROLE OF CYTOSOLIC CALCUIM	02-10-94/01-31-95	NEW YORK UNIVERSITY	630,349
R29AG09486-04	CHAPMAN, SANDRA B COGNITIVE DISCOURSE PROCESSING IN ELDERLY POPULATIONS	09-01-94/08-31-95	UNIVERSITY OF TEXAS DALLAS	97,784
R29AG09486-04S1	CHAPMAN, SANDRA B COGNITIVE DISCOURSE PROCESSING IN ELDERLY POPULATIONS	09-01-94/08-31-95	UNIVERSITY OF TEXAS DALLAS	18,634
R01AG09519-04	KEEFOVER, ROBERT SCREENING FOR ALZHEIMERS DISEASE IN A RURAL POPULATION	06-10-94/05-31-95	WEST VIRGINIA UNIVERSITY	218,496
R01AG09521-08	BLAU, HELEN M ACTIVATORS OF MUSCLE GENES	05-01-94/03-31-95	STANFORD UNIVERSITY	311,409
R01AG09521-08S1	BLAU, HELEN M ACTIVATORS OF MUSCLE GENES	08-20-94/03-31-95	STANFORD UNIVERSITY	58,891
P01AG09524-03	FRISINA, ROBERT D AGING AUDITORY SYSTEM--PRESBYCUSIS AND ITS NEURAL BASES	04-05-94/03-31-95	ROCHESTER INSTITUTE OF TECHNOLOGY	779,780
P01AG09525-03	BLUSZTAJN, JAN K AGING OF BRAIN--EFFECTS OF PERINATAL CHOLINE EXPOSURE	12-10-93/11-30-94	BOSTON UNIVERSITY	856,054

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG09531-02	NAIR, SREEKUMARAN K MECHANISM OF MUSCLE WASTING IN AGING MAN	04-20-94/09-30-94	UNIVERSITY OF VERMONT & ST AGRIC CO	120,795
R01AG09531-03	NAIR, SREEKUMARAN K MECHANISM OF MUSCLE WASTING IN AGING MAN	09-30-94/03-31-95	MAYO FOUNDATION	124,433
R01AG09538-03	LIPSITZ, LEWIS A DRUG-RELATED HYPOTENSION IN THE AGED WITH HEART DISEASE	07-01-94/06-30-95	HEBREW REHABILITATION CENTER FOR AG	166,633
R01AG09542-03	SZILAGYI, JULIANNA E AGING AND CARDIOVASCULAR FUNCTION	07-01-94/06-30-95	UNIVERSITY OF HOUSTON-UNIVERSITY PA	97,022
R01AG09550-04	SCHWARTZ, JANICE B REGULATION OF CARDIAC RHYTHM AND CONDUCTION WITH AGING	02-10-94/01-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	273,753
R01AG09556-02	PSATY, BRUCE M EPIDEMIOLOGY OF ANTI-HYPERTENSIVE DRUGS IN THE ELDERLY	09-01-94/08-31-95	UNIVERSITY OF WASHINGTON	154,822
R01AG09557-05	STRONG, RANDY MODULATION OF TH GENE EXPRESSION BY RESERPINE AND AGE	02-10-94/07-31-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	127,331
R01AG09568-04	JINKS, MARTIN J REDUCTION IN ADRS VIA COMPUTERIZED PHARMACY INTERVENTION	02-16-94/01-31-95	WASHINGTON STATE UNIVERSITY	121,971
R01AG09574-04	RUBIN, ROBERT L NEUTROPHIL MEDIATED DRUG TOXICITY IN THE ELDERLY	03-01-94/01-31-95	SCRIPPS RESEARCH INSTITUTE	236,192
R01AG09594-05	SMITH, PHILIP C PROTEIN GLYCATION BY ACYL GLUCURONIDES IN THE ELDERLY	02-15-94/01-31-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	169,867
R01AG09597-04	HOFFMAN, BRIAN B MOLECULAR PHARMACOLOGY OF ADRENERGIC RECEPTORS IN AGING	02-10-94/01-31-95	STANFORD UNIVERSITY	157,780
R01AG09632-04	GRAVENSTEIN, STEFAN AMANTADINE IN THE NURSING HOME	08-01-94/07-31-95	UNIVERSITY OF WISCONSIN MADISON	219,713
R01AG09644-03	MC NEILL, THOMAS H AGING OF THE STRIATAL MOTOR SYSTEM IN MAN	07-01-94/06-30-95	UNIVERSITY OF SOUTHERN CALIFORNIA	145,384
P20AG09646-05	HAYWARD, MARK D EXPLORATORY CENTER ON AGING AND HEALTH IN RURAL AMERICA	09-01-94/08-31-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	246,892
P20AG09646-05S1	HAYWARD, MARK D EXPLORATORY CENTER ON AGING AND HEALTH IN RURAL AMERICA	09-30-94/08-31-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	29,534

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ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
P20AG09648-05	DEFRIESE, GORDON H HEALTH RESEARCH FOR THE OLDER RURAL POPULATION	09-10-94/08-31-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	249,999
P20AG09649-04	COWARD, RAYMOND T FLORIDA EXPLORATORY CENTER ON THE HEALTH OF RURAL ELDERS	09-30-94/05-31-95	UNIVERSITY OF FLORIDA	249,985
R01AG09657-04	LANDEFELD, C SETH ANTICOAGULANT THERAPY IN OLDER PATIENTS	07-01-94/06-30-95	CASE WESTERN RESERVE UNIVERSITY	227,858
R01AG09661-03	CAPLAN, DAVID N PROCESSING RESOURCES AND SENTENCE COMPREHENSION	05-01-94/04-30-95	MASSACHUSETTS GENERAL HOSPITAL	211,721
R01AG09663-04	REVES, JOSEPH G AGING AND COGNITION AFTER CARDIAC SURGERY	02-10-94/01-31-95	DUKE UNIVERSITY	384,761
R01AG09665-09	POTTER, HUNTINGTON EXPRESSION STUDIES ON ALZHIEMERS DISEASE RELATED GENES	07-01-94/06-30-95	HARVARD UNIVERSITY	145,566
U01AG09675-04A1	WOLFSON, LESLIE I TRAINING PHYSICAL PERFORMANCE TO IMPROVE FUNCTION	09-30-94/08-31-95	UNIVERSITY OF CONNECTICUT HEALTH CE	459,100
P20AG09682-03S1	WALLACE, ROBERT B CENTER FOR RESEARCH ON OLDER RURAL POPULATIONS	09-15-94/08-31-95	UNIVERSITY OF IOWA	250,000
R01AG09686-04	BAKER, HARRIET D PLASTICITY IN THE AGING OLFACTORY SYSTEM	02-15-94/01-31-95	WINIFRED MASTERSON BURKE MED RES IN	187,251
R01AG09690-04	FLOYD, ROBERT A AGE INFLUENCE ON ISCHEMIA REPERFUSION IN BRAIN	05-01-94/04-30-95	OKLAHOMA MEDICAL RESEARCH FOUNDATIO	152,477
R01AG09690-04S1	FLOYD, ROBERT A AGE INFLUENCE ON ISCHEMIA REPERFUSION IN BRAIN	09-20-94/04-30-95	OKLAHOMA MEDICAL RESEARCH FOUNDATIO	61,850
R37AG09692-05	WOLINSKY, FREDRIC D PANEL ANALYSIS OF THE AGED'S USE OF HEALTH SERVICES	06-05-94/05-31-95	INDIANA UNIV-PURDUE UNIV AT INDIANA	145,422
R01AG09693-04	BALOH, ROBERT W DIZZINESS IN OLDER PEOPLE	04-01-94/03-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	431,686
R01AG09694-03	BOLTON, DAVID C AGING AND BRAIN AMYLOID PRECURSORS ON LYMPHOCYTES	08-01-94/07-31-95	INSTITUTE FOR BASIC RES IN DEV DISA	164,902
R01AG09699-05	GOLDMAN, NOREEN MARITAL STATUS, HEALTH AND MORTALITY AMONG THE ELDERLY	08-01-94/07-31-95	PRINCETON UNIVERSITY	123,045

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ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R44AG09712-02	SYED, DANIEL ADVISOR FOR CAREGIVERS TO ALZHEIMERS PATIENTS	03-01-94/02-28-95	ATLANTIC MICROSYSTEMS INC.	249,955
R44AG09715-03	JETTE, ALAN M MUSCLE STRNGTHNING VIDEOTAPE FOR OLDER PERSONS	03-18-94/02-28-95	NEW ENGLAND RESEARCH INSTITUTE, INC	239,854
R44AG09716-03	PINCUS, STEVEN M NONLINEAR CARDIOVASCULAR DYNAMICS OF AGING	08-01-94/07-31-95	CHAOTIC DYNAMICAL SYSTEMS	202,589
R44AG09720-02A2	TENNSTEDT, SHARON VIDEOTAPE TO TRAIN INTERVIEWERS IN SURVEYS OF OLD PEOPLE	03-01-94/02-28-95	NEW ENGLAND RESEARCH INSTITUTE, INC	323,791
R44AG09727-03	ROENKER, DANIEL L PERCEPTUAL ASSESSMENT IMPROVEMENT OF THE OLDER DRIVER	09-01-94/08-31-95	VISUAL RESOURCES, INC.	183,531
R01AG09735-13	BRADSHAW, RALPH A STRUCTURE AND FUNCTION OF NERVE GROWTH FACTOR	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA IRVINE	230,145
U01AG09740-05	JUSTER, F THOMAS HEALTH AND RETIREMENT STUDY	01-15-94/12-31-94	UNIVERSITY OF MICHIGAN AT ANN ARBOR	4,941,059
U01AG09740-05S1	JUSTER, F THOMAS HEALTH AND RETIREMENT STUDY	08-01-94/12-31-94	UNIVERSITY OF MICHIGAN AT ANN ARBOR	55,000
U01AG09740-05S2	JUSTER, F THOMAS HEALTH AND RETIREMENT STUDY	09-01-94/12-31-94	UNIVERSITY OF MICHIGAN AT ANN ARBOR	100,000
U01AG09740-05S3	JUSTER, F THOMAS HEALTH AND RETIREMENT STUDY	09-20-94/12-31-94	UNIVERSITY OF MICHIGAN AT ANN ARBOR	150,000
U01AG09740-05S4	JUSTER, F THOMAS HEALTH AND RETIREMENT STUDY	09-30-94/12-31-94	UNIVERSITY OF MICHIGAN AT ANN ARBOR	50,000
U01AG09740-05S5	JUSTER, F THOMAS HEALTH AND RETIREMENT STUDY	09-30-94/12-31-94	UNIVERSITY OF MICHIGAN AT ANN ARBOR	200,000
P01AG09743-04	BURKHAUSER, RICHARD V WELLBEING OF THE ELDERLY IN A COMPARATIVE CONTEXT	06-15-94/05-31-95	SYRACUSE UNIVERSITY AT SYRACUSE	446,460
R01AG09744-04	JOHNSON, MARCIA K SEMANTIC MEMORY AND ALZHIEMERS DISEASE	08-01-94/07-31-95	PRINCETON UNIVERSITY	166,316
R01AG09752-04	WOODRUFF-PAK, DIANA S AGING, CLASSICAL CONDITIONING, AND MEMORY SYSTEMS	05-12-94/04-30-95	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	144,708

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ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG09755-04	MACKAY, DON G ORIGIN OF COGNITIVE PROCESSES IN OLD AGE	06-01-94/04-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	165,616
R01AG09755-04S1	MACKAY, DON G ORIGIN OF COGNITIVE PROCESSES IN OLD AGE	09-05-94/04-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	20,933
R01AG09761-05	GAFNI, ARI LASER SPECTROSCOPY OF TRIPLET STATES IN PROTEINS	09-01-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	226,060
R01AG09769-04	LARSON, ERIC B EPIDEMIOLOGY OF DEMENTIA	05-15-94/04-30-95	UNIVERSITY OF WASHINGTON	793,934
R01AG09769-04S1	LARSON, ERIC B EPIDEMIOLOGY OF DEMENTIA	07-20-94/04-30-95	UNIVERSITY OF WASHINGTON	44,943
R01AG09771-02S1	APPLEGATE, WILLIAM B DIETARY INTERVENTIONS IN THE ELDERLY TRIAL	04-09-93/03-31-94	UNIVERSITY OF TENNESSEE AT MEMPHIS	115,333
R01AG09771-03	APPLEGATE, WILLIAM B DIETARY INTERVENTIONS IN THE ELDERLY TRIAL	04-18-94/03-31-95	UNIVERSITY OF TENNESSEE AT MEMPHIS	392,731
R01AG09773-04	ESPELAND, MARK A DIETARY INTERVENTION IN THE ELDERLY TRIAL (DIET)	09-01-94/08-31-95	WAKE FOREST UNIVERSITY	488,849
R01AG09775-03S1	HAUSER, ROBERT M LONGITUDINAL STUDY--PARENTS AND CHILDREN AT AGE 50	09-15-94/05-31-95	UNIVERSITY OF WISCONSIN MADISON	50,000
R29AG09777-03	WALLSTEN, SHARON M ELDERLY CAREGIVERS, CARE RECEIVERS AND THEIR INTERACTION	08-01-94/07-31-95	DUKE UNIVERSITY	108,540
R01AG09779-07	LANG, PETER J EMOTION AND AGING--COGNITIVE PSYCHOPHYSIOLOGY	02-01-94/01-31-95	UNIVERSITY OF FLORIDA	52,374
R01AG09781-03	WACHTER, KENNETH W PROJECTING KINSHIP RESOURCES FOR THE ELDERLY	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA BERKELEY	145,579
R29AG09785-04	HAAN, MARY N EPIDEMIOLOGY OF SURVIVAL IN OLDER BLACKS AND WHITES	08-01-94/07-31-95	KAISER FOUNDATION RESEARCH INSTITUT	71,493
R13AG09787-04	SCHAIE, K WARNER CONFERENCE--STRUCTURE AND AGING	04-01-94/03-31-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	22,879
R01AG09791-03	YOUNG, ROSALIE F CULTURAL IMPACT ON CAREGIVING OUTCOME--ALZHEIMER'S PTS	07-01-94/05-31-95	WAYNE STATE UNIVERSITY	181,686

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ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
P01AG09793-04	HEFTI, FRANZ F DOPAMINERGIC AND BASAL PLASTICITY IN AGING	06-15-94/05-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	771,651
R01AG09799-03	ETTINGER, WALTER H, JR DIETARY INTERVENTIONS IN THE ELDERLY TRIAL	05-01-94/04-30-95	WAKE FOREST UNIVERSITY	491,802
R37AG09801-05	MILLER, RICHARD A ACTIVATION DEFECTS IN AGING T CELLS	08-01-94/07-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	241,397
R01AG09822-03	HOBBS, MONTE V CYTOKINE GENE EXPRESSION BY CD4+ CELLS IN AGING MICE	02-15-94/12-31-94	SCRIPPS RESEARCH INSTITUTE	217,432
R01AG09825-03	LACROIX, ANDREA Z THIAZIDE DIURETICS AND RATE OF BONE LOSS IN THE ELDERLY	07-01-94/06-30-95	CENTER FOR HEALTH STUDIES	356,054
R01AG09834-04	STABLER, SALLY P PREVALENCE AND SPECTRUM OF B12 DEFICIENCY IN THE AGED	06-01-94/05-31-95	UNIVERSITY OF COLORADO HLTH SCIENCE	201,402
R29AG09837-03	KINOSIAN, BRUCE ASSESSMENT OF MALNUTRITION IN THE HOSPITALIZED ELDERLY	09-01-94/08-31-95	UNIVERSITY OF PENNSYLVANIA	85,860
R01AG09839-04	ROSS, A CATHERINE NUTRITION AND AGING--VITAMIN AND IMMUNE FUNCTION	07-01-94/05-31-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	164,419
R01AG09857-03	GERBER, JOHN G AGE RELATED CHANGES IN ADRENERGIC CLINICAL PHARMACOLOGY	08-01-94/07-31-95	UNIVERSITY OF COLORADO HLTH SCIENCE	208,470
R01AG09862-05	SNOWDON, DAVID A INDEPENDENT AND DEPENDENT LIFE IN THE ELDERLY	09-01-94/08-31-95	UNIVERSITY OF KENTUCKY	784,347
R01AG09868-03	PARK, DENISE C AGING, ARTHRITIS AND MEDICATION ADHERENCE	02-15-94/01-31-95	UNIVERSITY OF GEORGIA	362,665
R01AG09872-03	NADEL, ETHAN R BODY FLUID REGULATION IN AGING ADULTS WITH EXERCISE	06-01-94/05-31-95	JOHN B. PIERCE LABORATORY, INC.	344,560
R01AG09884-04	WOLFE, BARRY B AGING AND CENTRAL CHOLINERGIC SYSTEMS	07-01-94/05-31-95	GEORGETOWN UNIVERSITY	151,989
R01AG09884-04S1	WOLFE, BARRY B AGING AND CENTRAL CHOLINERGIC SYSTEMS	09-30-94/05-31-95	GEORGETOWN UNIVERSITY	23,902
R01AG09892-03	PELCHAT, MARCIA L FOOD PREFERENCES AND AVERSIONS IN THE ELDERLY	06-05-94/05-31-95	MONELL CHEMICAL SENSES CENTER	107,860

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG09900-04	EBERWINE, JAMES H GENE EXPRESSION IN SINGLE AGING NEURONS AND GLIA	05-20-94/04-30-95	UNIVERSITY OF PENNSYLVANIA	177,971
R37AG09901-03	MAGAZINER, JAY S DETERMINANTS OF RECOVERY FROM HIP FRACTURE (BONE/MUSCLE)	07-01-94/06-30-95	UNIVERSITY OF MARYLAND BALT PROF SC	294,443
R37AG09901-03S1	MAGAZINER, JAY S DETERMINANTS OF RECOVERY FROM HIP FRACTURE	09-30-94/06-30-95	UNIVERSITY OF MARYLAND BALT PROF SC	189,952
R01AG09905-03S1	ABRAHAM, CARMELA R AMYLOIDOGENESIS ROLE OF REACTIVE ASTROCYTES	06-15-94/11-30-94	BOSTON UNIVERSITY	41,125
R44AG09907-03	LERNER, NEIL D INTEGRATED CLIMBING/REACHING PRODUCT FOR THE ELDERLY	05-10-94/04-30-95	COMSIS CORPORATION	120,266
R01AG09909-05	CAMPISI, JUDITH CELLULAR SENESCENCE AND CONTROL OF GENE EXPRESSION	09-10-94/08-31-95	UNIVERSITY OF CALIFORNIA BERKELEY	257,414
R44AG09911-03	GLASKY, ALVIN J AIT-082--A DRUG FOR TREATMENT OF ALZHEIMER'S DISEASE	08-01-94/07-31-95	ADVANCED IMMUNOTHERAPEUTICS	177,235
R29AG09927-05	PEACOCKE, MONICA AGING EFFECT ON RETINOIC ACID RECEPTOR EXPRESSION	09-20-94/08-31-95	NEW ENGLAND MEDICAL CENTER HOSPITAL	110,646
R01AG09936-04	HORN, JOHN L CAUSES IN ADULT DEVELOPMENT OF DIFFERENCES IN ABILITIES	09-05-94/08-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	131,830
R01AG09945-02	STERN, JUDITH S AGING IN MALE AND FEMALE OBESE RATS	01-01-94/12-31-94	UNIVERSITY OF CALIFORNIA DAVIS	160,223
R01AG09948-03	THOMAN, MARILYN L T CELL MAINTENANCE AND THYMIC ACTIVITY IN THE AGED	09-15-94/08-31-95	SCRIPPS RESEARCH INSTITUTE	221,400
R01AG09951-03	GUSTMAN, ALAN L PENSION TRENDS, RETIREMENT INCOMES AND BEHAVIOR	06-01-94/05-31-95	NATIONAL BUREAU OF ECONOMIC RESEARC	84,478
R01AG09952-01A3	KEMPER, SUSAN SPEECH ACCOMMODATIONS BY AND TO OLDER ADULTS	12-01-93/11-30-94	UNIVERSITY OF KANSAS LAWRENCE	100,655
R01AG09952-01A3S1	KEMPER, SUSAN SPEECH ACCOMMODATIONS BY AND TO OLDER ADULTS	07-01-94/11-30-94	UNIVERSITY OF KANSAS LAWRENCE	27,396
R01AG09956-04	HENDRIE, HUGH C DEMENTIAS--INDIANAPOLIS/IBADAN COMPARATIVE PREVALENCE	07-10-94/06-30-95	INDIANA UNIV-PURDUE UNIV AT INDIANA	595,020

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R01AG09956-04S1	HENDRIE, HUGH C DEMENTIAS--INDIANAPOLIS/IBADAN COMPARATIVE PREVALENCE	07-15-94/06-30-95	INDIANA UNIV-PURDUE UNIV AT INDIANA	50,689
R01AG09957-01A3	MEYER, BONNIE J F MINIMIZING AGE DIFFERENCES IN READING--HOW AND WHY	01-01-94/12-31-94	PENNSYLVANIA STATE UNIVERSITY-UNIV	176,400
R01AG09966-04	EVANS, DENIS A EPIDEMIOLOGIC STUDY OF PERSONS WITH ALZHEIMERS DISEASE	09-01-94/08-31-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	214,678
P01AG09970-03	ROSE, MICHAEL R POSTONED AGING IN DROSOPHILA	08-01-94/06-30-95	UNIVERSITY OF CALIFORNIA IRVINE	442,093
P01AG09973-04	GALLAGHER, MICHELA COGNITION AND HIPPOCAMPAL/CORTICAL SYSTEMS IN AGING	08-20-94/07-31-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	998,589
P01AG09975-04	CZEISLER, CHARLES A SLEEP, AGING, AND CIRCADIAN RHYTHM DISORDERS	08-01-94/07-31-95	BRIGHAM AND WOMEN'S HOSPITAL	767,243
R29AG09976-04	JOHNSON, MITZI M AGE DIFFERENCES IN DECISION MAKING PERFORMANCE	09-01-94/08-31-95	UNIVERSITY OF KENTUCKY	88,573
R01AG09978-02	HOUSE, JAMES S STRATIFICATION, ADAPTATION, AGING AND HEALTH	07-01-94/06-30-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	358,375
R29AG09986-03	MEANS, KEVIN M FUNCTIONAL PERFORMANCE-BASED REHABILITATION OF FALLERS	08-25-94/06-30-95	UNIVERSITY OF ARKANSAS MED SCIS LTL	82,186
R01AG09989-12	COWAN, NICHOLAS J MAMMALIAN TUBULIN ISOTYPES & THEIR INTERACTION WITH MAPS	07-01-94/04-30-95	NEW YORK UNIVERSITY	275,260
R01AG09991-03	HASKELL, WILLIAM L COMMUNITY EXERCISE TRAINING IN OLDER WOMEN AND MEN	07-01-94/06-30-95	STANFORD UNIVERSITY	348,869
R01AG09997-03	WELSH, KATHLEEN A NEUROPSYCHOLOGICAL STUDY OF ALZHEIMERS DISEASE	07-01-94/06-30-95	DUKE UNIVERSITY	123,801
R01AG10002-03S1	FASMAN, GERALD D SYNTHETIC MODELS OF ALZHEIMER PROTEINS	09-01-93/02-28-95	BRANDEIS UNIVERSITY	33,385
R01AG10002-03S2	FASMAN, GERALD D SYNTHETIC MODELS OF ALZHEIMER PROTEINS	09-30-94/02-28-95	BRANDEIS UNIVERSITY	131,660
R01AG10003-03	POIRIER, JUDES SYNAPTIC PLASTICITY DURING AGING AND ALZHEIMERS DISEASE	09-01-94/08-31-95	MC GILL UNIVERSITY	75,579

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG10004-07	CAMPISI, JUDITH GROWTH REGULATION IN NORMAL AND TRANSFORMED CELLS	08-01-94/07-31-95	UNIVERSITY OF CALIF-LAWRENC BERKELE	215,592
R01AG10009-04	FURMAN, JOSEPH M VESTIBULO/OCULAR FUNCTION IN THE ELDERLY	08-08-94/07-31-95	UNIVERSITY OF PITTSBURGH AT PITTSBU	99,422
R01AG10014-03	ROHLAND, NEIL E THIRST MECHANISMS IN AGING	09-01-94/07-31-95	UNIVERSITY OF FLORIDA	127,255
R29AG10025-03	HOUMARD, JOSEPH A GLUCOSE TRANSPORTERS AND THE INSULIN RESISTANCE OF AGING	06-01-94/05-31-95	EAST CAROLINA UNIVERSITY	82,875
R29AG10026-03	CARTEE, GREGORY D AGE EFFECTS ON EXERCISE STIMULATION OF GLUCOSE TRANSPORT	05-01-94/04-30-95	UNIVERSITY OF WISCONSIN MADISON	89,576
R01AG10030-03	KALARIA, RAJESH N AMYLOID PROTEINS OF CEREBRAL MICROVESSELS IN AGING	07-01-94/06-30-95	CASE WESTERN RESERVE UNIVERSITY	129,036
N03AG10042-04	PROFESSIONAL AND MEDICAL SUPPORT SERVICES	10-01-93/09-30-94	CHESAPEAKE PHYSICIANS PROFESSIONAL	29,475
N03AG10046-03	PROVIDE UNARMED GUARD SERVICES	10-01-93/09-30-94	SSC SMALL BUSINESS MARYLAND	141,228
N03AG10046-04	PROVIDE UNARMED GUARD SERVICES	11-09-93/09-30-94	SSC SMALL BUSINESS MARYLAND	
N03AG10046-05	PROVIDE UNARMED GUARD SERVICES	06-29-94/09-30-94	SSC SMALL BUSINESS MARYLAND	7,832
R29AG10047-04	MUTTER, SHARON A JUDGMENT AND DECISION MAKING ACROSS THE LIFE SPAN	03-01-94/02-28-95	WESTERN KENTUCKY UNIVERSITY	95,886
N03AG10050-08	PROVIDE CLEARINGHOUSE SERVICES	12-02-93/01-10-94	SSC SMALL BUSINESS INDIANA	
N03AG10050-09	PROVIDE CLEARINGHOUSE SERVICES	01-10-94/01-31-94	SSC SMALL BUSINESS INDIANA	50,691
N03AG10050-10	PROVIDE CLEARINGHOUSE SERVICES	02-01-94/02-15-94	SSC SMALL BUSINESS INDIANA	33,794
N03AG10050-11	PROVIDE CLEARINGHOUSE SERVICES	02-16-94/01-10-95	SSC SMALL BUSINESS INDIANA	726,567

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R01AG10053-03	SUPIANO, MARK A SYMPATHETIC FUNCTION AND GERIATRIC HYPERTENSION	07-01-94/06-30-96	UNIVERSITY OF MICHIGAN AT ANN ARBOR	102,454
R29AG10059-03	CRISP, TERRIANN AGE RELATED CHANGES IN SPINAL OPIATE INDUCED ANALGESIA	06-05-94/05-31-95	NORTHEASTERN OHIO UNIVERSITIES COLL	106,300
R01AG10070-03	BAKER, JOHN R CARTILAGE MATRIX PROTEIN INTERACTIONS--CHANGES WITH AGE	05-10-94/04-30-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	198,676
R44AG10082-03	AVIS, NANCY E WOMEN IN THE MIDDLE VIDEO	02-15-94/01-31-95	NEW ENGLAND RESEARCH INSTITUTE, INC	218,321
R01AG10101-04	LOCKSHIN, RICHARD A CELL DEATH IN A HIGH CONNECTIVITY INVERTEBRATE MODEL	06-05-94/05-31-95	ST. JOHN'S UNIVERSITY	194,158
R01AG10102-04	GORELICK, PHILIP B DEMENTIA IN AGED BLACKS--AD AND MID	07-01-94/06-30-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	345,218
R01AG10102-04S1	GORELICK, PHILIP B DEMENTIA IN THE BLACK AGED--AD AND MID	07-05-94/06-30-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	50,705
R01AG10106-02S1	KATZMAN, ROBERT INCIDENCE AND COURSE OF DEMENTIA IN SHANGHAI	03-18-94/08-31-94	UNIVERSITY OF CALIFORNIA SAN DIEGO	38,040
R01AG10106-03	KATZMAN, ROBERT INCIDENCE AND COURSE OF DEMENTIA IN SHANGHAI	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	259,333
R01AG10109-03	SEIDENBERG, MARK SEMANTIC MEMORY IN NORMAL AGING AND ALZHEIMERS DISEASE	06-05-94/05-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	229,172
R01AG10111-03	EMERSON, ROBERT M CAREGIVING PRACTICES IN HISPANIC AND ANGLO FAMILIES	08-01-94/07-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	98,760
R01AG10113-01A2	NAM, CHARLES B SOCIODEMOGRAPHY OF SMOKING AND ADULT MORTALITY	01-01-94/12-31-94	FLORIDA STATE UNIVERSITY	140,161
R01AG10118-03	SCHULZE, DAN H HETEROGENEOUS ANTIBODY RESPONSES IN AGING	02-15-94/12-31-95	UNIVERSITY OF MARYLAND BALT PROF SC	126,786
P01AG10120-03	FOGEL, ROBERT W EARLY INDICATORS OF LATER WORK LEVELS, DISEASE AND DEATH	12-01-93/11-30-94	NATIONAL BUREAU OF ECONOMIC RESEARC	816,653
R01AG10121-03	BECKLEY, DENNIS J POSTURE IN AGE RELATED NEURODEGENERATIVE DISEASE	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA DAVIS	103,362

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
P30AG10123-04	CUMMINGS, JEFFREY L UCLA ALZHEIMERS DISEASE CENTER	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	520,816
P30AG10123-04S1	CUMMINGS, JEFFREY L ALZHEIMERS DISEASE CENTER	08-05-94/06-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	199,999
P30AG10124-04	TROJANOWSKI, JOHN Q ALZHEIMERS DISEASE CENTER CORE	07-01-94/06-30-95	UNIVERSITY OF PENNSYLVANIA	730,786
P30AG10129-04	JAGUST, WILLIAM J UC DAVIS ALZHEIMERS DISEASE CENTER CORE	07-15-94/06-30-95	UNIVERSITY OF CALIFORNIA DAVIS	638,857
P30AG10130-04	MIRRA, SUZANNE S ALZHEIMERS DISEASE CENTER CORE	08-01-94/06-30-95	EMORY UNIVERSITY	781,256
R01AG10131-02	KAYSER-JONES, VIRGENE S BEHAVIORAL CONTEXT OF EATING AND NUTRITIONAL SUPPORT	06-15-94/05-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	249,506
P30AG10133-04	GHETTI, BERNARDINO ALZHEIMER DISEASE CENTER	07-15-94/06-30-95	INDIANA UNIV-PURDUE UNIV AT INDIANA	944,626
R01AG10135-03	TAYLOR, ROBERT J RELIGIOUS PARTICIPATION AMONG OLDER BLACKS AND WHITES	09-01-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	139,953
R01AG10138-03	HAROUTUNIAN, VAHRAM SYNTHESIS OF B-APP IN TRANSMITTER DEFICIENT MODELS OF AD	08-01-94/07-31-95	MOUNT SINAI SCHOOL OF MEDICINE	124,422
R01AG10143-12	CLARK, RICHARD A FIBRONECTIN AND CELL RECRUITMENT	05-01-94/04-30-95	STATE UNIVERSITY NEW YORK STONY BRO	183,437
R01AG10145-03	MORRIS, JOHN C ATTENTION, COGNITION AND DRIVING PERFORMANCE IN SDAT	04-01-94/03-31-95	JEWISH HOSPITAL OF ST. LOUIS	172,097
R01AG10147-01A2	KOEPSELL, THOMAS D CASE CONTROL STUDY OF OLDER PEDESTRIAN INJURY SITES	09-01-94/07-31-95	UNIVERSITY OF WASHINGTON	255,739
R01AG10149-02	BAUMGARTNER, RICHARD N BODY COMPOSITION CHANGES IN THE ELDERLY	08-01-94/07-31-95	UNIVERSITY OF NEW MEXICO ALBUQUERQU	263,532
R01AG10152-03	KRONENBERG, MITCHELL E THYMUS INVOLUTION AND AGING IN TL TRANSGENIC MICE	02-10-94/12-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	156,118
R01AG10156-03	SPENCER, BRUCE D UNCERTAINTY INTERVALS--POPULATION & FUNCTIONAL FORECASTS	07-20-94/06-30-95	NORTHWESTERN UNIVERSITY	96,756

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R29AG10160-03	BALIN, BRIAN J NEURONAL CYTOSKELETON IN AGING AND ALZHEIMERS DISEASE	04-01-94/03-31-95	MEDICAL COLLEGE OF PENNSYLVANIA	105,325
P30AG10161-04	EVANS, DENIS A RUSH ALZHEIMERS DISEASE CENTER CORE	07-01-94/06-30-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	829,390
P30AG10161-04S2	EVANS, DENIS A ALZHEIMERS DISEASE	08-25-94/06-30-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	46,320
P30AG10163-04	HARRELL, LINDY E ALZHEIMERS DISEASE CENTER CORE	07-15-94/06-30-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	597,140
R37AG10168-03	PRESTON, SAMUEL H AFRICAN-AMERICAN MORTALITY, 1930-1990	02-15-94/01-31-95	UNIVERSITY OF PENNSYLVANIA	242,505
Y02AG10168-03	COWDRY, REX W PSYCHOLOGICAL FUNCTIONING IN OLDER PEOPLE	06-01-94/09-30-94	U.S. NATIONAL INSTITUTE OF MENTAL H	312,500
Y02AG10169-03	MCPHILLIPS, REGINA THE SELECTION OR FOLLOW-UP OF RESEARCH STUDY SUBJECTS	10-01-93/09-30-94	U.S. HEALTH CARE FINANCING ADMIN	25,000
R29AG10170-03	MENDES DE LEON, CARLOS F RACE, SOCIAL FACTORS AND COURSE OF DISABILITY	09-01-94/08-31-95	YALE UNIVERSITY	110,406
R01AG10172-03	COHEN-MANSFIELD, JISKA TREATMENT OF AGITATION IN THE NURSING HOME	08-01-94/07-31-95	HEBREW HOME OF GREATER WASHINGTON	159,845
Y02AG10174-03	FORDIS, MICHAEL ADVERTISING, RESIDENT AWARDS PROGRAM & SUPPORT OF OE	10-01-93/09-30-94	U.S. NATIONAL INSTITUTES OF HEALTH	11,265
R01AG10175-03	PEDERSEN, NANCY L GENETIC & ENVIRONMENTAL INFLUENCES--BIOBEHAVIORAL AGING	09-01-94/08-31-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	407,678
P01AG10179-03	JUSTER, F THOMAS WEALTH, SAVINGS, FINANCIAL SECURITY IN OLDER HOUSEHOLDS	07-15-94/06-30-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	691,559
Y01AG10179-05	RAFF, BARRY HONOLULU AGING STUDY	10-01-93/09-30-94	U.S. DEPT/VETS AFFAIRS REGIONAL OFF	15,876
R01AG10181-03	MC FADDEN, DANIEL L DEMOGRAPHICS, HOUSING, AND WELFARE OF THE ELDERLY	08-01-94/07-31-95	NATIONAL BUREAU OF ECONOMIC RESEARC	97,544
Y02AG10182-03	FEINLEIB, MANNING NHANES I EPIDEMIOLOGIC FOLLOW-UP (NHNEFS)	10-01-93/09-30-94	U.S. NATIONAL CENTER FOR HLTH STATI	75,000

NATIONAL INSTITUTE ON AGING ACTIVE GRANTS IN FY94

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
P30AG10182-04	KOLLER, WILLIAM C ALZHEIMERS DISEASE CENTER CORE GRANT	07-01-94/06-30-95	UNIVERSITY OF KANSAS MEDICAL CENTER	731,265
Y02AG10183-04	FEINLEIB, MANNING SUPPLEMENT OF AGING-II (SOA-II)	10-01-93/09-30-94	U.S. NATIONAL CENTER FOR HLTH STATI	500,000
P01AG10184-03	WEST, SHEILA K VISUAL IMPAIRMENT AND FUNCTIONAL STATUS IN OLDER PERSONS	08-10-94/07-31-95	JOHNS HOPKINS UNIVERSITY	1,786,061
N03AG10186-03	JANITORIAL SERVICES FOR GRC IN BALTIMORE	09-13-94/09-12-95	SSC SMALL BUSINESS MARYLAND	359,347
Y01AG10188-04	PSID: TIME AND MONEY BURDENS OF ILL HEALTH	10-01-93/09-30-94	U.S. NATIONAL SCIENCE FOUNDATION	175,000
N03AG10188-05	SUMMER INSTITUTES IN RESEARCH ON AGING	06-17-94/07-02-95	AIRLIE FOUNDATION-AIRLIE CONFERENCE	44,623
Y01AG10188-05	PSID: TIME AND MONEY BURDENS OF ILL HEALTH	10-01-93/09-30-94	U.S. NATIONAL SCIENCE FOUNDATION	163,000
Y02AG10191-03	HODES, RICHARD J WHO CONSULTATIONS	10-01-93/09-30-94	U.S. PHS OFFICE OF ASST SECRETARY H	14,400
R01AG10197-03	HALE, SANDRA S AGING AND COGNITIVE SLOWING--THE INFORMATION LOSS MODEL	07-01-94/06-30-95	WASHINGTON UNIVERSITY	96,493
R29AG10199-03	DONAHUE, HENRY J AGE-RELATED CHANGES IN BONE CELL SIGNAL TRANSDUCTION	01-01-94/05-31-94	STATE UNIVERSITY NEW YORK STONY BRO	63,478
R29AG10199-04	DONAHUE, HENRY J AGE RELATED CHANGES IN BONE CELL SIGNAL TRANSDUCTION	08-15-94/12-31-94	PENNSYLVANIA STATE UNIV HERSHEY MED	38,828
N03AG10200-03	LEASE TO OWNERSHIP--MASS SPECTROMETER	09-16-94/09-18-95	SSC SMALL BUSINESS COLORADO	33,581
P01AG10207-03	KELSOE, GARNETT MECHANISMS OF IMMUNOSENESENCE	04-05-94/03-31-95	UNIVERSITY OF MARYLAND BALT PROF SC	529,827
P01AG10208-03	AZMITIA, EFRAIN C S-100B--NEURONAL GLIAL LINK TO ALZHEIMERS DISEASE	05-20-94/04-30-95	NEW YORK UNIVERSITY	593,791
P01AG10208-03S1	AZMITIA, EFRAIN C S-100B--A NEURONAL-GLIAL LINK TO ALZHEIMERS DISEASE	06-20-94/04-30-95	NEW YORK UNIVERSITY	243,368

NATIONAL INSTITUTE ON AGING ACTIVE GRANTS IN FY94

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG10210-03	LEE, VIRGINIA M Y BIOLOGY OF ALZHEIMER PAIRED HELICAL FILAMENTS	06-10-94/05-31-95	UNIVERSITY OF PENNSYLVANIA	163,295
R01AG10213-03	CULP, LLOYD A MATRIX ADHESION OF AGING DERMAL FIBROBLASTS	06-05-94/05-31-95	CASE WESTERN RESERVE UNIVERSITY	151,393
R29AG10215-02S1	YEOWELL, HEATHER N LYSYL HYDROXYLASE--STRUCTURE AND REGULATORY STUDIES	06-05-94/08-31-94	DUKE UNIVERSITY	6,311
R29AG10215-03	YEOWELL, HEATHER N LYSYL HYDROXYLASE--STRUCTURE AND REGULATORY STUDIES	09-01-94/08-31-95	DUKE UNIVERSITY	105,560
R01AG10217-03	HOLDEN, JAMES E PET PROBES OF DOPAMINE NEURONS IN YOUNG & AGED ANIMALS	06-15-94/05-31-95	UNIVERSITY OF WISCONSIN MADISON	158,360
R01AG10220-03	MUNGAS, DAN M ENGLISH AND SPANISH ASSESSMENT OF COGNITION IN ELDERLY	07-15-94/06-30-95	UNIVERSITY OF CALIFORNIA DAVIS	119,631
M03AG10235-04	PROVIDE PARKING SERVICES	09-30-94/09-29-95	SSC LARGE BUSINESS-DISTRICT OF COLU	162,000
R29AG10250-02	LA VEIST, THOMAS A NATIONAL AFRICAN-AMERICAN MORTALITY ANALYSIS	05-01-94/04-30-95	JOHNS HOPKINS UNIVERSITY	107,438
R01AG10251-02	KLINE, JENNIE K EPIDEMIOLOGY OF TRISOMY AND AGING	02-10-94/12-31-94	NEW YORK STATE PSYCHIATRIC INSTITUT	228,127
R01AG10252-03	LEVINE, MICHAEL S NEUROPHYSIOLOGY OF AGING NEOSTRIATUM	08-01-94/07-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	161,148
R01AG10255-04	WOLF, DOUGLAS A C	01-01-94/12-31-95	SYRACUSE UNIVERSITY AT SYRACUSE	138,131
R01AG10263-03	HIRAMOTO, RAYMOND N PHYSIOLOGICAL FUNCTIONS OF OLD MICE AND LONGEVITY	04-05-94/03-31-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	144,127
R29AG10264-01A2	GLICKSMAN, ALLEN CULTURAL AND SOCIAL SOURCES OF WELL-BEING IN NORMAL AGED	01-01-94/12-31-94	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	112,502
R29AG10264-01A2S1	GLICKSMAN, ALLEN CULTURAL AND SOCIAL SOURCES OF WELL-BEING IN NORMAL AGED	07-01-94/12-31-94	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	21,230
R01AG10266-03	BUMPASS, LARRY L AGING AND THE FAMILY OVER THE LIFE COURSE	12-01-93/11-30-94	UNIVERSITY OF WISCONSIN MADISON	499,624

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R29AG10267-03	CRESS, MARIE E PHYSICAL FUNCTION PERFORMANCE AND EXERCISING IN AGING	05-12-94/04-30-95	UNIVERSITY OF WASHINGTON	92,876
R01AG10269-03	HEISTAD, DONALD D AGING EFFECTS ON CEREBRAL BLOOD VESSELS	06-01-94/05-31-95	UNIVERSITY OF IOWA	161,678
R01AG10279-03	VORBRODT, ANDRZEJ W TRANSPORT OF MODIFIED ALBUMIN ACROSS BLOOD-BRAIN BARRIER	06-10-94/04-30-95	INSTITUTE FOR BASIC RES IN DEV DISA	142,478
R01AG10280-03	SCHNEIDER, JAY S DEGENERATION, REPAIR AND AGING IN THE CNS	08-01-94/07-31-95	HAHNEMANN UNIVERSITY	206,699
R29AG10282-03	GEULA, CHANGIZ CHOLINERGIC SYSTEM IN ALZHEIMERS DISEASE	07-01-94/06-30-95	NEW ENGLAND DEACONESS HOSPITAL	123,351
N03AG10286-04	PROVIDE DRIVER MESSENGER SERVICE	03-16-94/09-28-94	SSC LARGE BUSINESS-DISTRICT OF COLU	3,047
N03AG10286-05	PROVIDE DRIVER MESSENGER SERVICE	04-10-94/09-28-94	SSC LARGE BUSINESS-DISTRICT OF COLU	
N03AG10286-06	PROVIDE DRIVER MESSENGER SERVICE	05-17-94/09-28-94	SSC LARGE BUSINESS-DISTRICT OF COLU	
N03AG10286-07	PROVIDE DRIVER MESSENGER SERVICE	09-29-94/09-28-95	SSC LARGE BUSINESS-DISTRICT OF COLU	81,907
R01AG10292-02	ROBERTS, JAMES A MODULATING URINARY TRACT INFECTION IN ELDERLY FEMALES	03-01-94/02-28-95	TULANE UNIVERSITY OF LOUISIANA	281,842
R01AG10295-03	STEVENS, JOSEPH C CUTANEOUS SENSITIVITY AND AGING	07-01-94/06-30-95	JOHN B. PIERCE LABORATORY, INC.	144,464
R01AG10297-03	LAHIRI, DEBOMOY K REGULATION OF BETA AMYLOID GENE PROMOTER IN CELL TYPES	08-01-94/07-31-95	INDIANA UNIV-PURDUE UNIV AT INDIANA	164,620
R01AG10299-03	SCHMIDT, ROBERT E NEUROPATHOLOGY OF THE AGING SYMPATHETIC NERVOUS SYSTEM	05-20-94/04-30-95	WASHINGTON UNIVERSITY	224,344
R29AG10303-03	AMIN, ASHOK R MURINE AND HUMAN IG-D-RECEPTORS	02-10-94/12-31-95	NEW YORK UNIVERSITY	119,784
U01AG10304-04	LAWTON, M POWELL STIMULATION--RETREAT PROGRAM FOR ALZHEIMERS PATIENTS	09-01-94/08-31-95	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	263,678

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
U01AG10305-04	MORRIS, JOHN N EVALUATING A FAMILY PARTNERSHIP PROGRAM IN SCUS	09-01-94/08-31-95	HEBREW REHABILITATION CENTER FOR AG	284,888
U01AG10311-04	LINDEMAN, DAVID A ALZHEIMERS SPECIAL CARE UNIT--LONGITUDINAL OUTCOME STUDY	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA DAVIS	371,181
U01AG10315-03	EVANS, DENIS A LONGITUDINAL STUDY OF 4 TYPES OF AD SPECIAL CARE UNITS	04-01-94/03-31-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	232,633
U01AG10317-04S1	LEON, JOEL NATIONAL EVALUATION OF SPECIAL CARE UNITS	04-08-94/08-31-94	PROJECT HOPE CENTER FOR HEALTH AFFA	29,485
U01AG10317-05	LEON, JOEL NATIONAL EVALUATION OF SPECIAL CARE UNITS	09-01-94/08-31-95	PROJECT HOPE CENTER FOR HEALTH AFFA	79,238
U01AG10317-05S1	LEON, JOEL PAYMENTS FOR EFFECTIVE CARE FOR RESIDENTS WITH DEMENTIA	09-10-94/08-31-95	PROJECT HOPE CENTER FOR HEALTH AFFA	228,743
U01AG10318-04	MONTGOMERY, RHONDA J SPECIAL CARE UNITS--IMPACT ON AD RESIDENTS/FAMILY/STAFF	08-01-94/06-30-95	UNIVERSITY OF KANSAS LAWRENCE	276,637
R01AG10321-03	BECK, CORNELIA M REDUCING DISRUPTIVE BEHAVIORS IN DEMENTED ELDERLY	01-01-94/12-31-95	UNIVERSITY OF ARKANSAS MED SCIS LTL	554,088
U01AG10328-04	GRANT, LESLIE A SPECIAL CARE UNITS IN MINNESOTA NURSING HOMES	09-01-94/08-31-95	UNIVERSITY OF MINNESOTA TWIN CITIES	245,897
U01AG10330-03S1	HOLMES, DOUGLAS DIFFERENTIAL COSTS AND INPUTS FOR SPECIAL CARE UNITS	09-25-94/08-31-95	HEBREW HOME FOR THE AGED AT RIVERDA	139,000
R44AG10350-03	BYRD, CECILIA A ELDER ACCEPTANCE OF HEALTH EDUCATION PRODUCTS	09-01-94/06-30-95	ELDER SOURCE, INC.	269,039
U01AG10353-04	DAWSON-HUGHES, BESS CALCIUM AND VITAMIN D EFFECT ON BONE LOSS FROM HIP	09-01-94/08-31-95	TUFTS UNIVERSITY BOSTON	510,001
U01AG10353-04S1	DAWSON-HUGHES, BESS CALCIUM AND VITAMIN D EFFECTS ON BONE LOSS FROM THE HIP	09-15-94/08-31-95	TUFTS UNIVERSITY BOSTON	126,257
U01AG10353-04S2	DAWSON-HUGHES, BESS CALCIUM AND VITAMIN D EFFECTS ON BONE LOSS FROM THE HIP	09-30-94/08-31-95	TUFTS UNIVERSITY BOSTON	86,734
R01AG10358-04	GALLAGHER, J CHRISTOPHER PATHOPHYSIOLOGY OF SENILE TYPE 11 OSTEOPOROSIS	09-15-94/08-31-95	CREIGHTON UNIVERSITY	157,018

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
U01AG10373-03S1	GALLAGHER, J CHRISTOPHER TREATMENT FOR OSTEOPOROSIS OF THE HIP	02-01-94/08-31-94	CREIGHTON UNIVERSITY	121,169
U01AG10373-03S2	GALLAGHER, J CHRISTOPHER TREATMENT FOR OSTEOPOROSIS OF THE HIP AG10358	02-01-94/08-31-94	CREIGHTON UNIVERSITY	
U01AG10373-04	GALLAGHER, J CHRISTOPHER TREATMENT FOR OSTEOPOROSIS OF THE HIP	09-01-94/08-31-95	CREIGHTON UNIVERSITY	627,585
R01AG10374-04	CODY, DIANNA D PROXIMAL FEMUR ARCHITECTURE IN OLDER WOMEN	09-15-94/08-31-95	CASE WESTERN RESERVE UNIV-HENRY FOR	85,427
R01AG10381-04	PARFITT, A MICHAEL ERT AND FOCAL BALANCE BETWEEN RESORPTION AND FORMATION	09-20-94/08-31-95	CASE WESTERN RESERVE UNIV-HENRY FOR	162,684
U01AG10382-04	DALSKY, GAIL P EXERCISE EFFECT ON FEMORAL BONE MASS IN OLDER ADULTS	09-01-94/08-31-95	UNIVERSITY OF CONNECTICUT HEALTH CE	618,027
U01AG10382-04S3	DALSKY, GAIL P EXERCISE EFFECT ON FEMORAL BONE MASS IN OLDER ADULTS	09-15-94/08-31-95	UNIVERSITY OF CONNECTICUT HEALTH CE	73,393
U01AG10383-04	JOCHEN, ALBERT TESTOSTERONE EFFECT ON BONE DENSITY/HYPOGONADAL MEN	09-15-94/08-31-95	MEDICAL COLLEGE OF WISCONSIN	203,288
U01AG10407-03S1	KLEEREKOPER, MICHAEL ESTROGEN IN THE PREVENTION OF BONE LOSS FROM THE HIP	09-30-94/01-31-95	WAYNE STATE UNIVERSITY	26,131
R01AG10412-04	ROSS, PHILIP D FALLS AND FRACTURES AMONG ELDERLY JAPANESE AMERICANS	07-01-94/06-30-95	STAUB PACIFIC HLTH FDN-HEALTH RES I	223,259
P60AG10415-04	RUEBEN, DAVID B UCLA OLDER AMERICANS INDEPENDENCE CENTER	09-30-94/06-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	859,670
P60AG10415-04S1	RUEBEN, DAVID B UCLA OLDER AMERICANS INDEPENDENCE CENTER	09-30-94/06-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	31,833
P60AG10418-02	KOWAL, JEROME CLAUDE D PEPPER OLDER AMERICANS INDEPENDENCE CENTER	12-10-93/11-30-94	CASE WESTERN RESERVE UNIVERSITY	919,739
R01AG10425-03	TUCKER, KATHERINE L NUTRITION AND FRAILTY AMONG ELDERLY HISPANIC GROUPS	09-01-94/08-31-95	TUFTS UNIVERSITY BOSTON	260,699
R01AG10430-04	MILES, TONI P BLACK ELDERLY TWIN STUDY	09-30-94/06-30-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	364,239

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
P01AG10435-04	GAGE, FRED H GENE THERAPY FOR ALZHEIMERS DISEASE	08-01-94/07-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	718,742
R01AG10436-04	MILLER, DOUGLAS K PHYSICAL FRAILTY IN URBAN AFRICAN AMERICANS	09-30-94/06-30-95	ST. LOUIS UNIVERSITY	222,238
R01AG10444-04	HAZUDA, HELEN P SAN ANTONIO LONGITUDINAL STUDY OF AGING	07-01-94/06-30-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	222,192
R01AG10454-04	KELSEY, JENNIFER L OSTEOPOROSIS AND FALLS IN MEXICAN AMERICAN ELDERS	09-01-94/08-31-95	STANFORD UNIVERSITY	241,075
P60AG10463-04	ABRAHAM, GEORGE N ROCHESTER AREA PEPPER CENTER	07-05-94/06-30-95	UNIVERSITY OF ROCHESTER	1,684,428
P60AG10469-03	TINETTI, MARY E CLAUDE D PEPPER OLDER AMERICANS INDEPENDENCE CENTER	08-01-94/07-31-95	YALE UNIVERSITY	999,299
P01AG10480-04	HEFTI, FRANZ F THERAPEUTIC POTENTIAL OF NEUROTROPHINS IN ALZHEIMERS	09-25-94/07-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	412,421
P01AG10481-04	KRAFFT, GRANT A NEURAL PROTEASES--NEW ALZHEIMERS DISEASE DRUG TARGETS	09-15-94/07-31-95	ABBOTT LABORATORIES	621,672
U01AG10483-04	THAL, LEON J ALZHEIMERS DISEASE COOPERATIVE STUDY UNIT	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	4,045,264
P60AG10484-04	ETTINGER, WALTER H, JR CLAUDE D PEPPER OLDER AMERICANS INDEPENDENCE CENTER	07-15-94/06-30-95	WAKE FOREST UNIVERSITY	1,066,914
P01AG10485-03S1	SIMPKINS, JAMES W DISCOVERY OF NOVEL DRUGS FOR ALZHEIMER'S DISEASE	12-01-93/07-31-94	UNIVERSITY OF FLORIDA	16,525
P01AG10485-04	SIMPKINS, JAMES W DISCOVERY OF NOVEL DRUGS FOR ALZHEIMERS DISEASE	08-01-94/07-31-95	UNIVERSITY OF FLORIDA	914,495
R01AG10486-02	ROY, ARUN K AGING AND ANDROGEN RECEPTOR GENE REGULATION	01-01-94/12-31-94	UNIVERSITY OF TEXAS HLTH SCI CTR SA	235,654
R01AG10489-04	LANTIGUA, RAFAEL ACTIVE LIFE EXPECTANCY AMONG URBAN MINORITY ELDERLY	07-01-94/06-30-95	COLUMBIA UNIVERSITY NEW YORK	215,757
P01AG10491-04	GREENGARD, PAUL INTERDISCIPLINARY APPROACH TO ALZHEIMER DRUG DISCOVERY	08-20-94/07-31-95	ROCKEFELLER UNIVERSITY	460,411

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG10496-03	ZURIF, EDGAR B COGNITIVE AGING--REAL TIME LANGUAGE PROCESSING	05-01-94/04-30-95	BRANDEIS UNIVERSITY	142,689
R01AG10499-04S1	NORR, KATHLEEN F PEER EDUCATION FOR AIDS PREVENTION	09-01-94/08-31-95	UNIVERSITY OF ILLINOIS AT CHICAGO	50,000
P01AG10514-03	PAPACONSTANTINOU, JOHN AGING EFFECTS ON MOLECULAR RESPONSES TO STRESS	06-01-94/05-31-95	UNIVERSITY OF TEXAS MEDICAL BR GALV	823,460
R01AG10518-03	HORIUCHI, SHIRO OLD AGE MORTALITY--LIFE TABLE AGING RATE ANALYSIS	08-01-94/07-31-95	ROCKEFELLER UNIVERSITY	26,563
R29AG10523-03	PETERSON, CHARLOTTE A ENOLASE GENE REGULATION IN DIFFERENTIATION AND AGING	07-01-94/05-31-95	UNIVERSITY OF ARKANSAS MED SCIS LTL	81,067
R01AG10528-01A3	VATASSERY, GOVIND N NEURONAL MEMBRANE LIPID OXIDATION IN PARKINSONS DISEASE	08-01-94/07-31-95	UNIVERSITY OF MINNESOTA TWIN CITIES	177,571
R01AG10530-02	MADJICONSTANTINOU-NEFF, MARIA GM1 GANGLIOSIDE CORRECTS RAT BRAIN CHOLINERGIC DEFICITS	05-15-94/04-30-95	OHIO STATE UNIVERSITY	155,051
R01AG10531-02	FERNANDES, GABRIEL AGING, FOOD RESTRICTION AND T-CELL SUBSET FUNCTION	09-30-94/08-31-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	169,564
R01AG10536-03	WEINDRUCH, RICHARD H CALORIES, FAT, AND SPONTANEOUS PROSTATE CANCER	05-01-94/04-30-95	UNIVERSITY OF WISCONSIN MADISON	168,689
R01AG10538-03	FITZGERALD, MALINDA E CHOROIDAL BLOOD FLOW AND RETINAL PATHOLOGY IN AGING	06-15-94/05-31-95	UNIVERSITY OF TENNESSEE AT MEMPHIS	94,345
P01AG10542-02	SCHULTZ, ALBERT B FUNDAMENTAL ASPECTS OF MOBILITY IN OLD ADULTS	04-01-94/03-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	650,191
P01AG10542-02S1	SCHULTZ, ALBERT B FUNDAMENTAL ASPECTS OF MOBILITY IN OLD ADULTS	09-30-94/03-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	193,402
R01AG10546-01A3	WENK, GARY L AGING VULNERABILITY TO EXCITATORY AMINO ACIDS	04-08-94/03-31-95	UNIVERSITY OF ARIZONA	130,304
R01AG10565-03	HEINRICH, GERHARD AGING AND ALZHEIMER DISEASE--INVOLVEMENT OF NEUROTROPHIL	08-20-94/07-31-95	UNIVERSITY HOSPITAL (BOSTON)	163,503
R01AG10566-02	GRIFFIN, MARIE R ACUTE RENAL INSUFFICIENCY AND NSAIDS	08-01-94/07-31-95	VANDERBILT UNIVERSITY	279,713

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG10569-02	ZELINSKI, ELIZABETH M LONGITUDINAL ASSESSMENT OF COGNITION IN ADULTS	09-01-94/08-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	221,843
R01AG10569-02S1	ZELINSKI, ELIZABETH M LONGITUDINAL ASSESSMENT OF COGNITION IN ADULTS	09-15-94/08-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	11,232
R29AG10593-03	HARTMAN, MARILYN D AGE DIFFERENCE IN ATTENTION--CONSEQUENCES FOR MEMORY	07-01-94/06-30-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	98,786
R01AG10598-12	CUNNINGHAM, DENNIS D REGULATION OF PROTEASE NEXIN 1 ACTIVITY AND SECRETION	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA IRVINE	201,501
R01AG10599-04	COOPERMAN, BARRY S ANTICHYMOTRYPSIN INTERACTION WITH SERINE PROTEASES	09-10-94/08-31-95	UNIVERSITY OF PENNSYLVANIA	205,322
R01AG10604-04	POLICH, JOHN M ASSESSMENT OF ALZHEIMERS DISEASE WITH P300	09-01-94/08-31-95	SCRIPPS RESEARCH INSTITUTE	134,969
R01AG10606-03	RAPP, PETER R COGNITIVE FUNCTION IN THE AGED	08-01-94/07-31-95	STATE UNIVERSITY NEW YORK STONY BRO	134,759
R29AG10607-03	MAGNUSSON, KATHY R AGING EFFECTS ON THE NMDA RECEPTOR COMPLEX	05-15-94/04-30-95	COLORADO STATE UNIVERSITY	99,336
R01AG10608-03	BENSON, MERRILL D AMYLOID PRECURSOR PROTEIN (APP) AND ALZHEIMER'S DISEASE	07-01-94/06-30-95	INDIANA UNIV-PURDUE UNIV AT INDIANA	219,449
R29AG10620-02	LAPOLT, PHILIP S REGULATION OF GENE EXPRESSION IN THE AGING OVARY	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	98,182
R01AG10624-03	FROST, J JAMES PARTIAL VOLUME CORRECTION IN PET IMAGING IN AGING	07-01-94/06-30-95	JOHNS HOPKINS UNIVERSITY	432,742
R01AG10634-04	SANES, JEROME N NEURAL CONTROL OF VOLUNTARY MOVEMENTS	09-01-94/08-31-95	BROWN UNIVERSITY	169,624
R01AG10637-03	MABRY, TOM J PLANT TOXINS AND DEMENTIA	05-10-94/04-30-95	UNIVERSITY OF TEXAS AUSTIN	91,479
R01AG10638-04	PROHOVNIK, ISAK A AD LIKE PATHOLOGY IN ELDERLY SCHIZOPHRENIA	09-01-94/08-31-95	NEW YORK STATE PSYCHIATRIC INSTITUT	285,620
R01AG10642-03S1	COHEN-MANSFIELD, JISKA MANAGEMENT OF SCREAMING IN NURSING HOME RESIDENTS	06-01-94/12-31-94	HEBREW HOME OF GREATER WASHINGTON	5,194

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG10643-04	BLIWISE, DONALD L SUNDOWN SYNDROME IN A SKILLED NURSING FACILITY	01-01-94/12-31-95	EMORY UNIVERSITY	88,471
R01AG10664-04	MARKESBERY, WILLIAM R ALZHEIMERS DISEASE, DENTAL AMALGAMS AND MERCURY	07-01-94/06-30-95	UNIVERSITY OF KENTUCKY	152,600
R01AG10667-04	MOISES, HYLAN C NGF AND CHOLINERGIC FUNCTION IN ADULT AND AGING BRAIN	07-01-94/06-30-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	174,181
R01AG10668-04	MUFSON, ELLIOTT J GALANIN IN ALZHEIMER'S DISEASE	07-01-94/06-30-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	146,363
R01AG10669-04	MARSH, RICHARD F PRION PROTEIN IN MINK ENCEPHALOPATHY	09-10-94/06-30-95	UNIVERSITY OF WISCONSIN MADISON	151,444
R01AG10670-04	OTVOS, LASZLO CONFORMATION OF PHOSPHORYLATED BRAIN PEPTIDES	07-01-94/06-30-95	WISTAR INSTITUTE OF ANATOMY AND BIO	129,783
R01AG10672-04	MOBLEY, WILLIAM C NEUROTROPHIC FACTOR THERAPY FOR ALZHEIMERS DISEASE	07-05-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	174,469
R01AG10675-05	MALTER, JAMES S APP MRNA DYSREGULATION AND ALZHEIMER'S DISEASE	07-01-94/06-30-95	UNIVERSITY OF WISCONSIN MADISON	116,862
R01AG10676-04	SALTON, STEPHEN R REGULATION OF VGF BY NEUROTROPHIC GROWTH FACTORS	07-05-94/06-30-95	MOUNT SINAI SCHOOL OF MEDICINE	174,924
R01AG10677-04	BROWN, GREGORY G SPECTROSCOPY OF ALZHEIMERS DISEASE & VASCULAR DEMENTIA	07-01-94/06-30-95	CASE WESTERN RESERVE UNIV-HENRY FOR	190,357
R01AG10678-04	GEDDES, JAMES W MAP 5, SPROUTING, AND ALZHEIMERS DISEASE PATHOLOGY	07-01-94/06-30-95	UNIVERSITY OF KENTUCKY	134,379
R01AG10681-04	CARLSON, GEORGE A TRANSGENIC MODELS FOR ALZHEIMERS DISEASE	07-01-94/06-30-95	MC LAUGHLIN RESEARCH INS FOR BIOMED	158,978
R01AG10682-04	STOPA, EDWARD G HEPARIN-BINDING GROWTH FACTORS IN AGING AND ALZHEIMER'S	01-01-94/11-30-94	RHODE ISLAND HOSPITAL (PROVIDENCE,	211,479
R01AG10684-04	SIMONS, ELIZABETH R PLATELET-ENDOTHELIAL CELL INTERACTIONS IN ALZHEIMERS	07-01-94/06-30-95	BOSTON UNIVERSITY	288,384
R01AG10686-03S1	KRUEGER, BRUCE K GLIAL/NEURONAL INTERACTIONS IN NEURODENGENERATION	09-30-94/06-30-95	UNIVERSITY OF MARYLAND BALT PROF SC	25,000

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG10687-04	LEVINE, ROBERT A BIOPTERIN/CATECHOLAMINE METABOLISM IN ALZHEIMERS/AGING	06-20-94/05-31-95	CASE WESTERN RESERVE UNIVERSITY	106,162
R01AG10689-03S1	MASLIAH, ELIEZER SUBCELLULAR BASIS OF SYNAPTIC PATHOLOGY ALZHEIMER DIS	09-30-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	38,999
R01AG10691-03	FINK, JOHN K APP GENE IN ALZHEIMERS DISEASE	07-01-94/06-30-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	234,776
R01AG10738-03	STANGE, KURT C BUFFERS OF IMPAIRMENT-DISABILITY CASCADE AMONG THE OLD	06-15-94/05-31-95	CASE WESTERN RESERVE UNIVERSITY	221,985
R01AG10746-03	KELNER, MICHAEL J GENETIC INSIGHT INTO OXIDATIVE DAMAGE	01-01-94/12-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	220,182
R01AG10747-04	BOOZE, ROSEMARIE M PROGRESSIVE CHOLINERGIC DYSFUNCTION IN AGING BRAIN	09-01-94/08-31-95	UNIVERSITY OF KENTUCKY	134,359
R01AG10755-04	ROSE, GREGORY M CHOLINERGIC CIRCUITS AND HIPPOCAMPAL FUNCTION IN AGING	07-05-94/06-30-95	UNIVERSITY OF COLORADO HLTH SCIENCE	87,594
R29AG10756-04	WRIGLEY, J MICHAEL DEMOGRAPHIC STUDY OF DEMENTIA AMONG THE ELDERLY	09-01-94/08-31-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	103,316
R01AG10760-04	VITALIANO, PETER P CAREGIVER MENTAL HEALTH AND AD PATIENT OUTCOMES	09-01-94/08-31-95	UNIVERSITY OF WASHINGTON	180,384
R01AG10765-03	FLEMING, SHARON E NUTRIENT UTILIZATION BY INTESTINAL CELLS OF AGED ANIMALS	06-01-94/05-31-95	UNIVERSITY OF CALIFORNIA BERKELEY	116,194
P01AG10770-02	PRUSINER, STANLEY B MOLECULAR PATHOGENESIS OF AGE-DEPENDENT CNS DEGENERATION	04-01-94/03-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	942,204
R44AG10782-03	SCHWARTZ, MARC D INFORMATION SYSTEM TO IMPROVE HOME HEALTH CARE	09-10-94/05-31-95	COMPUTERS IN PSYCHIATRY/PSYCHOLOGY	250,000
R01AG10785-02	STEWART, WALTER F AGE, LEAD EXPOSURE AND NEUROBEHAVIORAL DECLINE	09-01-94/08-31-95	JOHNS HOPKINS UNIVERSITY	552,958
R01AG10791-01A2	STOLLER, ELEANOR P ETHNICITY IN HELPING NETWORKS--STUDY OF RETIRED MIGRANTS	09-15-94/08-31-95	COLLEGE AT PLATTSBURGH	193,073
P01AG10794-03	SACK, ROBERT L SLEEP, MELATONIN AND THE AGING CIRCADIAN CLOCK	07-01-94/06-30-95	OREGON HEALTH SCIENCES UNIVERSITY	753,995

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R29AG10801-03	FREDMAN, LISA CAREGIVERS TO THE ELDERLY--RISKS AND OUTCOMES OF STRESS	07-01-94/06-30-95	UNIVERSITY OF MARYLAND BALT PROF SC	81,070
R29AG10816-02	CEFALU, WILLIAM T CALORIC RESTRICTION, AGING AND CARDIOVASCULAR DISEASE	09-01-94/08-31-95	WAKE FOREST UNIVERSITY	100,936
R29AG10818-02	MUSCHKIN, CLARA G LIVING ARRANGEMENTS OF THE ELDERLY IN THE CARIBBEAN	09-01-94/08-31-95	DUKE UNIVERSITY	86,458
R01AG10819-03	SAGER, RUTH MOLECULAR BASIS OF SENESCENCE IN BREAST EPITHELIAL CELLS	06-10-94/05-31-95	DANA-FARBER CANCER INSTITUTE	246,488
P01AG10821-02	CARLSON, BRUCE M AGE-RELATED INFLUENCES ON MUSCLE AND NERVE REGENERATION	02-10-94/12-31-94	UNIVERSITY OF MICHIGAN AT ANN ARBOR	654,055
R01AG10827-03	GELLER, ALFRED I HSV VECTOR SYSTEMS FOR GENE THERAPY OF AGING DISORDERS	08-15-94/07-31-95	CHILDREN'S HOSPITAL (BOSTON)	179,076
R01AG10828-03	WILLIAMS, MARK E FUNCTIONING AND MEDICATION MANAGEMENT IN OLDER PEOPLE	07-01-94/06-30-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	182,345
P01AG10829-02	WEI, JEANNE Y BASIC MECHANISMS OF AGING AND AGE-RELATED DISEASES	07-05-94/06-30-95	BETH ISRAEL HOSP (BOSTON)	785,485
P01AG10829-02S1	WEI, JEANNE Y BASIC MECHANISMS OF AGING--SUPPLEMENTAL APPLICATION	09-25-94/06-30-95	BETH ISRAEL HOSP (BOSTON)	
P01AG10829-02S2	WEI, JEANNE Y BASIC MECHANISMS OF AGING AND AGE RELATED DISEASES	09-30-94/06-30-95	BETH ISRAEL HOSP (BOSTON)	60,515
P01AG10829-02S3	WEI, JEANNE Y BASIC MECHANISMS OF AGING--SUPPLEMENTAL APPLICATION	09-25-94/06-30-95	BETH ISRAEL HOSP (BOSTON)	99,433
P01AG10836-03	LANDFIELD, PHILIP W CALICUM REGULATION IN BRAIN AGING AND ALZHEIMERS DISEASE	08-01-94/07-31-95	UNIVERSITY OF KENTUCKY	829,568
R01AG10837-03	ELBLE, RODGER J GAIT DISTURBANCES IN THE ELDERLY--INITIATION OF GAIT	07-01-94/06-30-95	SOUTHERN ILLINOIS UNIVERSITY SCH OF	113,075
R01AG10838-03	HARRISON, DAVID E HDL CHOLESTEROL LEVELS EFFECTS ON AGING	09-10-94/08-31-95	JACKSON LABORATORY	301,466
R01AG10838-03S1	HARRISON, DAVID E HDL CHOLESTEROL LEVELS EFFECTS ON AGING	09-30-94/08-31-95	JACKSON LABORATORY	

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG10845-02	TERI, LINDA AGING AND DEMENTIA--REDUCING DISABILITY IN ALZHEIMER'S	07-10-94/06-30-95	UNIVERSITY OF WASHINGTON	399,771
R29AG10848-03	OBER, BETH A SEMANTIC & REPETITION PRIMING IN NORMAL & ABNORMAL AGING	08-01-94/07-31-95	UNIVERSITY OF CALIFORNIA DAVIS	94,386
R01AG10851-01A2	COLLIER, TIMOTHY J REGENERATION IN THE AGED AND INJURED DOPAMINE SYSTEM	12-01-93/07-31-94	UNIVERSITY OF ROCHESTER	113,140
R01AG10851-02	COLLIER, TIMOTHY J REGNERATION IN THE AGED AND INJURED DOPAMINE SYSTEM	08-01-94/11-30-94	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	92,981
R01AG10853-03	CONLEY, KEVIN E AGE AND EXERCISE--MUSCLE FUNCTION BY NMR AND PERFORMANCE	08-01-94/07-31-95	UNIVERSITY OF WASHINGTON	216,258
R01AG10868-01A2	SAHU, ABHIRAM HYPOTHALAMIC NEUROPEPTIDE Y AND REPRODUCTIVE AGING	03-04-94/02-28-95	UNIVERSITY OF FLORIDA	177,632
R29AG10869-03	UDOM, CELESTINE E NEURONAL AGING AND NEURODEGENERATIVE DISEASES	07-05-94/06-30-95	UNIVERSITY OF COLORADO HLTH SCIENCE	111,398
R01AG10870-03	TUREK, FRED W AGING AND CIRCADIAN RHYTHMS	08-01-94/07-31-95	NORTHWESTERN UNIVERSITY	156,002
R29AG10871-01A2	ALWAY, STEPHEN E MECHANISMS FOR NEW FIBER FORMATION IN AGING MUSCLE	05-01-94/04-30-95	OHIO STATE UNIVERSITY	105,192
R01AG10875-02	RUBINSTEIN, ROBERT L CHILDREN'S PERSPECTIVES ON DEATH OF AN ELDERLY PARENT	03-01-94/02-28-95	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	194,125
R01AG10875-02S1	RUBINSTEIN, ROBERT L CHILDRENS PERSPECTIVES ON DEATH OF AN ELDERLY PARENT	03-10-94/02-28-95	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	33,834
R01AG10876-03	LAWRENCE, RENEE H INTERGENERATIONAL CONNECTIONS, ETHNICITY AND THE ELDERLY	08-01-94/07-31-95	NEW ENGLAND RESEARCH INSTITUTE, INC	121,281
R29AG10879-03	SANO, MARY MAINTAINING FUNCTIONS IN AGED COMMUNITY RESIDENTS	07-01-94/06-30-95	COLUMBIA UNIVERSITY NEW YORK	130,931
R29AG10885-03	EVERS, BERNARD M SURGICAL STUDIES OF ONTOGENY, AGING AND THE GUT	06-05-94/05-31-95	UNIVERSITY OF TEXAS MEDICAL BR GALV	99,629
R01AG10886-01A2	DE BEER, FREDERICK C SERUM AMYLOID A PROTEIN--ROLE IN ATHEROGENESIS	08-10-94/07-31-95	UNIVERSITY OF KENTUCKY	166,642

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R29AG10887-02	HURWICZ, MARGO L DECISIONS ABOUT HMO SERVICE USE FOR LATE LIFE ILLNESS	08-01-94/07-31-95	UNIVERSITY OF MISSOURI-ST. LOUIS	101,599
R01AG10897-11	WEINER, MICHAEL W 1H AND 31P MRSI OF AGING BRAIN AND SENILE DEMENTIA	08-01-94/07-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	334,827
R35AG10916-03	NIXON, RALPH A PROTEOLYSIS IN ALZHEIMERS DISEASE PATHOGENESIS	07-25-94/06-30-95	MC LEAN HOSPITAL (BELMONT, MA)	696,184
R35AG10917-03	MARTIN, GEORGE M LEADERSHIP AND EXCELLANCE IN ALZHEIMERS DISEASE AWARD	07-01-94/05-31-95	UNIVERSITY OF WASHINGTON	679,544
R01AG10925-02	ARNAUD, CLAUDE D BUILDING BONE IN OSTEOPOROSIS WITH PTH AND ESTROGEN	09-30-94/05-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	313,214
R01AG10936-03	BECERRA, ROSINA M OLDER MEXICAN AMERICANS--SOCIAL SUPPORT & HEALTH CARE	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	303,296
R01AG10939-03	MARKIDES, KYRIAKOS S LONGITUDINAL STUDY OF MEXICAN AMERICAN ELDERLY HEALTH	07-01-94/06-30-95	UNIVERSITY OF TEXAS MEDICAL BR GALV	693,330
R01AG10940-03	HAMMAN, RICHARD F HISPANIC HEALTH AND AGING IN SAN LUIS VALLEY, CO	07-01-94/06-30-95	UNIVERSITY OF COLORADO HLTH SCIENCE	381,579
R01AG10941-02S1	LINDEMAN, ROBERT D SURVEY OF HEALTH IN THE ELDERLY	07-01-94/08-31-94	UNIVERSITY OF NEW MEXICO ALBUQUERQU	64,393
R01AG10941-03	LINDEMAN, ROBERT D NEW MEXICO SURVEY OF HEALTH IN ELDERLY HISPANICS	09-01-94/08-31-95	UNIVERSITY OF NEW MEXICO ALBUQUERQU	395,944
R01AG10941-03S1	LINDEMAN, ROBERT D NEW MEXICO SURVEY OF HEALTH IN ELDERLY HISPANICS	09-01-94/03-31-95	UNIVERSITY OF NEW MEXICO ALBUQUERQU	52,794
R01AG10942-02S1	MACLEAN, DAVID B GROWTH HORMONE/EXERCISE FOR THE FRAIL ELDERLY	04-01-94/06-30-94	RHODE ISLAND HOSPITAL (PROVIDENCE,	17,915
R01AG10942-03	MACLEAN, DAVID B GROWTH HORMONE AND/OR EXERCISE FOR THE FRAIL ELDERLY	07-01-94/06-30-95	RHODE ISLAND HOSPITAL (PROVIDENCE,	737,000
R01AG10943-02S1	SCHWARTZ, ROBERT S GROWTH FACTORS AND EXERCISE IN OLDER WOMEN	11-26-93/06-30-94	UNIVERSITY OF WASHINGTON	15,000
R01AG10943-02S2	SCHWARTZ, ROBERT S GROWTH FACTORS AND EXERCISE	04-20-94/06-30-94	UNIVERSITY OF WASHINGTON	29,926

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R01AG10943-03	SCHWARTZ, ROBERT S GROWTH FACTORS AND EXERCISE IN OLDER WOMEN	07-01-94/06-30-95	UNIVERSITY OF WASHINGTON	385,259
R01AG10947-03	GITLIN, LAURA N DEMENTIA MANAGEMENT--HOME INTERVENTION FOR CAREGIVERS	08-01-94/07-31-95	THOMAS JEFFERSON UNIVERSITY	278,152
R35AG10953-03	FRANGIONE, BLAS ALZHEIMERS DISEASE AND AMYLOID PROTEINS	09-01-94/08-31-95	NEW YORK UNIVERSITY	783,715
R01AG10954-03	SNYDER, PETER J WILL TESTOSTERONE INCREASE MUSCLE STRENGTH IN OLDER MEN	07-01-94/06-30-95	UNIVERSITY OF PENNSYLVANIA	150,430
R35AG10963-03	MAYEUX, RICHARD P GENE-ENVIRONMENT INTERACTIONS IN ALZHEIMERS DISEASE	07-01-94/05-31-95	COLUMBIA UNIVERSITY NEW YORK	619,930
R01AG10975-03	TENOVER, JOYCE S TESTOSTERONE THERAPY IN THE HYPOGONADAL AGING MALE	07-01-94/06-30-95	EMORY UNIVERSITY	208,796
R01AG10979-03	YEN, SAMUEL S BENEFICIAL EFFECTS OF GHRH AND MELATONIN IN AGING	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	106,098
R01AG10997-03	HARTMAN, MARK L GROWTH HORMONE AND PHYSICAL TRAINING IN OLDER PERSONS	07-01-94/06-30-95	UNIVERSITY OF VIRGINIA CHARLOTTESVI	249,981
R01AG10998-03	FALANGA, VINCENT STANOZOLOL IN THE ELDERLY WITH VENOUS ULCERS	07-01-94/06-30-95	UNIVERSITY OF MIAMI	159,295
R01AG10999-03	HOFFMAN, ANDREW R GH AND IGF I TREATMENT OF ELDERLY WOMEN	07-01-94/06-30-96	STANFORD UNIVERSITY	249,427
R01AG10999-03S1	HOFFMAN, ANDREW R GH AND IGF IN TREATMENT OF ELDERLY WOMEN	09-30-94/06-30-96	STANFORD UNIVERSITY	68,640
R01AG11002-03	BLACKMAN, MARC R GROWTH HORMONE & SEX STEROID EFFECTS ON SKELETAL MUSCLE	07-01-94/06-30-95	JOHNS HOPKINS UNIVERSITY	280,469
R29AG11017-02	YUAN, JUNYING MOLECULAR STUDIES OF CELL DEATH GENES IN VERTEBRATES	01-01-94/12-31-94	MASSACHUSETTS GENERAL HOSPITAL	113,226
R01AG11023-02	OOI, WEE L EPIDEMIOLOGY OF ORTHOSTATIC HYPOTENSION IN OLD AGE	09-30-94/07-31-95	HEBREW REHABILITATION CENTER FOR AG	127,931
R01AG11026-16	MC CORMICK, J JUSTIN CARCINOGEN INDUCTION OF INFINITE LIFESPAN IN CELLS	04-05-94/03-31-95	MICHIGAN STATE UNIVERSITY	234,700

NATIONAL INSTITUTE ON AGING ACTIVE GRANTS IN FY94

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R01AG11032-01A2	WILLIS, SHERRY L ALZHEIMERS DISEASE AND EVERYDAY COMPETENCE	05-12-94/04-30-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	290,489
R01AG11037-02	BOOKSTEIN, FRED L STATISTICAL ANALYSIS OF BIOMARKERS OF AGING	04-01-94/03-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	142,272
R01AG11038-01A1	HUI, SIU LUI AFRICAN/AFRICAN AMERICAN FRACTURE INCIDENCE AND RISKS	09-30-94/07-31-95	INDIANA UNIV-PURDUE UNIV AT INDIANA	292,238
R01AG11042-02	BERKMAN, LISA F PHYSICAL AND COGNITIVE FUNCTIONING IN OLDEST-OLD	09-01-94/08-31-95	YALE UNIVERSITY	292,009
R01AG11047-02	BOULT, CHARLES E TRIAL OF OUTPATIENT GERIATRIC EVALUATION AND MANAGEMENT	09-30-94/08-31-95	UNIVERSITY OF MINNESOTA TWIN CITIES	579,779
R29AG11053-02	PERKINS, SHERRIE L VITAMIN D AND CSF-1 REGULATION OF OSTEOCLASTOGENESIS	01-05-94/12-31-94	UNIVERSITY OF UTAH	103,454
R01AG11054-02	RUBEN, GEORGE C TAU STRUCTURES IN ALZHEIMER TANGLES AND ON MICROTUBULES	03-18-94/02-28-95	DARTMOUTH COLLEGE	185,036
R01AG11056-01A1S1	WOOD, W GIBSON AGING, CALCIUM, AND BRAIN MEMBRANE CHOLESTEROL DOMAINS	06-01-94/08-31-94	UNIVERSITY OF MINNESOTA TWIN CITIES	13,558
R01AG11056-02	WOOD, W GIBSON AGING, BRAIN MEMBRANE CHOLESTEROL DOMAINS AND CALCIUM	09-01-94/08-31-95	UNIVERSITY OF MINNESOTA TWIN CITIES	243,224
R01AG11060-02	ROBERTS, JAY AGING BIOMARKER--CARDIAC NOREPINEPHRINE	04-01-94/03-31-95	MEDICAL COLLEGE OF PENNSYLVANIA	182,249
R01AG11066-03	SMITH, JAMES R SENESCENT CELL DERIVED INHIBITORS OF DNA SYNTHESIS	08-01-94/07-31-95	BAYLOR COLLEGE OF MEDICINE	247,277
R01AG11067-02	MILLER, RICHARD A IMMUNE AND MUSCLE FUNCTION ASSAYS AS BIOMARKERS OF AGING	04-01-94/03-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	230,406
R01AG11079-02	WITTEN, MATTHEW STATISTICAL ANALYSIS OF BIOMARKERS OF AGING	04-01-94/11-30-94	UNIVERSITY OF TEXAS AUSTIN	43,387
R01AG11080-02	SELL, DAVID R PENTOSIDINE AS A BIOMARKER OF AGING	04-01-94/03-31-95	CASE WESTERN RESERVE UNIVERSITY	120,637
P01AG11084-02	DEMENT, WILLIAM C CIRCADIAN AND HOMEOSTATIC DETERMINANTS OF SLEEP IN AGING	06-05-94/05-31-95	STANFORD UNIVERSITY	507,623

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
P01AG11084-02S1	DEMENT, WILLIAM C CIRCADIAN AND HOMEOSTATIC DETERMINANTS OF SLEEP IN AGING	09-30-94/05-31-95	STANFORD UNIVERSITY	389,083
R01AG11085-02	ELLEDGE, STEPHEN J CELL CYCLE GENES AND CELLULAR SENESCENCE AND AGING	02-25-94/12-31-94	BAYLOR COLLEGE OF MEDICINE	128,253
R01AG11087-02	MC FADDEN, PHILIP N DETERMINANTS OF LONGEVITY IN NEURONAL CELLS	01-01-94/12-31-94	OREGON STATE UNIVERSITY	65,528
R01AG11093-09	JOHNSON, LARRY CONTROL OF SERTOLI CELL NUMBER AND TESTICULAR SIZE	12-01-93/11-30-94	TEXAS A&M UNIVERSITY HEALTH SCIENCE	119,349
R01AG11098-01A1	LIU, JAMES H PROGESTOGEN EFFECT ON BONE AND COGNITION IN MENOPAUSE	03-10-94/02-28-95	UNIVERSITY OF CINCINNATI	365,405
R01AG11099-02	CRUICKSHANKS, KAREN J EPIDEMIOLOGY OF AGE-RELATED HEARING LOSS	03-01-94/02-28-95	UNIVERSITY OF WISCONSIN MADISON	492,614
R01AG11101-02	EVANS, DENIS A RISK FACTORS FOR INCIDENT ALZHEIMERS DISEASE	03-01-94/02-28-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	1,251,605
R01AG11119-02	GUARENTE, LEONARD P CELL SENESCENCE IN SACCHAROMYCES CEREVISIAE	03-18-94/02-28-95	MASSACHUSETTS INSTITUTE OF TECHNOLO	151,387
R01AG11121-02	GABRIELI, JOHN D DECOMPOSITION OF MEMORY FAILURE IN ALZHEIMER'S DISEASE	05-01-94/04-30-95	STANFORD UNIVERSITY	205,326
R01AG11121-02S1	GABRIELI, JOHN D DECOMPOSITION OF MEMORY FAILURE IN ALZHEIMERS DISEASE	07-01-94/04-30-95	STANFORD UNIVERSITY	22,366
R01AG11123-14	WOOD, JOHN G FUNCTIONAL COMPARTMENTALIZATION OF NEURONS AND GLIA	06-20-94/05-31-95	EMORY UNIVERSITY	167,051
R01AG11124-02	RIGNEY, DAVID R BIOMATHEMATICS OF CYCLIN DURING CELL SENESCENCE	03-01-94/12-31-94	BETH ISRAEL HOSP (BOSTON)	100,642
R01AG11125-03	COLE, GREGORY M A NEW APPROACH TO ALZHEIMER PROTEIN BIOCHEMISTRY	06-10-94/05-31-95	SEPULVEDA RESEARCH CORPORATION	96,310
R01AG11126-02	ZAROW, CHRIS MICROGLIAL BIOLOGY--AGE-RELATED RESPONSE TO LESIONS	07-01-94/06-30-95	UNIVERSITY OF SOUTHERN CALIFORNIA	158,252
R01AG11133-01A1	KANE, ROSALIE A FAMILY CARE OF THE OLDEST OLD--A 5-YEAR STUDY	07-01-94/06-30-95	UNIVERSITY OF MINNESOTA TWIN CITIES	200,120

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R01AG11138-03	VAN ELDIK, LINDA J CELL BIOLOGY OF A NEUROTROPHIC PROTEIN FROM GLIAL CELLS	07-01-94/04-30-95	NORTHWESTERN UNIVERSITY	136,531
R01AG11143-03	MC CORMICK, WAYNE C LONG TERM CARE USE IN JAPANESE AMERICAN ELDERLY	07-01-94/06-30-95	UNIVERSITY OF WASHINGTON	236,789
R01AG11144-02	BECKER, GAYLENE CULTURAL RESPONSES TO ILLNESS IN THE MINORITY AGED	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	204,269
R01AG11152-03	CHAPLESKI, ELIZABETH LONG-TERM CARE--SOCIAL NETWORKS AND AMERICAN INDIAN AGE	07-01-94/06-30-95	WAYNE STATE UNIVERSITY	260,093
R01AG11171-03	TENNSTEDT, SHARON L PREDICTORS OF LONG TERM CARE USE--ETHNICITY VS CLASS	07-01-94/06-30-95	NEW ENGLAND RESEARCH INSTITUTE, INC	216,844
R01AG11171-03S1	TENNSTEDT, SHARON L PREDICTORS OF LONG TERM CARE USE--ETHNICITY VS CLASS	09-30-94/06-30-95	NEW ENGLAND RESEARCH INSTITUTE, INC	26,088
R01AG11182-03	LUBBEN, JAMES E OLDER KOREAN AMERICANS--SOCIAL SUPPORT & LONG TERM CARE	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	167,956
R01AG11183-03	COWARD, RAYMOND T RACE AND RESIDENCE DIFFERENCES IN LONG TERM CARE	08-01-94/06-30-95	UNIVERSITY OF FLORIDA	203,636
R25AG11191-03	BENNETT, RUTH COMMUNITY OUTREACH ON AD IN NORTH MANHATTAN AND HARLEM	07-10-94/06-30-95	COLUMBIA UNIVERSITY NEW YORK	108,000
R25AG11196-03	GWYTHER, LISA P DEMENTIA OUTREACH TO MINORITIES--LINKING CARE NETWORKS	07-10-94/06-30-95	DUKE UNIVERSITY	108,000
R25AG11197-03	RANKIN, ERIC D THREE TIERED ALZHEIMERS TRAINING FOR WV PROFESSIONALS	07-10-94/06-30-95	WEST VIRGINIA UNIVERSITY	99,377
R25AG11204-03	LIEBERMAN, MORTON A ALZHEIMERS EDUCATIONAL PROG IN CHINESE/HISPANIC COMMUNIT	08-05-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	103,257
R25AG11213-03	POTTER, JANE F REACHING RURAL COMMUNITIES WITH ALZHEIMERS EDUCATION	07-10-94/06-30-95	UNIVERSITY OF NEBRASKA MEDICAL CENT	108,000
R25AG11216-03	LOMBARDO, NANCY E BOSTON MINORITY DEMENTIA OUTREACH AND EDUCATION PROGRAM	07-20-94/06-30-95	HEBREW REHABILITATION CENTER FOR AG	107,995
R25AG11219-03	CONNELL, CATHLEEN M MICHIGAN ALZHEIMERS DISEASE COMMUNITY EDUCATION	08-10-94/06-30-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	108,000

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG11227-02	NESTLER, JOHN E INSULIN REGULATION OF HUMAN ADRENAL ANDROGEN METABOLISM	01-01-94/12-31-94	VIRGINIA COMMONWEALTH UNIVERSITY	109,633
R01AG11230-02	RAZ, NAFTALI NEURAL CORRELATES OF AGE-RELATED DIFFERENCES IN MEMORY	07-01-94/06-30-95	UNIVERSITY OF MEMPHIS	156,641
R01AG11230-02S1	RAZ, NAFTALI NEURAL CORRELATES OF AGE RELATED DIFFERENCES IN MEMORY	07-01-94/06-30-95	UNIVERSITY OF MEMPHIS	4,896
R01AG11233-01A2	RUBINSTEIN, ROBERT L CHRONIC POVERTY AND THE SELF IN LATER LIFE	09-01-94/08-31-95	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	208,768
R01AG11234-02	KATZ, IRA R DELIRUM RECONSIDERED--ACUTE COGNITIVE IN THE AGED	04-20-94/02-28-95	UNIVERSITY OF PENNSYLVANIA	298,339
R01AG11235-02	CRIMMINS, EILEEN M ACTIVE LIFE EXPECTANCY IN THE OLDER POPULATION	08-01-94/07-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	154,645
R01AG11240-02	MC LAUGHLIN, DIANE K LIFE COURSE TRANSITIONS, GEORAPHY, ELDERLY POVERTY	03-01-94/02-28-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	125,094
R29AG11241-02	FISHER, JANE E CLASSIFICATION OF AGITATION IN ALZHEIMER'S DISEASE	09-01-94/08-31-95	NORTHERN ILLINOIS UNIVERSITY	88,602
R29AG11248-03	MINTZER, JACOBO E CAREGIVING FOR ALZHEIMERS PATIENTS	06-01-94/05-31-95	MEDICAL UNIVERSITY OF SOUTH CAROLIN	100,036
R01AG11249-02	BURKE, DAVID T AGING-RELATED REACTIVATION OF X CHROMOSOME GENES	01-10-94/12-31-94	UNIVERSITY OF MICHIGAN AT ANN ARBOR	174,180
R01AG11255-01A2	KREBS, DAVID E VESTIBULAR REHAB & STABILITY MODELING FOR OLDER PATIENTS	09-01-94/08-31-95	MASSACHUSETTS GENERAL HOSPITAL	192,257
P60AG11268-03	COHEN, HARVEY J CLAUDE D PEPPER OLDER AMERICANS INDEPENDENCE CENTERS	07-15-94/06-30-95	DUKE UNIVERSITY	1,774,478
P60AG11268-03S1	COHEN, HARVEY J CLAUDE D PEPPER OLDER AMERICANS INDEPENDENCE CENTERS	08-10-94/06-30-95	DUKE UNIVERSITY	74,638
R01AG11285-03	MILLER, BAILA H MINORITY USE OF LONG TERM CARE--METHOD AND MEANING	07-01-94/06-30-95	UNIVERSITY OF ILLINOIS AT CHICAGO	218,752
R01AG11290-01A2	MEHTA, PANKAJ D CYTOKINES IN DOWN SYNDROME--LINK TO AD NEUROPATHOLOGY	09-01-94/08-31-95	NEW YORK STATE CNCL FOR MTL HYGIENE	187,650

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R43AG11303-01A1	MOERDER, KARL E TRACKING AND MONITORING TECHNOLOGIES FOR ELDER CARE	06-15-94/12-10-94	TORREY SCIENCE AND TECHNOLOGY CORP	54,906
R44AG11315-02	TORDELLA, STEPHEN J OLDER AMERICANS MARKET--FORCASTS FOR US COUNTIES	07-01-94/05-31-95	DECISION DEMOGRAPHICS	235,015
R25AG11325-03	CUMMINGS, JEFFREY L LOS ANGELES AREA ALZHEIMERS OUTREACH PROJECT	07-10-94/06-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	107,338
R01AG11331-03	CAPLAN, ARNOLD I EXTRACELLULAR MATRIX AND AGING (SKIN)	06-10-94/05-31-95	CASE WESTERN RESERVE UNIVERSITY	413,203
P01AG11337-01A1	YOUNG, A B METABOLIC & EXCITOTOXIC CASCADE IN AGING & ALZHEIMERS	05-15-94/04-30-95	MASSACHUSETTS GENERAL HOSPITAL	1,087,357
U01AG11343-03	FRENCH, FRANK S TRANSCRIPTION REGULATOR MUTATIONS IN PROSTATE CANCER	07-01-94/06-30-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	254,846
R01AG11350-02	RUSSELL, MICHAEL J ANIMAL MODEL OF ALZHEIMER'S DISEASE	06-20-94/05-31-95	UNIVERSITY OF CALIFORNIA DAVIS	159,290
R01AG11350-02S1	RUSSELL, MICHAEL J ANIMAL MODEL OF ALZHEIMERS DISEASE	09-30-94/05-31-95	UNIVERSITY OF CALIFORNIA DAVIS	30,000
R29AG11351-02	SKINNER, MICHAEL H COGNITIVE EFFECTS OF ANTIHYPERTENSIVE DRUGS IN AGED RATS	06-01-94/05-31-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	98,113
R01AG11352-03	MC KINLAY, JOHN B IMPROVING BREAST CANCER CARE THROUGH PATIENT ACTIVATION	09-15-94/08-31-95	NEW ENGLAND RESEARCH INSTITUTE, INC	322,261
R01AG11354-03	ZARIT, STEVEN H MENTAL HEALTH OF CAREGIVERS OF THE ELDERLY	06-15-94/05-31-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	446,305
R29AG11357-01A1	BAKOUCHE, OUAHID ANTITUMORAL PROTERTIES OF AGED MONOCYTES	04-01-94/02-28-95	NORTHWESTERN UNIVERSITY	95,151
R37AG11375-02	KAPLAN, GEORGE A HEALTH AND FUNCTION OVER THREE DECADES IN ALAMEDA COUNTY	04-05-94/03-31-95	CALIFORNIA PUBLIC HEALTH FOUNDATION	556,962
R01AG11378-02	JACK, CLIFFORD R MR HIPPOCAMPAL CHANGES IN ALZHEIMER'S DISEASE AND AGING	06-01-94/05-31-95	MAYO FOUNDATION	146,665
R01AG11379-01A1	AVIS, NANCY E AGE-RELATED DECLINE IN SEXUAL ACTIVITY	01-15-94/12-31-94	NEW ENGLAND RESEARCH INSTITUTE, INC	100,001

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R01AG11379-01A1S1	AVIS, NANCY E AGE-RELATED DECLINE IN SEXUAL ACTIVITY	09-20-94/12-31-94	NEW ENGLAND RESEARCH INSTITUTE, INC	50,000
R01AG11380-01A1	BREITNER, JOHN C S EPIDEMIOLOGY OF ALZHEIMERS DEMENTIA IN CACHE COUNTY UT	09-30-94/08-31-95	DUKE UNIVERSITY	1,591,534
R01AG8[illegible] 2-03	POLLAK, CHARLES P DISRUPTIVE NOCTURNAL BEHAVIORS IN ELDER-CAREGIVER PAIRS	07-01-94/06-30-95	CORNELL UNIVERSITY MEDICAL CENTER	247,078
R01AG11383-03	SCHUBERT, DAVID R BIOLOGY OF EXTRACELLULAR BETA AMYLOID PROTEIN PRECURSOR	08-01-94/07-31-95	SALK INSTITUTE FOR BIOLOGICAL STUDI	198,635
R01AG11384-03	POTTER, PAMELA E CHOLINERGIC RECEPTOR CHANGES IN ALZHEIMERS MODEL	07-01-94/06-30-95	MONTEFIORE MEDICAL CENTER (BRONX, N	95,594
R01AG11385-03	MUCKE, LENNART TRANSGENIC MODELS TO STUDY ALZHEIMERS DISEASE	08-01-94/07-31-95	SCRIPPS RESEARCH INSTITUTE	232,486
R01AG11386-03	MONTEIRO, MERVYN J NOVEL NEUROFILAMENT KINASE	08-01-94/07-31-95	UNIVERSITY OF MARYLAND BALT PROF SC	143,730
R55AG11392-01A1	CRYSTAL, STEPHEN LATER LIFE ECONOMIC OUTCOMES IN LONGITUDINAL PERSPECTIVE	09-30-94/09-29-96	RUTGERS THE STATE UNIV NEW BRUNSWIC	100,000
R01AG11398-03	GOODMAN, MYRON F DNA ENZYMES IN AGING IN DIVIDING AND NONDIVIDING CELLS	06-01-94/05-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	308,153
R29AG11403-01A1	FERRARIS, RONALDO P DIETARY REGULATION OF NUTRIENT ABSORPTION IN AGING	04-01-94/02-28-95	UNIVERSITY OF MEDICINE & DENTISTRY	133,079
R29AG11407-02	ZIMMERMAN, SHERYL I AGED WITH DEMENTIA--FACILITY EFFECTS ON HEALTH OUTCOMES	09-01-94/08-31-95	UNIVERSITY OF MARYLAND BALT PROF SC	135,928
P01AG11412-01A1	VAN CAUTER, EVE ALTERATIONS OF CIRCADIAN TIMING IN AGING	09-01-94 31-95	UNIVERSITY OF CHICAGO	867,482
R01AG11427-02	PFEFFERBAUM, ADOLF MR SPECTROSCOPIC BRAIN IMAGING IN AGING AND DEMENTIA	07-01-94/06-30-95	STANFORD UNIVERSITY	187,136
R01AG11431-03	MC KINLAY, SONJA M TRANSMENOPAUSAL CHANGES IN SEX HORMONES AND LIPIDS	09-20-94/08-31-95	NEW ENGLAND RESEARCH INSTITUTE, INC	180,280
R01AG11432-03	MCKINLAY, SONJA M RISK FACTORS FOR TRANSMENOPAUSAL BONE LOSS	09-20-94/08-31-95	NEW ENGLAND RESEARCH INSTITUTE, INC	188,622

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R15AG11435-01A1	ZWEIFEL, STEPHAN G TRANSMISSION OF MUTANT MITOCHONDRIAL GENOMES IN YEAST	06-15-94/05-31-97	CARLETON COLLEGE	119,262
R15AG11438-01S1	FUTTERMAN, ANDREW M RELIGIOSITY, SOCIAL SUPPORT AND LATE-LIFE STRESS	06-01-94/08-31-95	COLLEGE OF THE HOLY CROSS	19,368
R01AG11441-02	WRONSKI, THOMAS J NOVEL HORMONE DELIVERY SYSTEM FOR TREATING OSTEOPENIA	08-01-94/07-31-95	UNIVERSITY OF FLORIDA	92,179
R15AG11444-01A1	KRUSE, KIPP C LONGEVITY COSTS OF REPRODUCTION IN THE GIANT WATERBUG	06-10-94/05-31-97	EASTERN ILLINOIS UNIVERSITY	99,136
R01AG11451-02	HOYER, WILLIAM J AGING OF VISUAL-COGNITIVE MECHANISMS ON A NEURAL NETWORK	04-01-94/03-31-95	SYRACUSE UNIVERSITY AT SYRACUSE	106,140
R01AG11455-02	BURKHALTER, ANDREAS H AGED-RELATED CHANGES IN CORTICAL CIRCUITS IN HUMANS	07-01-94/06-30-95	WASHINGTON UNIVERSITY	102,678
R01AG11465-01A1	SCARPACE, PHILIP J BROWN FAT THERMOGENESIS RESPONSE TO COLD AND AGE	12-01-93/11-30-94	UNIVERSITY OF FLORIDA	121,676
R01AG11472-01A1	THORPE, SUZANNE R LIPOPROTEIN OXIDATION IN ATHEROSCLEROSIS AND AGING	01-01-94/12-31-94	UNIVERSITY OF SOUTH CAROLINA AT COL	168,009
R01AG11475-02	DAYNES, RAYMOND A PDGF EFFECTS ON T-CELL BEHAVIOR IN AGING	05-01-94/03-31-95	UNIVERSITY OF UTAH	188,548
R01AG11480-03	VOGT, BRENT A ALZHEIMERS DISEASE CLASSES AND CINGULATE REORGANIZATION	08-01-94/07-31-95	WAKE FOREST UNIVERSITY	117,952
R01AG11481-03	LEVY, EFRAT EXPRESSION AND PROCESSING OF APP VARIANTS	08-05-94/07-31-95	NEW YORK UNIVERSITY	231,351
R01AG11482-03	MUFSON, ELLIOTT J GALANIN PLASTICITY IN ALZHEIMERS DISEASE	08-01-94/07-31-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	132,454
R01AG11486-03	LINDEMAN, DAVID A COSTS OF AD SPECIAL CARE UNITS	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA DAVIS	209,667
R01AG11491-02	DOBSON, JAMES G, JR MECHANISMS OF AGING--ENHANCED HEART ADENOSINE	05-01-94/04-30-95	UNIVERSITY OF MASSACHUSETTS MEDICAL	188,995
R01AG11492-02	ARNHEIM, NORMAN MITOCHONDRIAL DNA MUTATION AND AGING	05-01-94/04-30-95	UNIVERSITY OF SOUTHERN CALIFORNIA	158,855

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R01AG11501-03	ALGASE, DONNA L WANDERING--COGNTITION AND ENVIRONMENT	07-10-94/06-30-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	112,998
R01AG11502-03	COHEN-MANSFIELD, JISKA MANAGEMENT OF PACING IN NURSING HOME RESIDENTS	07-01-94/06-30-95	HEBREW HOME OF GREATER WASHINGTON	111,450
R01AG11503-03	GREEN, ROBERT C BEHAVIOR MANAGEMENT INTERVENTIONS IN ALZHEIMERS DISEASE	08-01-94/06-30-95	EMORY U RSITY	114,681
R01AG11505-03	REISBERG, BARRY NON-PHARMACOLOGIC MODIFICATIONS OF BEHAVIOR IN AD	07-01-94/06-30-95	NEW YORK UNIVERSITY	123,508
R01AG11506-03	SLOANE, PHILIP D REDUCING DISRUPTIVE BEHAVIORS IN DEMENTIA DURING BATHING	07-01-94/06-30-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	108,254
R01AG11508-03	GANDY, SAMUEL E MOLECULAR CELL BIOLOGY OF ALZHEIMER AMYLOIDOGENESIS	08-01-94/07-31-95	CORNELL UNIVERSITY MEDICAL CENTER	191,987
R44AG11520-02	RAGER, ROBERT IMPROVING OLDER PERSONS MEMORY SKILLS WITH CD-I TV	08-20-94/03-31-95	COMPACT DISC, INC.	275,000
R01AG11525-03	ANDERSON, STEPHEN STRUCTURAL ASPECTS OF ABPP FUNCTION AND PATHOLOGY	08-01-94/06-30-95	RUTGERS THE STATE UNIV NEW BRUNSWIC	302,755
R01AG11526-03	DAVIES, THERESA A AMYLOID PRECURSOR PROTEIN IN NORMAL/DEMENTIA PLATELETS	07-01-94/06-30-95	BOSTON UNIVERSITY	252,354
R01AG11527-03	DOUGLAS, MICHAEL G BETA AMYLOID PRECURSOR BINDING TO MOLECULAR CHAPERONES	07-01-94/06-30-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	223,851
R01AG11530-02	MC CALLUM, RODERICK E AGING AND TNF-GLUCOCORTICOID INTERACTIONS IN SEPSIS	08-01-94/07-31-95	TEXAS A&M UNIVERSITY HEALTH SCIENCE	165,259
P01AG11531-08	WISNIEWSKI, HENRY M CHANGES IN FUNCTION AMONG MENTALLY RETARDED ADULTS	07-01-94/06-30-95	NEW YORK ST OFF OF MR AND DEV DISAB	633,843
R01AG11534-03	AUSTAD, STEVEN N MANIPULATION OF AGING--DIETARY	07-01-94/06-30-95	UNIVERSITY OF IDAHO	138,410
R01AG11535-03	MUSCH, TIMOTHY I VASCULAR TRANSPORT CAPACITY OF MUSCLE IN HEART FAILURE	09-15-94/08-31-95	PENNSYLVANIA STATE UNIV HERSHEY MED	109,281
R01AG11536-06	WEITZMAN, SIGMUND A OXYGEN RADICAL INDUCED MALIGNANT TRANSFORMATION	08-01-94/07-31-95	NORTHWESTERN UNIVERSITY	111,580

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R01AG11538-02	KAUFMAN, SHARON R PHYSICIAN DILEMMAS IN GERIATRIC CARE	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	113,690
P01AG11542-02	LEE, VIRGINIA M Y IN VITRO AND IN VIVO MODELS OF ALZHEIMER'S DISEASE	09-01-94/08-31-95	UNIVERSITY OF PENNSYLVANIA	726,106
R13AG11543-01	COE, RODNEY M TOTAL QUALITY MANAGEMENT--IMPROVING GERIATRIC CARE	09-30-94/02-28-95	ST. LOUIS UNIVERSITY	22,750
R01AG11549-01A1	GILMORE, GROVER C CONTRAST ENHANCEMENT AND READING IN ALZHEIMERS DISEASE	07-01-94/06-30-95	CASE WESTERN RESERVE UNIVERSITY	160,027
R01AG11552-02	WILMOTH, JOHN R MEASUREMENT AND ANALYSIS OF OLDEST-OLD MORTALITY	07-01-94/06-30-95	UNIVERSITY OF CALIFORNIA BERKELEY	92,972
R01AG11561-01A1	VOOGT, JAMES L AGING AND CHANGES IN DOPAMINE NEURONS	09-01-94/08-31-95	UNIVERSITY OF KANSAS MEDICAL CENTER	162,096
R29AG11564-01A1	PAVALKO, ELIZA K WORK AND HEALTH AMONG WOMEN IN MIDLIFE AND BEYOND	04-01-94/03-31-95	INDIANA UNIVERSITY BLOOMINGTON	95,725
R01AG11567-01A1	IDLER, ELLEN L EPIDEMIOLOGY OF SELF-RATED HEALTH AND FUNCTIONAL ABILITY	08-20-94/06-30-95	RUTGERS THE STATE UNIV NEW BRUNSWIC	90,311
R13AG11570-02	WISE, DAVID A SUMMER INSTITUTE WORKSHOP ON AGING AND HEALTH CARE	07-01-94/06-30-95	NATIONAL BUREAU OF ECONOMIC RESEARC	30,000
P01AG11585-01A1	GLASER, RONALD M STRESS, AGING, AND NEUROENDOCRINE/IMMUNE CHANGES	08-10-94/07-31-95	OHIO STATE UNIVERSITY	985,780
R01AG11595-01A1	GOLDSTEIN, IRIS BLOOD PRESSURE, COGNITIVE FUNCTION, AND MRI	04-15-94/03-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	402,513
R29AG11605-01A2	SHARPS, MATTHEW J AGING AND MEMORY FOR RELATIONAL AND IMAGERIC INFORMATION	09-30-94/06-30-95	CALIFORNIA STATE UNIVERSITY FRESNO	99,988
R01AG11622-02	MADDEN, DAVID J NEUROIMAGING OF AGE-RELATED COGNITIVE CHANGES	09-01-94/08-31-95	DUKE UNIVERSITY	272,488
R37AG11624-01A1	MOR, VINCENT DO GOOD NURSING HOMES ACHIEVE GOOD OUTCOMES?	07-01-94/06-30-95	BROWN UNIVERSITY	248,579
R01AG11628-01	SPEAR, PETER D NEURAL BASES OF VISUAL DEFICITS DURING AGING	05-01-94/04-30-95	UNIVERSITY OF WISCONSIN MADISON	320,401

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG11636-02	SCHULTZ, STEVE C THREE-DIMENSIONAL STRUCTURE OF THE ENDS OF CHROMOSOMES	09-30-94/08-31-95	UNIVERSITY OF COLORADO AT BOULDER	168,075
R29AG11638-02	SMITH, GLENN E PREDICTORS OF INSTITUTIONALIZATION IN DEMENTIA PATIENTS	09-01-94/08-31-95	MAYO FOUNDATION	109,886
R01AG11643-02	HARRISON, DAVID E SELECTING AND IDENTIFYING GENES IMPORTANT IN LONGEVITY	09-20-94/08-31-95	JACKSON LABORATORY	326,918
R01AG11644-02	TOWER, JOHN G I	09-20-94/08-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	186,824
R01AG11653-02	MOUNTZ, JOHN D CORRECTION OF T-CELL AGING IN TRANSGENIC MICE	08-01-94/07-31-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	167,700
R01AG11658-02	CAMPISI, JUDITH SENESCENCE AND LONGEVITY-MODULATING GENES	09-20-94/08-31-95	UNIVERSITY OF CALIFORNIA BERKELEY	265,232
R01AG11659-02	WARD, SAMUEL LIFESPAN ENHANCING MUTATIONS IN C ELEGANS	08-01-94/07-31-95	UNIVERSITY OF ARIZONA	168,260
R01AG11659-02S1	WARD, SAMUEL LIFESPAN ENHANCING MUTATIONS IN C ELEGANS	09-01-94/07-31-95	UNIVERSITY OF ARIZONA	14,353
R01AG11660-01S1	JAZWINSKI, S MICHAL YEAST--A SOURCE AND A TEST SYSTEM FOR LAGS	03-10-94/08-31-94	LOUISIANA STATE UNIV MED CTR NEW OR	7,840
R01AG11660-02	JAZWINSKI, S MICHAL YEAST--A SOURCE AND A TEST SYSTEM FOR MAMMALIAN LAGS	09-20-94/08-31-95	LOUISIANA STATE UNIV MED CTR NEW OR	254,704
P50AG11669-01S1	JETTE, ALAN M RESEARCH CENTER ON APPLIED GERONTOLOGY	04-01-94/08-31-94	NEW ENGLAND RESEARCH INSTITUTE, INC	8,031
P50AG11669-02	JETTE, ALAN M RESEARCH CENTER ON APPLIED GERONTOLOGY	09-10-94/08-31-95	NEW ENGLAND RESEARCH INSTITUTE, INC	448,992
P50AG11684-01S1	BALL, KARLENE K ENHANCING MOBILITY IN THE ELDERLY	06-10-94/08-31-94	WESTERN KENTUCKY UNIVERSITY	250,000
P50AG11684-02	BALL, KARLENE K ENHANCING MOBILITY IN THE ELDERLY	09-01-94/08-31-95	WESTERN KENTUCKY UNIVERSITY	357,148
R01AG11687-02	MILLER, RICHARD A GENETIC CONTROL OF LONGEVITY IN MICE	09-30-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	273,471

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG11703-01A1	FRIED, LINDA P RISK FACTORS FOR PHYSICAL DISABILITY IN AGING WOMEN	06-10-94/05-31-95	JOHNS HOPKINS UNIVERSITY	372,775
R01AG11703-01A1S1	FRIED, LINDA P RISK FACTORS FOR PHYSICAL DISABILITY IN AGING WOMEN	09-30-94/05-31-95	JOHNS HOPKINS UNIVERSITY	235,000
R01AG11705-01A1	FERRARO, KENNETH F AGING & HEALTH ASSESSMENTS AMONG BLACK & WHITE ADULTS	09-01-94/07-31-95	PURDUE UNIVERSITY WEST LAFAYETTE	105,481
R29AG11706-02	MC CLELLAN, MARK BARR HEALTH TECHNOLOGIES' COSTS AND OUTCOMES IN THE ELDERLY	06-05-94/05-31-95	NATIONAL BUREAU OF ECONOMIC RESEARC	99,620
P50AG11711-01S1	PILLEMER, KARL A APPLIED GERONTOLOGY	06-01-94/07-31-94	CORNELL UNIVERSITY ITHACA	10,597
P50AG11711-02	PILLEMER, KARL A CORNELL CENTER ON APPLIED GERONTOLOGY	09-10-94/07-31-95	CORNELL UNIVERSITY ITHACA	495,203
P50AG11715-02	PARK, DENISE C SOUTHEASTERN CENTER FOR APPLIED COGNITIVE AGING RESEARCH	09-10-94/07-31-95	UNIVERSITY OF GEORGIA	483,770
P50AG11719-02	MORRIS, JOHN N CENTER OF RESEARCH ON APPLIED GERONTOLOGY	09-10-94/08-31-95	HEBREW REHABILITATION CENTER FOR AG	452,875
R01AG11722-02	CURTSINGER, JAMES W QTL-MAPPING OF LONGEVITY GENES IN DROSOPHILA	09-25-94/08-31-95	UNIVERSITY OF MINNESOTA TWIN CITIES	201,756
R01AG11728-02	LUNDBLAD, VICTORIA J TELOMERE REPLICATION AND SENESCENCE IN YEAST	09-25-94/08-31-95	BAYLOR COLLEGE OF MEDICINE	169,025
P50AG11748-01S1	CZAJA, SARA J MIAMI CENTER ON HUMAN FACTORS AND AGING RESEARCH	06-15-94/07-31-94	UNIVERSITY OF MIAMI CORAL GABLES	4,639
P50AG11748-02	CZAJA, SARA J MIAMI CENTER ON HUMAN FACTORS AND AGING RESEARCH	09-10-94/07-31-95	UNIVERSITY OF MIAMI CORAL GABLES	306,189
R01AG11755-01A1	GREENAMYRE, JOHN T ELECTRON TRANSPORT ENZYMES IN ALZHEMIERS DISEASE	05-01-94/04-30-95	UNIVERSITY OF ROCHESTER	204,486
R01AG11758-02	HAYWARD, MARK D ACTIVE LIFE EXPECTANCY IN THE OLDER POPULATION	08-01-94/07-31-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	51,919
R01AG11759-02	FUTRELL, NANCY N CALICIFICATION AND LACUNE FORMATION IN AGED RAT BRAIN	02-17-94/01-31-95	CREIGHTON UNIVERSITY	157,125

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG11759-02S1	FUTRELL, NANCY N CALICIFICATION AND LACUNE FORMATION IN AGED BRAIN	09-20-94/01-31-95	CREIGHTON UNIVERSITY	1,332
R37AG11761-01A1	LEE, RONALD D ECONOMIC DEMOGRAPHY OF INTER-AGE TRANSFER	04-20-94/03-31-95	UNIVERSITY OF CALIFORNIA BERKELEY	175,466
R01AG11762-01A1	SCHELLENBERG, GERARD D CLONING OF THE CHROMOSOME 14 ALZHEIMERS DISEASE GENE	06-01-94/04-30-95	UNIVERSITY OF WASHINGTON	247,814
R01AG11773-01A1	MACDONALD, MARYELLEN C SENTENCE PROCESSING IN NORMAL AGING AND DEMENTIA	09-30-94/08-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	232,687
R29AG11805-02	BABB, TONY G NORMAL AGING AND VENTILATORY LIMITS TO PERFORMANCE	04-15-94/03-31-95	UNIVERSITY OF TEXAS SW MED CTR/DALL	85,161
R13AG11807-01	MILLER, RICHARD A 1994 GORDON CONFERENCE ON THE BIOLOGY OF AGING	02-01-94/01-31-95	GORDON RESEARCH CONFERENCES	34,000
R13AG11808-01	OUSLANDER, JOSEPH G URINARY INCONTINENCE IN FRAIL OLDER ADULTS	01-01-94/12-31-94	UNIVERSITY OF CALIFORNIA LOS ANGELE	12,100
R13AG11809-01S1	YU, BYUNG P PHYSIOLOGICAL BASIS OF AGING--MOLECULE TO ORGANISM	11-12-93/11-30-93	GERONTOLOGICAL SOCIETY OF AMERICA	12,160
R01AG11810-01	CLARK, FLORENCE A EFFECTIVENESS OF TWO OT TREATMENTS FOR THE ELDERLY	02-15-94/01-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	220,001
R01AG11810-01S1	CLARK, FLORENCE A EFFECTIVENESS OF TWO TREATMENTS FOR THE ELDERLY	06-20-94/01-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	26,624
R01AG11811-03	EVANS, WILLIAM J PROTEIN, ENERGY & EXERCISE: EFFECTS ON SENESCENT MUSCLE	07-05-94/04-30-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	224,362
R01AG11811-03S1	EVANS, WILLIAM J PROTEIN, ENERGY, AND EXERCISE--EFFECTS ON SENESCENT MUSC	08-10-94/04-30-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	27,070
R01AG11812-02	FIATARONE, MARIA A EXERCISE TRAINING IN FUNCTIONALLY IMPAIRED OLDER WOMEN	05-01-94/04-30-95	TUFTS UNIVERSITY BOSTON	338,198
R01AG11814-01A1	FERAMISCO, JAMES R MECHANISMS OF HUMAN CELL SENESCENCE	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	182,590
R01AG11815-01A1	WOLF, DOUGLAS A DYNAMIC MICROSIMULATION OF ELDERS' HEALTH AND WELL-BEING	08-20-94/06-30-95	SYRACUSE UNIVERSITY AT SYRACUSE	224,913

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG11816-01	KENYON, CYNTHIA J GENETIC ANALYSIS OF AGING IN C ELEGANS	04-01-94/03-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	161,356
R01AG11820-01	STUART, BRUCE C C	08-25-94/07-31-95	PENNSYLVANIA STATE UNIVERSITY-UNIV	114,525
R13AG11822-01	LANDFIELD, PHILIP W BRAIN CORTICOSTERONE RECEPTORS	02-01-94/01-31-95	NEW YORK ACADEMY OF SCIENCES	43,900
R01AG11833-01	TOWER, JOHN G AGING-SPECIFIC GENE EXPRESSION IN DROSOPHILA	12-01-93/11-30-94	UNIVERSITY OF SOUTHERN CALIFORNIA	167,597
R01AG11836-01A1	GALE, WILLIAM G PUBLIC POLICIES EFFECTS ON SAVING FOR RETIREMENT	09-01-94/07-31-95	BROOKINGS INSTITUTION	106,242
R01AG11852-01A1	MANTYH, PATRICK W AGGREGATION/DEPOSITION OF B AMYLOID IN ALZHEIMER DISEASE	09-10-94/06-30-95	UNIVERSITY OF MINNESOTA TWIN CITIES	121,004
R01AG11854-01A1	GERON, SCOTT M SATISFACTION OF FRAIL ELDERLY WITH HOME BASED SERVICES	09-15-94/08-31-95	BOSTON UNIVERSITY	142,131
R01AG11859-01A1	PEARLSON, GODFREY D AGING, BRAIN IMAGING, AND COGNITION	09-30-94/06-30-95	JOHNS HOPKINS UNIVERSITY	344,762
R29AG11862-01A1	HEBERT, LIESI E EPIDEMIOLOGY OF A D IN WOMEN--RISK AND IMPACT	09-15-94/06-30-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	103,508
R01AG11871-02	HARDY, JOHN GENETICS OF EARLY-ONSET ALZHEIMER'S DISEASE	07-01-94/06-30-95	UNIVERSITY OF SOUTH FLORIDA	284,302
R01AG11872-01S1	SMALL, GARY W HLA ASSOCIATION IN ALZHEIMERS DISEASE	03-21-94/07-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	19,743
R01AG11874-01	WISE, DAVID A FIRM HEALTH INSURANCE PLANS	07-01-94/06-30-95	NATIONAL BUREAU OF ECONOMIC RESEARC	202,248
R01AG11875-01A1	LI, CHRISTINE BETA-AMYLOID PRECURSOR-LIKE GENE IN C. ELEGANS	09-10-94/08-31-95	BOSTON UNIVERSITY	177,551
R01AG11886-01A1	LITVIN, SANDRA GRANDDAUGHTERS' INVOLVEMENT IN FILIAL CAREGIVING	09-15-94/08-31-95	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	198,110
R29AG11895-01	GRUBER, JONATHAN H HEALTH INSURANCE REFORM, OLDER WORKERS, AND RETIREMENT	08-20-94/07-31-95	NATIONAL BUREAU OF ECONOMIC RESEARC	117,555

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG11899-01	TANZI, RUDOLPH APP-RELATED GENES AND ALZHEIMER'S DISEASE	01-01-94/12-31-94	MASSACHUSETTS GENERAL HOSPITAL	216,220
R01AG11903-01A1	CUELLO, A CLAUDIO TROPHIC FACTOR-INDUCED SYNAPTIC REGROWTH IN THE CNS	09-30-94/08-31-95	MC GILL UNIVERSITY	77,875
R01AG11906-02	STEPHENS, MARY A MULTIPLE ROLES OF MIDDLE GENERATION CAREGIVING WOMEN	09-15-94/08-31-95	KENT STATE UNIVERSITY AT KENT	220,660
P01AG11915-01A1	WEINDRUCH, RICHARD H DIETARY RESTRICTION AND AGING	04-20-94/02-28-95	UNIVERSITY OF WISCONSIN MADISON	670,854
R01AG11930-01	HUGHES, SUSAN L IMPACT OF TEAM MANAGED/HOSPITAL LINKED HOME CARE	04-21-94/03-31-95	NORTHWESTERN UNIVERSITY	207,239
R01AG11932-01A1	SINGH, TOOLSEE J PROLINE DIRECTED KINASES IN ALZHEIMERS DISEASE	08-10-94/07-30-95	INSTITUTE FOR BASIC RES IN DEV DISA	162,229
R43AG11938-01A1	LAPKOFF, SHELLEY F NEW POPULATION PROJECTION METHOD FOR SMALL AREAS	02-25-94/01-31-95	LAPKOFF AND GOBALET DEMOGRAPHIC RES	73,926
P01AG11952-01A1	GERTLER, PAUL J DETERMINANTS OF HEALTHY AGING IN RURAL POPULATIONS	09-30-94/07-31-95	RAND CORPORATION	498,000
R25AG11953-02	JONES, JAMES M PREDOCTORAL RESEARCH SCIENTIST PROGRAM IN PSYCHOLOGY	09-01-94/08-31-95	AMERICAN PSYCHOLOGICAL ASSOCIATION	98,631
R01AG11957-01	DEATON, ANGUS S AGING AND SAVING IN DEVELOPED AND DEVELOPING COUNTRIES	08-20-94/07-31-95	NATIONAL BUREAU OF ECONOMIC RESEARC	25,000
R01AG11958-01	WYSS, J MICHAEL MECHANISMS OF AGE RELATED PLASTICITY IN THE CORTEX	05-01-94/04-30-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	174,708
R01AG11965-01	BOX, HAROLD C MULTILESIONAL ASSAYS FOR OXIDATIVE DNA DAMAGE	12-01-93/11-30-94	ROSWELL PARK MEMORIAL INSTITUTE	99,430
R29AG11966-03	SANDS, LAURA P DETECTING ACUTE COGNITIVE CHANGES IN ALZHEIMERS PATIENTS	09-01-94/08-31-95	MOUNT ZION INSTITUTE ON AGING	102,323
R01AG11967-02	CORTOPASSI, GINO A AGING, SOMATIC MUTATION, AND HEART DISEASE	05-01-94/04-30-95	UNIVERSITY OF SOUTHERN CALIFORNIA	120,537
R01AG11967-02S1	CORTOPASSI, GINO A AGING, SOMATIC MUTATION, AND HEART DISEASE	08-20-94/04-30-95	UNIVERSITY OF SOUTHERN CALIFORNIA	9,750

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R01AG11971-01A1	LONGINO, CHARLES F, JR FUNCTIONAL HEALTH AND GEOGRAPHIC MOBILITY IN OLD AGE	08-10-94/07-31-95	WAKE FOREST UNIVERSITY	140,000
R03AG11982-01S1	LEE, SANDRA S ETHNIC IDENTITY OF KOREAN ELDERLY IN JAPAN	08-25-94/08-31-94	UNIVERSITY OF CALIFORNIA SAN FRANCI	10,606
R29AG11985-02	MYERS, ELIZABETH R BIOMECHANICS OF VERTEBRAL FRACTURE RISK	08-01-94/07-31-95	BETH ISRAEL HOSP (BOSTON)	110,035
R29AG11985-02S1	MYERS, ELIZABETH R BIOMECHANICS OF VERTEBRAL FRACTURE RISK	08-05-94/07-31-95	BETH ISRAEL HOSP (BOSTON)	20,204
R01AG11987-01	COLBY, HOWARD D CHANGES IN ADRENAL ALPHA-TOCOPHEROL WITH AGING	01-01-94/12-31-94	PHILADELPHIA COLLEGE OF PHARMACY-SC	125,386
R01AG11994-01	LILLARD, LEE A HEALTH, MORTALITY, SOCIAL INSURANCE, AND SAVING	09-30-94/07-31-95	RAND CORPORATION	128,998
R03AG12000-01S1	BRODIE, STEVEN G GENETIC REGULATION OF IRON STORES	09-20-93/04-30-95	UNIVERSITY OF NEW MEXICO ALBUQUERQU	18,036
R03AG12003-01S1	MAKI, REIKO EXCITATORY TRANSMISSION MODULATION BY GLUTAMATE UPTAKE	09-25-94/08-31-95	UNIVERSITY OF PENNSYLVANIA	15,000
R13AG12006-01A1	TORREY, BARBARA B WORKSHOPS ON THE DEMOGRAPHY OF AGING	02-15-94/02-14-95	NATIONAL ACADEMY OF SCIENCES	110,000
R01AG12019-01A1	SCHELLENBERG, GERARD D CLONING OF THE CHROMOSOME 8 WERNERS SYNDROME GENE	09-10-94/08-31-95	UNIVERSITY OF WASHINGTON	174,798
R01AG12025-01	GOLDSTEIN, MICHAEL G MEDICAL OFFICE-BASED ACTIVITY COUNSELING OF OLDER ADULTS	02-15-94/01-31-95	MIRIAM HOSPITAL	360,736
R01AG12028-01	HARDY, JOHN APP TRANSFECTION TO STUDY ALPHA- AND BETA- SECRETASES	05-12-94/04-30-95	UNIVERSITY OF SOUTH FLORIDA	139,945
R01AG12033-01	RILEY, JAMES C FEMALE HEALTH EXPERIENCE OVER THE ADULT LIFE COURSE	01-01-94/12-31-94	INDIANA UNIVERSITY BLOOMINGTON	49,608
R01AG12033-01S1	RILEY, JAMES C FEMALE HEALTH EXPERIENCE OVER THE ADULT LIFE COURSE	06-15-94/12-31-94	INDIANA UNIVERSITY BLOOMINGTON	1,737
P20AG12042-02	PROHASKA, THOMAS MINORITY ELDERLY HEALTH PROMOTION CENTER	09-25-94/08-31-95	UNIVERSITY OF ILLINOIS AT CHICAGO	482,249

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
P20AG12044-02	HAZUDA, HELEN P HISPANIC HEALTHY AGING CENTER	09-30-94/08-31-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	422,676
P20AG12057-02	LEVKOFF, SUE E HEALTH PROMOTION FOR DEMENTED ETHNIC MINORITY ELDERS	09-10-94/08-31-95	HARVARD UNIVERSITY	489,928
P20AG12058-02	ANDERSON, NORMAN B EXPLORATORY CENTER FOR RESEARCH ON HEALTH PROMOTION	09-10-94/08-31-95	DUKE UNIVERSITY	493,986
P20AG12059-02	ALLEN, WALTER R FAMILY AND THE HEALTH OF AFRICAN-AMERICAN ELDERLY	09-10-94/08-31-95	RAND CORPORATION	529,589
P20AG12059-02S1	ALLEN, WALTER R FAMILY AND THE HEALTH OF AFRICAN AMERICAN ELDERLY	09-30-94/08-31-95	RAND CORPORATION	55,488
P20AG12072-01S1	LEVENTHAL, HOWARD PROMOTING HEALTH	06-01-94/08-31-94	RUTGERS THE STATE UNIV NEW BRUNSWIC	6,602
P20AG12072-02	LEVENTHAL, HOWARD PROMOTING HEALTH IN ELDERLY AFRICAN-AMERICANS	09-25-94/08-31-95	RUTGERS THE STATE UNIV NEW BRUNSWIC	448,805
R43AG12074-01	ARONSTEIN, ZELDA RECREATION PRODUCT INTERVENTIONS FOR DEMENTIA RESIDENTS	04-01-94/10-31-94	CROSS CREEK RECREATIONAL PRODUCT	73,710
R43AG12080-01A1	EVANS, MARI-LYNN C DEVELOPING VIDEO AND PRINT LIBRARY OF LIFE CARE PROGRAM	09-30-94/03-31-95	EVENING STAR PRODUCTIONS OF OHIO	76,850
R43AG12081-01	GERTMAN, PAUL M INTERACTIVE HOME HEALTH COMPUTER SYSTEM	04-21-94/10-31-94	LAZO, GERTMAN AND ASSOCIATES, INC.	80,157
R43AG12085-01	CHEN, SUIO-LING INHIBITION OF B-AMYLOID-INDUCED COMPLEMENT ACTIVATION	04-05-94/04-30-95	GLIATECH, INC.	80,249
R01AG12101-02	DE LEON, MONY J PREDICTORS OF COGNITIVE DECLINE IN NORMAL AGING	09-01-94/08-31-95	NEW YORK UNIVERSITY	266,292
N01AG12101-04	MULIVOR, RICHARD A. SELECTION, PRODUCTION, CHARACTERIZATION OF GENETICALLY	01-31-94/12-15-94	CORIELL INSTITUTE FOR MEDICAL RESEA	626,762
N01AG12101-05	MULIVOR, RICHARD A. GENETICALLY MARKED CELLS FOR AGING RESEARCH	06-29-94/01-31-95	CORIELL INSTITUTE FOR MEDICAL RESEA	85,695
N01AG12102-06	BLAZER, DAN POPULATIONS FOR EPIDEMIOLOGIC STUDIES OF THE ELDERLY	04-28-94/02-28-95	DUKE UNIVERSITY	

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG12105-02	GROVES, ROBERT M SURVEY DESIGN ACKNOWLEDGING NONRESPONSE	09-01-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	142,335
R01AG12106-02	GLYNN, ROBERT J MISSING AND MISMEASURED DATA IN STUDIES OF THE ELDERLY	08-01-94/07-31-95	BRIGHAM AND WOMEN'S HOSPITAL	112,059
N01AG12112-05	FRIED, LINDA P WOMEN'S AGING STUDY	04-20-94/12-15-94	JOHNS HOPKINS UNIVERSITY	
N01AG12112-06	FRIED, LINDA P WOMEN'S AGING STUDY	06-29-94/07-15-95	JOHNS HOPKINS UNIVERSITY	938,294
N01AG12112-07	FRIED, LINDA P WOMEN'S HEALTH AND AGING	06-30-94/11-30-96	JOHNS HOPKINS UNIVERSITY	1,300,000
R01AG12117-01	ATTARDI, GIUSEPPE MITOCHONDRIAL DNA MUTATIONS AND AGING	05-01-94/04-30-95	CALIFORNIA INSTITUTE OF TECHNOLOGY	200,105
N01AG12117-05	RUSSELL, ROBERT J MAINTENANCE OF A LONG TERM COLONY OF AGED HYBRID RATS	06-30-94/12-31-95	HARLAN SPRAGUE DAWLEY, INC.	511,414
R01AG12122-01	GRANHOLM, ANN-CHARLOTTE E AGED FOREBRAIN CHOLINERGIC NEURONS AND NGF DELIVERY	04-08-94/03-31-95	UNIVERSITY OF COLORADO HLTH SCIENCE	146,522
R13AG12130-01	PACKER, LESTER OXIDATIVE STRESS AND AGING CONFERENCE	04-20-94/02-28-95	BAY AREA OXYGEN CLUB	15,000
R01AG12131-01	SCHON, ERIC A MITOCHONDRIAL DNA MUTATIONS AND HUMAN AGING	06-10-94/05-31-95	COLUMBIA UNIVERSITY NEW YORK	219,390
R29AG12141-01	ANDERSEN, JULIE MODELS FOR EXPLORING FREE RADICAL DAMAGE	04-20-94/03-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	107,599
R13AG12154-01	SCHNEIDER, EDWARD L SUMMER TRAINING COURSE IN EXPERIMENTAL AGING RESEARCH	04-10-94/03-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	29,292
R44AG12157-03	KILBRIDE, PAUL E DRIVING PERFORMANCE ANALYSIS SYSTEM	09-01-94/08-31-95	VIRTUAL WORLDS, INC.	178,325
R55AG12158-01A1	DAVIS, LISA M ISOLATION AND CHARACTERIZATION OF GENES INVOLVED IN AGIN	09-30-94/09-29-96	FLORIDA INSTITUTE OF TECHNOLOGY	100,000
R29AG12161-01A1	GOLDSTEIN-SHAPSES, SUE A NUTRITIONAL REGULATION OF BONE TURNOVER	09-30-94/08-31-95	RUTGERS THE STATE UNIV NEW BRUNSWIC	123,700

NT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG12163-01	MORROW, DANIEL G DESIGNING REMINDER MESSAGES FOR OLDER ADULTS	09-30-94/08-31-95	DECISION SYSTEMS	180,453
R01AG12171-01	BARKER, WILLIAM H HIP FRACTURE AND STROKE TRENDS IN AN AGING POPULATION	09-01-94/08-31-95	KAISER FOUNDATION RESEARCH INSTITUT	284,225
R01AG12194-02	KRONENBERG, FREDI TEMPERATURE & SLEEP MODULATION OF MENOPAUSAL HOT FLASHES	09-30-94/08-31-95	COLUMBIA UNIVERSITY NEW YORK	230,622
R01AG12203-01	KRAMER, ARTHUR F COGNITIVE PLASTICITY & AGING--DUAL-TASK TRAINING EFFECTS	04-08-94/03-31-95	UNIVERSITY OF ILLINOIS URBANA-CHAMP	143,698
R01AG12210-02	DUTHIE, EDMUND H, JR CAUSES OF LEAN BODY MASS ATROPHY IN AGING MEN	09-01-94/08-31-95	MEDICAL COLLEGE OF WISCONSIN	237,332
R01AG12222-01	SANTORO, NANETTE F REPRODUCTIVE PHYSIOLOGY OF OVARIAN FAILURE	08-15-94/07-31-95	UNIVERSITY OF MEDICINE & DENTISTRY	239,634
R01AG12249-01	KASS, DAVID A VENTRICULAR VASCULAR STIFFENING IN ELDERLY HUMANS	08-10-94/06-30-95	JOHNS HOPKINS UNIVERSITY	191,903
R01AG12257-01	KITZMAN, DALANE W EXERCISE TRAINING EFFECT ON DIASTOLIC DYSFUNCTION	09-01-94/06-30-95	WAKE FOREST UNIVERSITY	158,609
R15AG12263-01	BASHORE, THEODORE R, JR NEUROCOGNITIVE AGING ASSESSED BY SOMATOSENSORY ERP'S	08-20-94/07-31-97	UNIVERSITY OF NORTHERN COLORADO	89,012
R01AG12271-01A1	GLOMACKI, JULIE MARROW BIOLOGY AND BONE MASS--EFFECTS OF AGE AND HORMONE	09-30-94/08-31-95	BRIGHAM AND WOMEN'S HOSPITAL	330,806
R15AG12272-01	HART, BARBARA A AGING HAND--SENSORIMOTOR COMPONENTS OF PRECISION GRIP	06-15-94/05-31-97	UNIVERSITY OF WISCONSIN MILWAUKEE	104,081
R13AG12274-01	WILKING, SPENCER V 1994 SUMMER INSTITUTE IN GERIATRIC MEDICINE	07-05-94/06-30-95	BOSTON UNIVERSITY	49,775
R01AG12275-01	BIGELOW, DIANA J OXIDATION AND AGING IN CARDIAC AND SKELETAL MUSCLE	06-01-94/05-31-95	UNIVERSITY OF KANSAS LAWRENCE	155,776
R01AG12282-01	BREDESEN, DALE E MECHANISM OF INHIBITION OF NEURODEGENERATION AND AGING	05-01-94/04-30-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	174,177
R01AG12287-01A1	HORNSBY, PETER J TYPE II 3BETA HSD GENE REGULATION OF DHEAS SYNTHESIS	09-30-94/08-31-95	BAYLOR COLLEGE OF MEDICINE	146,440

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG12288-01	SIMON, MELVIN I ANIMAL MODELS OF AGING IN RETINAL DEGENERATION	02-10-94/12-31-94	CALIFORNIA INSTITUTE OF TECHNOLOGY	359,679
R01AG12289-01	BENZER, SEYMOUR GENES MAINTAINING NERVOUS SYSTEM INTEGRITY DURING AGING	02-01-94/12-31-94	CALIFORNIA INSTITUTE OF TECHNOLOGY	194,072
R01AG12291-01	FREY, WILLIAM H MIGRATION AND REDISTRIBUTION OF THE US ELDERLY	08-25-94/07-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	143,345
P30AG12300-01	ROSENBERG, ROGER N NEUROBIOLOGY OF ALZHIMERS DISEASE AND AGING	05-01-94/03-31-95	UNIVERSITY OF TEXAS SW MED CTR/DALL	1,100,000
R43AG12305-01A1	VERTREES, JAMES C SUPPORT ENVIRONMENT FOR GRADE OF MEMBERSHIP (GOM) MODEL	07-05-94/12-31-94	SOLON CONSULTING GROUP, LTD.	74,763
R43AG12306-01	KOHNKEN, RUSSELL E CELL CULTURE MODEL FOR ALZHEIMERS ASSOCIATED EPITOPES	04-15-94/09-14-94	MOLECULAR GERIATRICS CORPORATION	75,628
R43AG12308-01	SCHWARTZ, MARK H COMPUTER TOOLS FOR OUTCOMES ANALYSIS OF HIP REPLACEMENT	06-20-94/02-28-95	MANDALA SCIENCES	78,326
R43AG12309-01	BARNEY, HAROLD L CONTINUING CARE RETIREMENT COMMUNITY EXPERIENCE	06-15-94/12-31-94	ACTUARIAL FORECASTING AND RESEARCH	78,713
R43AG12311-01	CALKINS, MARGARET P ENVIRONMENTAL ASSESSMENT PROTOCOL FOR SPECIAL CARE UNITS	08-15-94/02-14-95	INNOVATIVE DESIGNS/ENVIRONMENT/AGIN	74,078
R01AG12316-02	ROSENTHAL, NADIA A TRANSGENIC MOUSE MODELS OF LONGEVITY	09-20-94/08-31-95	MASSACHUSETTS GENERAL HOSPITAL	239,041
R43AG12317-01	NYHUS, LLOYD M PROTECTION OF THE ELDERLY HIP BY PADDED UNDERWEAR	05-01-94/12-31-94	HIPCO, INC.	79,878
R43AG12322-01	ERB, JUDITH L FIBER OPTIC SENSOR FOR REPRODUCTIVE HORMONES	05-10-94/12-31-94	INNOVATION ASSOCIATES, INC.	78,232
R43AG12326-01	HOLMES, DOUGLAS BARCODE TECHNOLOGY APPLIED TO PHYSICIAN MEDICARE BILLING	07-05-94/12-31-94	DMH ASSOCIATES, INC.	80,233
R43AG12343-01	ZEISEL, JOHN R DESIGN CRITERIA FOR ALZHEIMERS SPECIAL CARE PROGRAM	05-20-94/11-15-94	HEARTHSTONE ALZHEIMER CARE	53,500
R01AG12345-02	FISHER, ANNE G DEVELOPMENT OF A PERFORMANCE EVALUATION FOR GERONTOLOGY	09-01-94/08-31-95	JOHNS HOPKINS HOSPITAL	230,198

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ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R29AG12348-02	FOX, KATHLEEN M EPIDEMIOLOGY OF BONE DENSITY IN MOTHERS AND DAUGHTERS	07-01-94/06-30-95	UNIVERSITY OF MARYLAND BALT PROF SC	101,822
R01AG12349-02	HAYES, WILSON C DXA-BASED BONE GEOMETRY AND OSTEOPOROTIC FRACTURE RISK	07-01-94/06-30-95	BETH ISRAEL HOSP (BOSTON)	187,714
R29AG12350-02	KREGEL, KEVIN C SYMPATHETIC NERVOUS SYSTEM ACTIVITY AND AGING IN THE RAT	09-01-94/08-31-95	UNIVERSITY OF IOWA	95,271
R13AG12351-01	MILLER, RICHARD A 1994 GSA MEETING--BIOLOGY OF AGING AND GERIATRIC DISEASE	09-01-94/08-31-95	GERONTOLOGICAL SOCIETY OF AMERICA	34,045
R13AG12351-01S1	MILLER, RICHARD A 1994 GSA MEETING--BIOLOGY OF AGING AND GERIATRIC DISEASE	09-01-94/08-31-95	GERONTOLOGICAL SOCIETY OF AMERICA	12,500
R13AG12353-01	JANICKI, MATTHEW P COLLOQUIUM ON ALZHEIMER DISEASE AND MENTAL RETARDATION	07-25-94/06-30-95	NEW YORK ST OFF OF MR AND DEV DISAB	37,500
R43AG12355-01	LYNDS, JAMES S DEVELOPMENT OF A PORTABLE SPEECH RECOGNITION SYSTEM	02-15-94/07-30-94	WESTEST ENGINEERING CORPORATION	75,000
R55AG12358-01	KING, ABBY C EXERCISE FUNCTIONING AND STRESS IN WOMEN CAREGIVERS	09-30-94/09-29-96	STANFORD UNIVERSITY	100,000
R01AG12364-01	KRIPKE, DANIEL F ILLUMINATION IN HUMAN AGING--SLEEP AND MOOD EFFECTS	09-30-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	258,455
R01AG12366-01	STEEVES, RICHARD H BEREAVEMENT IN AFRICAN AMERICAN AND APPALACHIAN ELDERS	08-01-94/07-31-95	UNIVERSITY OF VIRGINIA CHARLOTTESVI	138,478
R01AG12376-01	KOO, EDWARD H APP INTERNALIZATION--PREREQUISITE FOR AB FORMATION	09-01-94/06-30-95	BRIGHAM AND WOMEN'S HOSPITAL	217,170
R13AG12379-01	DARLINGTON, GRETCHEN J REGULATION OF CELL AND TISSUE DIFFERENTIATION	08-20-94/07-31-95	TISSUE CULTURE ASSOCIATION	6,121
R01AG12381-01	TAYLOR, THOMAS R PHYSICIANS POLICIES IN PREVENTIVE HORMONE THERAPY	09-30-94/08-31-95	UNIVERSITY OF WASHINGTON	236,294
R01AG12387-01	GREENWOOD, PAMELA M SPATIALLY CUED VISUAL PROCESSING OVER THE ADULT LIFESPAN	09-10-94/06-30-95	CATHOLIC UNIVERSITY OF AMERICA	114,708
R01AG12388-01	LASSITER, DONALD L EXPERTISE AND AGE EFFECTS ON PILOT MENTAL WORKLOAD	09-30-94/09-29-95	METHODIST COLLEGE	41,862

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG12393-01	MIROWSKY, JOHN AGING, STATUS, AND THE SENSE OF CONTROL	01-01-94/12-31-94	OHIO STATE UNIVERSITY	287,403
R01AG12396-01	JOHNSON, GAIL V CALCIUM EFFECTS ON TAU PROTEOLYSIS AND CROSSLINKING	09-25-94/08-31-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	136,734
R03AG12397-01	NUNEZ, CHRISTOPHER AGING AND ENERGY EXPENDITURE AMONG HISPANIC WOMEN	06-01-94/05-30-95	ST. LUKE'S ROOSEVELT HOSP CTR (NEW	27,000
R01AG12406-01	HYMAN, BRADLEY T APOLIPOPROTEIN E AND ALZHEIMERS DISEASE	09-01-94/06-30-95	MASSACHUSETTS GENERAL HOSPITAL	244,239
R01AG12412-01	MULLAN, MICHAEL J APOE LOCUS AND RISK FOR ALZHEIMERS DISEASE	09-01-94/06-30-95	UNIVERSITY OF SOUTH FLORIDA	197,074
R03AG12418-01	CHANG, JULIA W SECRETED ASTROCYTIC PROTEINS MODULATED BY INTERLEUKIN-1B	05-15-94/04-30-95	UNIVERSITY OF ROCHESTER	27,000
R03AG12433-01	BARNUM-HUCKINS, KATRINA M LEAD EFFECTS ON TRANSFERRIN FUNCTION AND SYNTHESIS	05-20-94/04-30-95	UNIVERSITY OF TEXAS HLTH SCI CTR SA	27,000
P01AG12435-01	CHUI, HELENA CHANG AGING BRAIN--VASCULATURE, ISCHEMIA AND BEHAVIOR	09-30-94/08-31-95	UNIVERSITY OF SOUTHERN CALIFORNIA	1,088,653
R01AG12447-01	LESNEFSKY, EDWARD J AGING, CARDIAC MITOCHONDRIA, AND ISCHEMIC INJURY	08-01-94/07-31-95	CASE WESTERN RESERVE UNIVERSITY	140,610
R29AG12448-01	SLIWINSKI, MARTIN J AGE-ASSOCIATED CHANGES IN THE SPEED OF COGNITIVE PROCESS	09-10-94/06-30-95	YESHIVA UNIVERSITY	117,418
R29AG12449-01	ALLEN, SUSAN MARITAL GENDER ROLES AND DYNAMICS OF SPOUSAL CARE	09-01-94/08-31-95	BROWN UNIVERSITY	104,541
R01AG12461-01	FISHER, DONALD L MODELS OF AGING--THE MICROSTRUCTURE OF COGNITION	09-30-94/06-30-95	UNIVERSITY OF MASSACHUSETTS AMHERST	68,740
R55AG12467-01	OBEID, LINA M CERAMIDE AND CELL SENESCENCE	09-30-94/09-29-96	DUKE UNIVERSITY	100,000
U01AG12495-01	MIDGLEY, A REES, JR MENOPAUSE AND HEALTH IN AGING WOMEN	09-30-94/07-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	391,106
U01AG12505-01	POWELL, LYNDA H POPULATION STUDY OF MENOPAUSE IN AFRICAN AMERICAN WOMEN	09-30-94/07-31-95	RUSH-PRESBYTERIAN-ST LUKES MEDICAL	424,267

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
U01AG12531-01	NEER, ROBERT M MENOPAUSAL TRANSITION IN BLACK AND WHITE WOMEN	09-30-94/07-31-95	MASSACHUSETTS GENERAL HOSPITAL	406,111
R01AG12532-01	STRITTMATTER, WARREN J APOLIPOPROTEIN E/TAU INTERACTIONS IN ALZHEIMERS DISEASE	09-01-94/06-30-95	DUKE UNIVERSITY	180,956
U01AG12535-01	WEISS, GERSON GYNECOLOGIC IMPACT OF THE MENOPAUSAL TRANSITION	09-30-94/07-31-95	UNIVERSITY OF MEDICINE & DENTISTRY	356,830
U01AG12539-01	GREENDALE, GAIL A EPIDEMIOLOGY AND BIOLOGY OF THE MENOPAUSAL TRANSITION	09-30-94/07-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	401,028
U01AG12546-01	MATTHEWS, KAREN A MENOPAUSAL TRANSITION IN BLACK/WHITE WOMEN	09-30-94/07-31-95	UNIVERSITY OF PITTSBURGH AT PITTSBU	379,151
U01AG12553-01	MC KINLAY, SONJA M MENOPAUSE AND HEALTH IN AGING WOMEN	09-30-94/07-31-95	NEW ENGLAND RESEARCH INSTITUTE, INC	634,859
U01AG12554-01	GOLD, ELLEN B LIFESTYLE AND OVARIAN FUNCTION IN MID-LIFE WOMEN	09-30-94/07-31-95	UNIVERSITY OF CALIFORNIA DAVIS	344,615
R01AG12561-01	KREBS, DAVID E DOES EXERCISE IMPROVE LOCOMOTION IN DISABLED ELDERS?	09-10-94/06-30-95	MASSACHUSETTS GENERAL HOSPITAL	98,664
R41AG12573-01	PARL, STEEN A LOW COST PATIENT LOCATOR SYSTEM FOR GERIATRIC WANDERING	09-01-94/05-31-95	SIGNATRON TECHNOLOGY CORPORATION	99,896
R01AG12575-01	HUDSON, MARGARET F ELDER ABUSE--ITS MEANING TO MIDDLE AGED AND OLDER ADULTS	04-08-94/03-31-95	UNIVERSITY OF NORTH CAROLINA CHAPEL	239,101
R41AG12576-01	SAH, DINAH W HUMAN NEURONS IN VITRO--CHARACTERIZATION OF RECEPTORS	09-08-94/08-31-95	SIGNAL PHARMACEUTICALS, INC.	100,000
P60AG12583-01	GOLDBERG, ANDREW P CLAUDE D PEPPER OLDER AMERICANS INDEPENDENCE CENTER	07-15-94/06-30-95	UNIVERSITY OF MARYLAND BALT PROF SC	977,270
R01AG12587-01	ARMBRECHT, HARVEY J INTESTINAL CALCIUM ABSORPTION--EFFECT OF AGE	09-01-94/08-31-95	ST. LOUIS UNIVERSITY	161,461
R43AG12595-01	PANZER, VICTORIA P REALITY BASED MULTISYSTEM BALANCE ASSESSMENT IN THE AGED	09-10-94/03-31-95	BROOKSIDE RESEARCH AND DEVELOPMENT	80,225
R43AG12601-01	PECHACEK, LARRY D LOCATING DEVICE FOR WANDERING ALZHEIMER PATIENTS	09-30-94/02-28-95	BIOMEDICAL DEVELOPMENT CORPORATION	80,250

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG12609-01	BARNES, CAROL A CELL ASSEMBLIES, PATTERN COMPLETION, AND THE AGING BRAIN	04-15-94/03-31-95	UNIVERSITY OF ARIZONA	144,847
R55AG12610-01	HERNDON, JAMES G NEUROENDOCRINE AND COGNITIVE MECHANISMS OF AGING	09-30-94/09-29-96	EMORY UNIVERSITY	100,000
R01AG12611-01	JANOWSKY, JERI S SEX HORMONES ON COGNITION	04-20-94/03-31-95	OREGON HEALTH SCIENCES UNIVERSITY	131,926
R01AG12611-01S1	JANOWSKY, JERI S SEX HORMONES ON COGNITION	08-01-94/03-31-95	OREGON HEALTH SCIENCES UNIVERSITY	6,281
R43AG12618-01	COHEN, MARC A STATE MODEL FOR ESTIMATING THE USE AND COST OF HOME CARE	09-05-94/02-28-95	LIFEPLANS, INC.	71,423
R43AG12620-01	EVANS, EARL AUTOMATION OF LONG TERM CARE RISK FACTOR GUIDELINES	09-05-94/02-28-95	LIFEPLANS, INC.	73,064
R43AG12621-01	ANDERSON, JOSEPH M ECONOMIC RESOURCES OF THE ELDERLY	09-10-94/02-28-95	CAPITAL RESEARCH ASSOCIATES	77,436
R43AG12626-01	FRIEDMAN, MARK B WIRELESS MONITOR TO PREVENT BED SORES IN NURSING HOMES	08-05-94/02-28-95	AUGMENTECH, INC.	80,246
R43AG12644-01	TOMKINS, EDWARD L MD ACCESS TO DRUG PROFILES TO REDUCE ADVERSE REACTIONS	09-01-94/03-31-95	PROVIDER ADVANTAGE NW, INC.	80,250
R01AG12673-01	NEUNDORFER, MARCIA M DEPRESSION AND AGITATION IN AD--EFFECTS ON CAREGIVERS	09-30-94/08-31-95	CASE WESTERN RESERVE UNIVERSITY	102,923
R29AG12674-01	BONDI, MARK W COGNITIVE ABILITIES OF AT RISK ELDERLY FOR DEMENTIA	04-20-94/03-31-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	84,127
R01AG12685-01	YOUNKIN, STEVEN G FACTORS GOVERNING ALZHEIMERS ABETA PROTEIN	05-01-94/03-31-95	CASE WESTERN RESERVE UNIVERSITY	295,361
R43AG12711-01	OWENS, BOONE B LONG LIFE, RECHARGEABLE HEARING AID	08-15-94/03-31-95	RESEARCH INTERNATIONAL, INC.	80,250
R13AG12719-01	BALL, SHELDON S FREE RADICAL THEORY OF AGING	09-01-94/08-31-95	AMERICAN AGING ASSOCIATION	8,400
S15AG12756-01	REVOILE, SALLY G SMALL INSTRUMENTATION GRANT	09-01-94/08-31-95	GALLAUDET UNIVERSITY	6,133

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ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
S15AG12757-01	WESTFALL, UNA E SMALL INSTRUMENTATION GRANT	09-01-94/08-31-95	OREGON HEALTH SCIENCES UNIVERSITY	5,000
S15AG12758-01	PENDER, NOLA J SMALL INSTRUMENTATION GRANT	09-01-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	18,336
S15AG12759-01	TAUBMAN, PAULA SMALL INSTRUMENTATION GRANT	09-01-94/08-31-95	CALIFORNIA PUBLIC HEALTH FOUNDATION	13,117
S15AG12760-01	VICKROY, THOMAS W SMALL INSTRUMENTATION GRANT	09-01-94/08-31-95	UNIVERSITY OF FLORIDA	20,329
S15AG12761-01	WISE, DAVID A SMALL INSTRUMENTATION GRANT	09-01-94/08-31-95	NATIONAL BUREAU OF ECONOMIC RESEARC	25,247
S15AG12762-01	LOCKSHIN, RICHARD A SMALL INSTRUMENTATION GRANT	09-01-94/08-31-95	ST. JOHN'S UNIVERSITY	7,901
S15AG12763-01	LAWTON, M POWELL SMALL INSTRUMENTATION GRANT	09-01-94/08-31-95	PHILADELPHIA GERIATRIC CTR-FRIEDMAN	14,477
S15AG12764-01	FITZPATRICK, JOYCE J SMALL INSTRUMENTATION GRANT	09-01-94/08-31-95	CASE WESTERN RESERVE UNIVERSITY	18,941
R03AG12782-01	SMITH, KENNETH D FAMILY, HEALTH, OCCUPATION AND THE RETIREMENT PROCESS	09-01-94/08-31-95	JOHNS HOPKINS UNIVERSITY	13,554
R03AG12783-01	APARICIO, CARLOS L INTRAVASCULAR ADHESION OF PROGENITOR T CELLS	09-30-94/09-29-95	RUTGERS THE STATE UNIV NEW BRUNSWIC	19,764
R03AG12785-01	NEYMAN, MICHELLE R MODERATE ALCOHOL INTAKE AND NUTRITION IN THE ELDERLY	09-01-94/08-31-95	UNIVERSITY OF CALIFORNIA DAVIS	24,736
R03AG12786-01	SITARAM, MAHESHWARI MOLECULAR BASIS OF LACTOFERRIN-PROTEIN INTERACTIONS	09-01-94/08-31-95	UNIVERSITY OF NOTRE DAME	22,212
R03AG12787-01	BURTON-DANNER, KERRI B AGING EFFECTS ON PARALLEL GUIDANCE OF VISUAL SEARCH	09-01-94/08-31-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	26,381
R03AG12790-01	ARROYO, ANA M ACCULTURATION, SUPPORT & HEALTH IN PUERTO RICAN ELDERLY	09-01-94/08-31-95	INDIANA UNIVERSITY BLOOMINGTON	25,844
R03AG12791-01	KIM, LINDA Y CONTRAST SENSITIVITY IN DOWN SYNDROME	09-01-94/08-31-95	CASE WESTERN RESERVE UNIVERSITY	27,000

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ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R03AG12793-01	SHIPP, MELVIN D VISION TESTING AND ELDERLY DRIVERS--BENEFIT OR BARRIER	09-01-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	19,273
R03AG12794-01	DALU, ABRAHAM EFFECTS ON CHLORDECONE-POTENTIATED CC14 HEPATOTOXICITY	09-01-94/08-31-95	NORTHEAST LOUISIANA UNIVERSITY	24,750
R03AG12795-01	BASKERVILLE, KAREN A ACH AND CORTICAL PLASTICITY AND THE AGING BRAIN	09-01-94/08-31-95	UNIVERSITY OF TENNESSEE AT MEMPHIS	19,359
R03AG12802-01	CHINAPEN, SANDRA AGING AND RESPONSES TO VAGINOCERVICAL STIMULATION	09-01-94/08-31-95	RUTGERS THE STATE UNIV NEWARK	23,696
P20AG12810-01	WISE, DAVID A NBER CENTER FOR AGING AND HEALTH RESEARCH	09-30-94/08-31-95	NATIONAL BUREAU OF ECONOMIC RESEARC	312,969
P20AG12815-01	LILLARD, LEE A RAND CENTER FOR THE STUDY OF AGING	09-30-94/08-31-95	RAND CORPORATION	237,923
P20AG12836-01	MENKEN, JANE A CENTER ON THE DEMOGRAPHY OF AGING	09-30-94/08-31-95	UNIVERSITY OF PENNSYLVANIA	155,006
P20AG12837-01	WOLF, DOUGLAS A CENTER FOR DEMOGRAPHY AND ECONOMICS OF AGING	09-30-94/08-31-95	SYRACUSE UNIVERSITY AT SYRACUSE	217,980
P20AG12839-01	LEE, RONALD D CENTER ON THE DEMOGRAPHY AND ECONOMICS OF AGING	09-30-94/08-31-95	UNIVERSITY OF CALIFORNIA BERKELEY	155,024
P20AG12844-01	NATHANSON, CONSTANCE A HOPKINS CENTER ON THE DEMOGRAPHY OF AGING	09-30-94/08-31-95	JOHNS HOPKINS UNIVERSITY	154,000
P20AG12846-01	HERMALIN, ALBERT I MICHIGAN EXPLORATORY CENTER ON DEMOGRAPHY OF AGING	09-30-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	346,992
R01AG12850-01	FUKUCHI, KEN-ICHIRO EXPRESSION OF PERLECAN & BETA-AMYLOID PRECURSOR PROTEIN	09-30-94/08-31-95	UNIVERSITY OF WASHINGTON	213,999
P20AG12852-01	MANTON, KENNETH G CENTER FOR LONGITUDINAL ANALYSIS IN MEDICAL DEMOGRAPHY	09-30-94/08-31-95	DUKE UNIVERSITY	306,017
P20AG12857-01	WAITE, LINDA J CENTER ON DEMOGRAPHY AND ECONOMICS OF AGING (COA)	09-30-94/08-31-95	NATIONAL OPINION RESEARCH CENTER	155,090
R01AG12859-01	YUAN, JUNYING CELL DEATH GENES IN TUMORIGENESIS AND DEVELOPMENT	09-01-94/08-31-95	MASSACHUSETTS GENERAL HOSPITAL	229,212

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG12899-01	SILVERMAN, MYRNA HEALTH CARE RESPONSES OF OLDER AFRICAN AMERICANS/WHITES	09-30-94/08-31-95	UNIVERSITY OF PITTSBURGH AT PITTSBU	232,329
R13AG12901-01	HERSH, LOUIS B SUMMER NEUROPEPTIDE CONFERENCE	08-15-94/07-31-95	UNIVERSITY OF KENTUCKY	5,000
R01AG12907-01	GOLDSCHNEIDER, IRVING THYMUS INVOLUTION AND RECENT THYMIC EMIGRANTS	08-15-94/07-31-95	UNIVERSITY OF CONNECTICUT HEALTH CE	196,117
R01AG12908-01	THOMAN, MARILYN L HORMONE AND CYTOKINE INFLUENCES ON THYMIC INVOLUTION	09-15-94/08-31-95	SCRIPPS RESEARCH INSTITUTE	217,600
R43AG12909-01	DROGE, JANET A ADVANCE DIRECTIVES FOR ELDERLY COMMUNITY RESIDING ADULTS	06-05-94/11-30-94	HEALTH AND EDUCATION RESOURCES	80,250
R01AG12910-05	PEARLIN, LEONARD I STRESS AND COPING AMONG AIDS CAREGIVERS	09-30-94/08-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	400,000
R01AG12914-04	YESAVAGE, JEROME A TREATMENTS FOR INSOMNIA	09-30-94/05-31-95	STANFORD UNIVERSITY	191,605
R01AG12915-01	PRINZ, PATRICIA N SLEEP & MENTAL FUNCTION IN THE AGED--ANABOLIC INFLUENCE	09-30-94/08-31-95	UNIVERSITY OF WASHINGTON	151,057
R01AG12928-06	MALENKA, ROBERT C MECHANISMS OF SYNAPTIC PLASTICITY IN THE HIPPOCAMPUS	09-10-94/08-31-95	UNIVERSITY OF CALIFORNIA SAN FRANCI	150,895
R01AG12951-01	BLAIR, HARRY C CALMODULIN AND OSTEOCLAST CONTROL	09-01-94/08-31-95	UNIVERSITY OF ALABAMA AT BIRMINGHAM	165,014
R13AG12952-01	KELLY, REGIS B GORDON CONFERENCE ON THE CELL BIOLOGY OF THE NEURON	08-20-94/07-31-95	GORDON RESEARCH CONFERENCES	9,000
R01AG12953-01	SNOW, ALAN D RAT MODEL TO STUDY BETA/A4 AMYLOID DEPOSITION IN BRAIN	09-30-94/06-30-95	UNIVERSITY OF WASHINGTON	115,788
R01AG12954-04	NEVE, RACHAEL L MOLECULAR BIOLOGY OF ALZHEIMER DISEASE NEURODEGENERATION	09-01-94/06-30-95	MC LEAN HOSPITAL (BELMONT, MA)	181,345
R01AG12963-01	SALMON, DAVID P COGNITIVE STUDIES OF THE LEWY BODY VARIANT OF AD	09-30-94/06-30-95	UNIVERSITY OF CALIFORNIA SAN DIEGO	176,608
R43AG12964-01	OUELLETTE, FRANCES POSTITIONAL DEVICE FOR ESSENTIAL ELEVATION OF UPPER TORS	09-30-94/02-28-95	DESIGN ABLE, INC.	75,495

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
R01AG12981-01	KINDY, MARK S STRUCTURAL PREREQUISITES FOR AMYLOID FIBRILLOGENESIS	09-01-94/06-30-95	UNIVERSITY OF KENTUCKY	156,331
R43AG13050-01	NEDD, KENNETH LONG-TERM CARE AND DISCHARGE ACCESS INFORMATION SYSTEM	09-30-94/03-31-95	HEALTHNET PAGES DATA LINK	68,469
R43AG13051-01	BOAN, DAVID M EVALUATION OF ON-LINE HEALTH SERVICE REFERRAL SYSTEM	09-30-94/03-31-95	BOAN AND ASSOCIATES	76,904
R01AG13056-01	SHEA, THOMAS B EXACERBATION OF AD NEUROPATHOLOGY BY ASTROGLIAL FACTORS	09-30-94/06-30-95	UNIVERSITY OF MASSACHUSETTS LOWELL	143,317
R01AG13059-01	HASLAM, SANDRA Z HORMONAL RESPONSIVENESS OF POSTMENOPAUSAL MAMMARY GLAND	09-01-94/08-31-95	MICHIGAN STATE UNIVERSITY	172,541
R01AG13078-07	FINK, PAMELA J SELECTION OF THE T CELL RECEPTOR REPERTOIRE	09-01-94/08-31-95	UNIVERSITY OF WASHINGTON	188,213
R01AG13087-01	DONAHUE, HENRY J GAP JUNCTIONS AND BONE CELL RESPONSE TO PHYSICAL SIGNALS	09-15-94/08-31-95	PENNSYLVANIA STATE UNIV HERSHEY MED	198,432
P20AG13094-01	WICHA, MAX S BREAST CANCER IN ELDERLY WOMEN	09-30-94/08-31-95	UNIVERSITY OF MICHIGAN AT ANN ARBOR	150,000
P20AG13095-01	GANZ, PATRICIA A BREAST CANCER PREVENTION AND CONTROL IN OLDER WOMEN	09-30-94/08-31-95	UNIVERSITY OF CALIFORNIA LOS ANGELE	147,864
R01AG13107-01	COUNTE, MICHAEL A ANALYSES OF HEALTH MAINTENANCE BEHAVIOR OF OLDER PEOPLE	09-15-94/08-31-95	ST. LOUIS UNIVERSITY	67,003
Y02AO20192-02	FEINLEIB, MANNING 1993 NATIONAL MORTALITY FOLLOWBACK SURVEY	10-01-93/09-30-94	U.S. NATIONAL CENTER FOR HLTH STATI	210,000
Y01AG20195-03	ROTHBART, H L BIOLOGICAL MEDIATORS OF DISEASE-WEIGHT LOSS IN ELDERLY	10-01-93/09-30-94	U.S. AGRICULTURAL RESEARCH SERVICE	48,979
Y02AG20210-02	SNOW, JAMES B AXOPLASMIC TRANSPORT THROUGH OLFACTORY RECEPTOR NEURONS	10-01-93/09-30-94	U.S. NATIONAL INST ON DEAFNESS/COMM	654,000
Y02AG20212-02	HURD, SUZANNE S MANAGEMENT OF ALZHEIMER'S DISEASE SYMPTOMS	10-01-93/09-30-94	U.S. NATIONAL CENTER FOR NURSING RE	851,430
N01AG22102-03	ALLEN, ANTON M HEALTH MONITORING OF AGED HYBRID RAT COLONY	04-25-94/03-30-95	MICROBIOLOGICAL ASSOCIATES, INC.	39,876

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
N03AG30007-01	MAINTENANCE ON ELEVATORS	10-13-93/10-12-94	SSC LARGE BUSINESS-MARYLAND	11,100
N03AG30030-01	MULTI LAYER PAN LINERS	10-22-93/04-15-94	SSC SMALL BUSINESS NEW YORK	24,982
N03AG30030-02	MULTI LAYER PAN LINERS	04-16-94/04-15-95	SSC SMALL BUSINESS NEW YORK	22,853
N03AG30048-01	MINORITY RECRUITMENT	09-27-94/06-26-95	SSC SMALL BUSINESS CALIFORNIA	
Y01AG30216-01	HEMPERLEY, JOHN D FEDLINK MEMBERSHIP-LIBRARY OF CONGREE # 690428, CRLV	10-01-93/09-30-94	U.S. LIBRARY OF CONGRESS	30,240
Y01AG30220-01	FEINLEIB, MANNING MEDICAL CARE EXPENDITURE ESTIMATES	10-01-93/09-30-94	U.S. NATIONAL CENTER FOR HLTH STATI	197,010
Y02AG30224-01	FEINLEIB, MANNING NAT'L DEATH INDEX-MEDICARE-MEDICAID LINKAGE OLDEST OLD	10-01-93/09-30-94	U.S. NATIONAL CENTER FOR HLTH STATI	40,000
N01AG32124-01	BRYAN, R NICK EARLY MARKERS OF ALZHEIMERS DISEASE	06-29-94/09-29-96	JOHNS HOPKINS UNIVERSITY	644,612
N01AG32129-02	RALL, WILLIAM F DEVELOP AND MAINTAIN A CRYOPRESERVED EMBRYO BANK	06-30-94/12-31-95	SMITHSONIAN INSTITUTION	144,506
N03AG40004-00	OPERATION ALZHEIMERS DISEASE EDUCATION/REFERRAL CENTER	01-13-94/12-31-94	HERNER AND COMPANY	940,800
N03AG40004-01	OPERATION ALZHEIMERS DISEASE EDUCATION/REFERRAL CENTER	08-16-94/12-31-94	HERNER AND COMPANY	
N03AG40014-00	VETERINARY SERVICES	06-07-94/07-07-95	UNIVERSITY OF MARYLAND BALT PROF SC	8,150
N03AG40016-00	MECHANICAL MAINTENANCE OF GRC	07-01-94/06-30-95	SSC SMALL BUSINESS MARYLAND	99,362
N03AG40021-00	PROVIDE METAMORPH/METAFLOUR IMAGING SYSTEM	06-13-94/09-11-94	SSC SMALL BUSINESS PENNSYLVANIA	57,465
N03AG40024-00	PROVIDE LASER SCAN CONFOCAL MICROSCOPE	09-02-94/09-02-95	SSC SMALL BUSINESS NEW JERSEY	59,296

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
N03AG40040-00	ASSAYS FOR APOLIPOPROTEIN E-4 GENOTYPE	09-29-94/09-29-95	BIOTECHNOLOGY RESEARCH INSTITUTE	108,000
Y01AG40245-00	ROTHBART, H L CHANGE IN BODY COMPOSITION & FUNCTION IN FRAMINGHAM STUD	10-01-93/09-30-94	U.S. AGRICULTURAL RESEARCH SERVICE	74,739
Y01AG40248-00	PSID EXPECTATIONS SUPPLEMENT & CATI METHODOLOGICAL PROJE	10-01-93/09-30-94	U.S. NATIONAL SCIENCE FOUNDATION	107,764
Y01AG40249-00	HINZ, RICHARD MICROSIMULATION MODELLING OF RETIREMENT INCOME	10-01-93/09-30-94	U.S. DEPARTMENT OF LABOR	40,000
Y01AG40250-00	MCGUFFIN, JOHN C ELEMENTAL ANALYSIS OF POSTMORTEM HUMAN BRAIN TISSUE	10-01-93/09-30-94	U.S. NATIONAL INST OF STANDARDS & T	10,000
Y01AG40250-01	ELEMENTAL ANALYSIS OF POSTMORTEM HUMAN BRAIN TISSUE	10-01-93/12-31-94	U.S. NATIONAL INST OF STANDARDS & T	
Y02AG40251-00	LENFANT, CLAUDE BODY COMPOSITION MEASUREMENT IN THE CARDIOVASCULAR HEALT	10-01-93/09-30-94	U.S. NATIONAL HEART LUNG & BLOOD IN	142,365
Y02AG40254-00	BALES, VIRGINIA S CONFERENCE OF PUBLIC HEALTH IN AGING	10-01-93/09-30-94	U.S. CENTERS FOR DISEASE CONTROL &	17,500
Y02AG40257-00	DU BUY, YVONNE H WORKSHOP OF HUMAN MODELS OF SKELETAL AGING - MARCH 1-2,	10-01-93/09-30-94	U.S. NATIONAL INSTITUTE OF DENTAL R	6,323
Y02AG40259-00	BOOTS, ANDREW J BLSA DATA ACQUISITION UPGARDE PROJECT	07-21-94/09-30-94	U.S. DEPARTMENT OF JUSTICE	31,871
Y01AG40260-00	O'CONNOR, ANDREA MEASURING EXERCISE TOLERANCE IN FRAIL OLDER ADULTS	08-15-94/09-30-94	U.S. DEPT/VETS AFFAIRS MED CTR(BALT	15,000
Y02AG40267-00	WILSON, MAUREEN NIA LABORATORY SUPPORT	10-01-93/09-30-94	U.S. NATIONAL CANCER INSTITUTE	330,000
N01AG42100-00	HANSEN, BARBARA C OBESITY, DIABETES, & AGING ANIMAL RESOURCES	12-17-93/06-20-94	UNIVERSITY OF MARYLAND BALT PROF SC	334,905
N01AG42100-01	HANSEN, BARBARA C OBESITY, DIABETES, & AGING ANIMAL RESOURCES	06-23-94/06-20-95	UNIVERSITY OF MARYLAND BALT PROF SC	348,327
N01AG42100-02	HANSEN, BARBARA C OBESITY, DIABETES, & AGING ANIMAL RESOURCES	09-26-94/06-30-95	UNIVERSITY OF MARYLAND BALT PROF SC	82,236

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
N01AG42142-00	BREITNER, JOHN HEAD INJURY & ALZHEIMER'S DISEASE	09-27-94/08-31-95	DUKE UNIVERSITY	724,070
N01AG42148-00	HURLEY, BEN AGE AND STRENGTH TRAINING EFFECTS ON MUSCLE STRENGTH	09-30-94/09-29-95	UNIVERSITY OF MARYLAND COLLEGE PK C	131,685
N01AG42149-00	FOLEY, DANIEL HONOLULU ASIA AGING STUDY	09-30-94/04-30-95	KUAKINI MEDICAL CENTER	1,767,608
N01AG42150-00	SCHAEFER, GERALD INVESTIGATIONAL NEW DRUG TOXICOLOGY TREAT ALZHEIMER'S	09-30-94/09-29-95	INTERNATIONAL RESEARCH & DEV CORP	450,163
Y01AG50055-11	SCARR, HARRY A INTERNATIONAL DATABASE ON AGING: MICRODATA SUPPLEMENT	10-01-93/09-30-94	U.S. BUREAU OF THE CENSUS	126,009
Y01AG50055-12	SCARR, HARRY INTERNATIONAL DATABASE ON AGING:	10-01-93/09-30-94	U.S. BUREAU OF THE CENSUS	260,000
Y01AG50055-13	SCARR, HARRY A INTERNATIONAL DATABASE ON AGING: MICRODATA SUPPLEMENT	10-01-93/09-30-94	U.S. BUREAU OF THE CENSUS	126,010
Y01AG50055-14	SCARR, HARRY A INTERNATIONAL DATABASE ON AGING	10-01-93/09-30-94	U.S. BUREAU OF THE CENSUS	48,053
Y02AG50072-12	FEINLEIB, MANNING LSDA (LONGITUDINAL STUDY ON AGING)	10-01-93/09-30-94	U.S. NATIONAL CENTER FOR HLTH STATI	30,000
N01AG52115-16	CAIL, STEPHEN P MAINTENANCE OF A LONG-TERM COLONY OF AGED HYBRID RATS	03-29-94/09-29-94	CHARLES RIVER LABORATORIES, INC.	
Y02AG60069-09	TIDMORE, JAMES L BIOMARKERS OF AGING: ANIMAL CARE	10-01-93/09-30-94	U.S. NATIONAL CTR FOR TOXICOLOGICAL	4,302,630
Y02AG60075-09	ASSESSMENT OF PRIMATE AGING: EFFECTS OF CALORIC MOD	10-01-93/09-30-94	U.S. NATIONAL CENTER/RESEARCH RESOU	609,790
Y01AG70094-08	SCARR, HARRY A FEDERAL FORUM SUPPORT AT BUREAU OF THE CENSUS	10-01-93/09-30-94	U.S. BUREAU OF THE CENSUS	260,000
Y02AG70095-08	FEINLEIB, MANNING FEDERAL FORUM ON AGING-RELATED STATISTICS	10-01-93/09-30-94	U.S. NATIONAL CENTER FOR HLTH STATI	225,000
Y01AG80115-09	CORE SUPPORT FOR COMMITTEE ON NATIONAL STATISTICS	10-01-93/09-30-94	U.S. NATIONAL SCIENCE FOUNDATION	39,500

NATIONAL INSTITUTE ON AGING ACTIVE GRANTS IN FY94

ANT NUMBER	PRINCIPAL INVESTIGATOR TITLE	BUDGET DATES START END	INSTITUTION	TOTAL
Y01AG80115-10	WOLFF, HERBERT D CORE SUPPORT FOR COMMITTEE ON NATIONAL STATISTICS	10-01-93/09-30-94	U.S. NATIONAL SCIENCE FOUNDATION	163,000
Y02AG80117-06	FEINLEIB, MANNING NHANES III: NUTRITION SURVEY SUPPLEMENT	10-01-93/09-30-94	U.S. NATIONAL CENTER FOR HLTH STATI	400,000
Y02AG90132-06	SARN, JAMES E MODELLING HEALTH INTERVENTIONS	10-01-93/09-30-94	U.S. OFFICE OF INTERNATIONAL HEALTH	147,515
Y02AG90135-05	AGREEMENT FOR BUILDING 10A, CENTRAL ANIMAL FACILITY	10-01-93/09-30-94	U.S. NATIONAL CENTER/RESEARCH RESOU	33,908
N01AG92116-05	WEISFELDT, MYRON NONINVASIVE ASSESSMENT OF CARDIAC STRUCTURE AND FUNCTION	06-29-94/09-29-95	JOHNS HOPKINS UNIVERSITY	392,309
				367,282,461 1,490

SOCIAL SECURITY ADMINISTRATION

PROGRAMS ADMINISTERED BY THE SOCIAL SECURITY ADMINISTRATION—FISCAL YEAR 1994

The Social Security Administration (SSA) administers the Federal old-age, survivors, and disability insurance (OASDI) program (title II of the Social Security Act). OASDI is the basic program in the United States that provides income to individuals and families when workers retire, become disabled, or die. The basic idea of the cash benefits program is that, while they are working, employees and their employers pay Social Security taxes; the self-employed also are taxed on their net earnings. Then, when earnings stop or are reduced because of retirement in old-age, death, or disability, cash benefits are paid to partially replace the earnings that were lost. Social Security taxes are deposited to the Social Security trust funds and are used only to pay Social Security benefits and administrative expenses of the program. Amounts not currently needed for these purposes are invested in interest bearing obligations of the United States. Thus, current workers help to pay current benefits and, at the same time, establish rights to future benefits.

SSA also administers the Supplemental Security Income (SSI) program for needy aged, blind, and disabled people (title XVI of the Social Security Act). SSI provides a federally financed floor of income for eligible individuals with limited income and resources. SSI benefits are financed from general revenues. In about 49 percent of the cases, SSI is reduced due to individuals having countable income from other sources, including Social Security benefits.

SSA shares responsibility for the black lung program with the Department of Labor. SSA is responsible, under the Federal Coal Mine Health and Safety Act, for payment of black lung benefits to coal miners and their families who applied for those benefits prior to July 1973 and for payment of black lung benefits to certain survivors of miners.

Local Social Security offices process applications for entitlement to the Medicare program and assist individuals with questions concerning Medicare benefits. Overall Federal administrative responsibility for the Medicare program rests with the Health Care Financing Administration, HHS.

Following is a summary of beneficiary data and selected administrative activities for Fiscal Year 1994.

I. OASDI BENEFITS AND BENEFICIARIES

At the beginning of 1994, about 95 percent of all jobs were covered under the Social Security program. It is expected that, under the present law, this percentage of jobs will increase slightly through the end of the century. The major groups of workers not covered under Social Security are Federal workers hired before January 1, 1984 and State and local government employees covered under a retirement system for whom the State has not elected Social Security coverage.

At the end of September 1994, 42.7 million people were receiving monthly Social Security cash benefits, compared to 42.1 million in September 1993. Of these beneficiaries, 26.3 million were retired workers, 3.5 million were dependents of retired workers, 5.5 million were disabled workers and their dependents, 7.4 million were survivors of deceased workers and about 1,800 were persons receiving special benefits for uninsured individuals who reached age 72 some years ago.

The monthly amount of benefits being paid at the end of September 1994 was $26 billion, compared to $24.9 billion at the end of September 1993. Of this amount, $19 billion was payable to retired workers and their dependents, $2.8 billion was payable to disabled workers and their dependents, $4.2 billion was payable to survivors, and $0.3 million was payable to uninsured persons who reached age 72 in the past. (The cost of these special benefits for aged uninsured persons is financed from general revenues, not from the Social Security trust funds.)

Retired workers were receiving an average benefit at the end of September 1994 of $677 (up from $655 in September 1993), and disabled workers received an average benefit of $642 (up from $625 in September 1993).

During the 12 months ending September 1994, $313 billion in Social Security cash benefits were paid, compared to $298 billion for the same period last year. Of that total, retired workers and their dependents received $213 billion, disabled workers and their dependents received $36.8 billion, survivors received $63.5 billion, and uninsured beneficiaries over age 72 received $4.3 million.

Monthly Social Security benefits were increased by 2.6 percent for December 1993 (payable beginning January 1994) to reflect a corresponding increase in the Consumer Price Index (CPI).

Monthly Social Security benefits increase by 2.8 percent for December 1994 (payable beginning January 1995) to reflect a corresponding increase in the CPI.

II. Supplemental Security Income Benefits and Beneficiaries

In January 1994, SSI payment levels (like Social Security benefit amounts) were automatically adjusted to reflect a 2.6 percent increase in the CPI. From January through December 1994, the maximum monthly Federal SSI payment level for an individual was $446. The maximum monthly benefit for a married couple, both of whom were eligible for SSI, was $669. In January 1995, these monthly rates increase to $458 for an individual and $687 for a couple, to reflect a 2.8 percent increase in the CPI.

As of September 1994, 6.3 million aged, blind, or disabled people received Federal SSI or federally administered State supplementary payments. Of the 6.3 million recipients on the rolls during September 1994, about 2.1 million were aged 65 or older. Of the recipients aged 65 or older, about 650,000 were eligible to receive benefits based on blindness or disability. About 4.2 million recipients were blind or disabled and under age 65. During September 1994, Federal SSI benefits and federally administered State supplementary payments totaling slightly over $2.2 billion were paid.

For fiscal year 1994, an estimated $27.7 billion in benefits (consisting of $24.5 billion in Federal funds and $3.2 billion in federally administered State supplementary payments) were paid.

III. Black Lung Benefits and Beneficiaries

Although responsibility for new black lung miner claims shifted to the Department of Labor (DOL) in July 1973, SSA continues to pay black lung benefits to a significant, but gradually declining, number of miners and survivors. (While DOL administers new claims taken by SSA under part C of the Federal Coal Mine Health and Safety Act, SSA is still responsible for administering part B of the Act.)

As of September 1994, about 157,000 individuals (126,000 age 65 or older) were receiving $61 million in black lung benefits which were administered by the Social Security Administration. These benefits are financed from general revenues. Of these individuals, 28,000 miners were receiving $12 million, 98,000 widows were receiving $43 million, and 31,000 dependents and survivors other than widows were receiving $6 million. During fiscal year 1994 SSA paid out black lung payments in the amount of $764 million. About 28,000 miners and 97,000 widows and wives were age 65 or older.

Black lung benefits increased by 2.2 percent effective January 1994 due to special legislation enacted to increase black lung benefits because there was no general Federal pay increase for 1994. The monthly payment to a coal miner disabled by black lung disease increased from $418.20 to $427.40. The monthly benefit for a miner or widow with one dependent increased from $627.30 to $641.10 and with two dependents from $731.90 to $748.00. The maximum monthly benefit payable when there are three or more dependents increased from $836.40 to $854.80. In action on the FY 1995 appropriations bill for the Departments of Labor, HHS, Education and Related Agencies, the Congress approved a general provision to authorize continuation of the January 1994 benefit rate into FY 1995.

IV. Communication and Services

SSA's public information initiatives are aimed at more than 43 million Social Security beneficiaries, 6 million SSI recipients and about 137 million workers currently paying into the system. SSA seeks to ensure that current and future recipients are aware of programs, services, and their rights and responsibilities.

In 1994, SSA planned public information outreach activities to help restore confidence in Social Security, especially among younger working Americans. The principal messages supporting this theme are that Social Security will be there for them; people get their money's worth from Social Security; the agency is striving to provide world-class service; and the disability benefits application and decision processes are being redesigned to provide better service.

These messages were placed in the form of news releases, radio and TV public service announcements, and publications such as the Social Security Courier, a newsletter distributed to national organizations. Messages were also placed on the agency's new Internet information server, which is accessible to Internet users world wide.

SSA produces a wide range of publications on all Social Security programs. About 50 consumer booklets and fact sheets keep the public informed about programs and

policies affecting them. Many publications are also available in Spanish. In 1994, SSA added several publications to the inventory. One, a fact sheet called "When You Retire from Your Own Business," explains to potential Social Security beneficiaries how the agency determines if they are retired from business. A booklet, "Putting Customers First," lists the agency's customer service standards. Another booklet, "Social Security . . . What Every Woman Should Know," explains provisions of special interest to women, including those who work inside and outside the home. The Public Information Distribution Center provides materials directly to external groups and organizations; publications are listed in catalog form for easy ordering.

The agency released several new videos designed to inform the public about Social Security. One, "Changing Focus," highlights important points for people planning to retire. A second video, "Focusing on Service," details services provided to the public by SSA. In addition, a video was distributed about work incentives for disabled beneficiaries under the Supplemental Security Income program.

In addition to these video products, SSA sends a package of radio public service announcements on Social Security themes to 5,000 radio stations twice a year.

V. Summary of Legislation That Affects SSA, 1994

SOCIAL SECURITY INDEPENDENCE AND PROGRAM IMPROVEMENTS ACT OF 1994 (H.R. 4277), P.L. 103–296, SIGNED ON AUGUST 15, 1994

INDEPENDENT AGENCY

Establishes SSA as an independent agency, responsible for the administration of the old-age, survivors, and disability insurance (OASDI) and Supplemental Security Income (SSI) programs. SSA is also required to continue to perform its current functions in assisting in the administration of the Medicare program, the Black Lung program, and the Coal Industry Retirees Health Benefits Act.

The independent SSA is to be headed by a Commissioner, appointed by the President within 60 days of enactment and subject to Senate confirmation, to serve a 6-year term, with the initial term of office ending January 19, 2001. The Commissioner exercises all powers and discharges all duties of SSA, and has authority and control over all SSA personnel and activities. The bill also provides for Presidential appointment and Senate confirmation of a Deputy Commissioner, whose duties and authority are to be prescribed by the Commissioner, to serve a 6-year term, with the initial term of office ending January 19, 2001.

Establishes a position of Inspector General in the Social Security Administration (to be appointed by the President) and provides for the appointment of a Chief Financial Officer by the Commissioner.

Establishes a seven-member, bipartisan Social Security Advisory Board, required to meet at least four times a year, to review and make recommendations to the Commissioner concerning matters of policy; the Board has no role with respect to SSA operations. Board members are to be appointed as follows: Three by the President (no more than two from the same political party), two by the Speaker of the House (with the advice of the Chairman and Ranking Minority Member of the Committee on Ways and Means), and two by the President pro tempore of the Senate (with the advice and consent of the Chairman and Ranking Minority Member of the Committee on Finance). Board members are to serve staggered 6-year terms. Eliminates the requirement of present law for the appointment of a quadrennial Advisory Council on Social Security after the current Advisory Council completes its work.

Requires the Commissioner and the Secretary to develop a joint plan for the transfer of personnel and resources to the independent SSA. For 1 year after the effective date all full-time or part-time permanent employees are protected against separation or reduction in grade or compensation if such action is caused solely as a result of transfer. Further, any employee who was not employed by SSA immediately prior to enactment will be exempt from directed reassignment for 1 year after the effective date; the exemption is limited to 6 months in the case of directed reassignments between Baltimore and Washington, D.C. duty stations.

As an independent agency, SSA will continue to adjudicate Medicare appeals. Under this arrangement, the Secretary will maintain the ultimate authority for appeal decisions, but SSA's Administrative Law Judge corps will continue to conduct Medicare hearings until and unless such time as the Commissioner and the Secretary reach a different agreement.

As required, the Secretary and Commissioner transmitted a report to the House Committee on Ways and Means and Senate Committee on Finance on October 31, 1994, regarding the progress made in developing the inter-agency transfer arrangement. The Secretary and the Commissioner have entered into a written inter-agency arrangement for the transfer of appropriate personnel and resources to the inde-

pendent agency effective March 31, 1995, and on December 29, 1994, submitted the arrangement to the House Committee on Ways and Means, the Senate Committee on Finance, and the General Accounting Office (GAO). GAO is required to submit a report to the Committees evaluating the plan by February 15, 1995.

The independent agency provision becomes effective on March 31, 1995.

RESTRICTIONS ON PAYMENT OF BENEFITS BASED ON DISABILITY TO SUBSTANCE ABUSERS

Places new restrictions on Social Security disability insurance (DI) and SSI benefit payments to individuals disabled by drug addiction and alcoholism (DA&A) and establishes barriers against a beneficiary's using Social Security or SSI benefits to support an addiction. The provisions are generally effective 180 days after enactment.

Payment Limitation

Limits the payment of SSI benefits to 36 months for individuals whose substance abuse is material to their disability. Likewise limits the payment of DI benefits to 36 months but begins with the first month for which treatment is available. The 36-month DA&A payment restrictions sunset October 1, 2004. Medicare, dependents' benefits, and Medicaid (in most States) will continue as long as a terminated beneficiary continues to be disabled and otherwise eligible (i.e., except for the 36-month payment limit). The payment limit will not apply to individuals who are disabled independent of their alcoholism or drug addiction at the close of the 36-month period.

Suspension For Non-Compliance

Provides for suspending benefits for non-compliance with treatment for both DI and SSI substance abusers, beginning the month after SSA sends notification of non-compliance. Once benefits are suspended for non-compliance, they may be reinstated only after demonstrated compliance with treatment requirements for specified periods—a minimum of 2 months, 3 months, and 6 months, respectively, for the first, second, third, and additional instances of non-compliance. Suspension of benefits for 12 consecutive months for non-compliance will result in termination of benefits.

Treatment Requirement

Extends the treatment participation requirement, which now applies only to SSI recipients, to DI beneficiaries whose substance abuse is material to their disability determination. The provision is to be implemented beginning with newly adjudicated cases and DI beneficiaries already on the rolls with a primary diagnosis of DA&A, and extending to other applicable beneficiaries as quickly as possible.

Referral and Monitoring

Requires the establishment of Referral and Monitoring Agency (RMA) contracts in each State and the issuance of regulations defining appropriate treatment for substance abusers.

Retroactive Benefits

Requires gradual payment of retroactive DI and SSI benefits to substance abusers, except for beneficiaries who have outstanding debts related to housing and are at high risk of homelessness. Retroactive benefits due an individual whose entitlement terminates will continue in prorated amounts until they are fully paid. In addition, if a beneficiary dies without having received all retroactive benefits, the unpaid amount becomes an underpayment.

Representative Payment

Extends the representative payee requirement, which now applies only to SSI beneficiaries, to DI beneficiaries whose drug addiction or alcoholism is material to a finding of disability.

Requires SSA to give preference to the appointment of Social Service Agencies or to Federal, State, or local government agencies as representative payees for DI and SSI substance abusers, unless SSA determines that a family member would be a more appropriate payee.

Permits organizations that meet the requirements and serve as representative payees for substance abusers to retain, as compensation for their services, the lesser of 10 percent of the monthly benefit or $50, indexed to the Consumer Price Index (CPI). Also, indexes to the CPI the maximum payee services fee ($25) for other beneficiaries with a qualified organizational payee.

Studies and Reports

Requires the following DA&A studies and reports:

A study of: (1) The feasibility, cost, and equity of requiring representative payees for all DI and SSI beneficiaries who suffer from drug addiction or alcoholism, regardless of whether their addiction is material to their disability; (2) the feasibility, cost, and equity of providing non-cash benefits; (3) the extent of substance abuse among child recipients and ways of addressing such afflictions; and (4) the extent to which children's representative payees are substance abusers and how to identify those that are. A report on the studies is due to the House Committee on Ways and Means and the Senate Committee on Finance by December 31, 1995.

A report on the Secretary's activities relating to the monitoring and testing of Social Security and SSI DA&A beneficiaries. The report is due to the House Committee on Ways and Means and the Senate Committee on Finance by December 31, 1996.

Demonstration projects designed to explore innovative referral, monitoring, and treatment approaches with respect to Social Security and SSI DA&A beneficiaries who are subject to a treatment requirement. A report on the demonstration projects is due to the House Committee on Ways and Means and the Senate Committee on Finance by December 31, 1997.

ISSUANCE OF PHYSICAL DOCUMENTS IN THE FORM OF BONDS, NOTES, OR CERTIFICATES TO THE SOCIAL SECURITY TRUST FUNDS

Requires each obligation issued by the Department of the Treasury for purchase by the Social Security trust funds (including those already issued) to be evidenced by a physical document in the form of a bond, note, or certificate of indebtedness, rather than simply by an accounting entry. Requires interest payments and proceeds from the sale or redemption of trust fund holdings to be paid by checks drawn on the general fund of the Treasury. The provision is effective 60 days after enactment.

GAO STUDY REGARDING TELEPHONE ACCESS TO LOCAL OFFICES OF THE SOCIAL SECURITY ADMINISTRATION.

Requires GAO to assess SSA's use of innovative technology to increase public telephone access to local Social Security offices (both phase I and II) and to report to the House Committee on Ways and Means and the Senate Committee on Finance no later than January 31, 1996.

EXPANSION OF STATE OPTION TO EXCLUDE SERVICE OF ELECTION OFFICIALS OR ELECTION WORKERS FROM COVERAGE

Increases from $100 to $1,000 a year the amount an election worker must be paid for the earnings to be covered under Social Security of Medicare. Beginning in the 2000, the coverage threshold increases automatically as wage levels rise. The provision is effective January 1, 1995.

USE OF SOCIAL SECURITY NUMBERS FOR JURY SELECTION PURPOSES

Allows State and local governments and Federal district courts to use Social Security numbers to eliminate duplicate names and convicted felons from jury selection lists. The provision is effective upon enactment.

AUTHORIZATION FOR ALL STATES TO EXTEND COVERAGE TO STATE AND LOCAL POLICE OFFICERS AND FIREFIGHTERS UNDER EXISTING COVERAGE AGREEMENTS

Gives all States, rather than only those now specifically authorized to do so, the option to extend Social Security coverage to police officers and firefighters who are under a retirement system. The provision is effective upon enactment.

LIMITED EXEMPTION FOR CANADIAN MINISTERS FROM CERTAIN SELF-EMPLOYMENT TAX LIABILITY

Exempts certain ministers who were American citizens and residents of Canada from liability for unpaid Social Security taxes and related penalties for 1979 through 1984. The provision is effective with respect to individuals who file a certificate with the Internal Revenue Service within 180 days after it issues implementing regulations.

EXCLUSION OF TOTALIZATION BENEFITS FROM THE APPLICATION OF THE WINDFALL ELIMINATION PROVISION

Disregards the windfall elimination provision in computing (1) the regular U.S. benefit of a person who receives a foreign totalization benefit that includes U.S. employment, provided they receive no other pension based on noncovered employment; and (2) any U.S. totalization benefit. The provision is effective for benefits for months after December 1994.

EXCLUSION OF MILITARY RESERVISTS FROM APPLICATION OF THE GOVERNMENT PENSION OFFSET AND THE WINDFALL ELIMINATION PROVISIONS

Excludes from the application of both the government pension offset and windfall elimination provisions military pensions that are based, at least in part, on noncovered military reserve duty after 1956 and before 1988. The provision is effective for benefits for months after December 1994.

REPEAL OF THE FACILITY-OF-PAYMENT PROVISION

Repeals the facility-of-payment provision, under which deductions are not now imposed against the benefits of an auxiliary beneficiary to whom they otherwise would apply if the maximum family benefit would continue to be payable to other auxiliaries living in the same household. Following repeal, deductions will be made for the beneficiary to whom they apply, and the benefits withheld will be redistributed to other entitled auxiliaries living in the same household as the auxiliary who is subject to deductions. The provision is effective for benefits payable for months after December 1995.

MAXIMUM FAMILY BENEFITS IN GUARANTEE CASES

Uses the maximum family benefit in effect in the last month of a worker's prior entitlement to disability benefits for the purpose of determining the maximum family benefit under a subsequent period of entitlement. The provision is effective for beneficiaries who become reentitled after December 1995, and for survivors of beneficiaries who die after December 1995 after previously having been entitled.

AUTHORIZATION FOR DISCLOSURE OF SSA INFORMATION FOR PURPOSES OF PUBLIC OR PRIVATE EPIDEMIOLOGICAL AND SIMILAR RESEARCH

Requires SSA, on a reimbursable basis, to disclose information showing whether an individual is alive or deceased, if it is needed for epidemiological or similar research that the Secretary of Health and Human Services determines has reasonable promise of contributing to national health interests. Requestors must agree to safeguard and to limit re-release of the information. The provision is effective upon enactment.

MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO SOCIAL SECURITY ADMINISTRATION (SSA) OR DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Broadens present-law deterrents against misleading mailings about Social Security and Medicare by:

Requiring specific written authorization from SSA or HHS for a person to reproduce, reprint, or distribute for a fee any SSA or HHS form, application, or other SSA or HHS publication;

Providing that a disclaimer on a mailing does not provide a defense against misleading mailing violations;

Providing that each piece of mail in an illegal mass mailing constitutes a violation;

Adding names, letters, symbols, and emblems of SSA, HCFA, SSI, and HHS to the items protected by the misleading advertising prohibitions;

Removing the $100,000 annual cap on civil penalties that may be imposed for misleading advertising activities, and providing that penalties SSA collects are to be deposited in the OASI Trust Fund; and

Requiring the Secretary and the Commissioner to report on the operation and enforcement of this provision to the Senate Committee on Finance and the House Committee on Ways and Means. The reports are due to the committees by December 1 of 1995, 1997, and 1999.

The provision is effective for violations occurring after March 31, 1995.

INCREASED PENALTIES FOR UNAUTHORIZED DISCLOSURE OF SOCIAL SECURITY INFORMATION

Makes unauthorized disclosure of information and fraudulent attempts to obtain personal information under the Social Security Act a felony. Each violation is punishable by a fine of up to $10,000, imprisonment for up to 5 years, or both. The provision is effective upon enactment.

INCREASE IN AUTHORIZED PERIOD FOR EXTENSION OF TIME TO FILE ANNUAL EARNINGS REPORT

Extends from 3 months to 4 months the additional time that an individual may be granted to file an annual earnings report. The provision is effective with respect to reports of earnings for taxable years ending on or after December 31, 1994.

EXTENSION OF DISABILITY INSURANCE PROGRAM DEMONSTRATION PROJECT AUTHORITY

Extends for 3 years (through June 10, 1996) authority to waive Social Security or Medicare benefit requirements in connection with demonstration projects and studies designed to promote the objectives or facilitate the administration of the Social Security disability insurance program and encourage disabled beneficiaries to return to work. A final report is due no later than October 1, 1996. The provision is effective upon enactment.

CROSS-MATCHING OF SOCIAL SECURITY ACCOUNT NUMBER INFORMATION AND EMPLOYER IDENTIFICATION NUMBER INFORMATION MAINTAINED BY THE DEPARTMENT OF AGRICULTURE

Permits the Department of Agriculture to disclose retail operators' names, Social Security numbers, and Employer Identification numbers to other Federal agencies for the purpose of investigating food stamp fraud and violations of other Federal laws. The provision is effective upon enactment.

CERTAIN TRANSFERS TO RAILROAD RETIREMENT ACCOUNT MADE PERMANENT

Makes permanent the provision that proceeds from the income taxation of railroad retirement tier 2 benefits be deposited in the railroad retirement account, rather than the General Fund of the Treasury. The change is effective for income taxes on tier 2 benefits received after September 30, 1992 (when the authority for depositing the proceeds from these income taxes in the railroad retirement account was last applicable).

AUTHORIZE THE DEPARTMENT OF LABOR TO USE SOCIAL SECURITY NUMBERS AS CLAIM IDENTIFICATION NUMBERS

Permits the Department of Labor to use Social Security numbers as claim identification numbers for workers' compensation claims. THe provision is effective upon enactment.

COVERAGE UNDER FICA OF FEDERAL EMPLOYEES TRANSFERRED TEMPORARILY TO INTERNATIONAL ORGANIZATIONS

Continues the Social Security coverage of Federal civilian employees temporarily assigned to an international organization, regardless of whether the international organization is within or outside the United States. Employees are to pay their share of the Social Security tax on their earnings and the loaning agency is to pay the employer's share of the tax. The provision is effective for services performed after the calendar quarter following the calendar quarter of the date of enactment.

EXTEND THE FICA TAX EXEMPTION AND CERTAIN TAX RULES TO INDIVIDUALS WHO ENTER THE UNITED STATES UNDER A VISA ISSUED UNDER SECTION 101(A)(15)(Q) OF THE IMMIGRATION AND NATIONALITY ACT

Excludes from Social Security coverage aliens who enter the United States as part of a cultural exchange program. The provision is effective with the calendar quarter following the date of enactment.

ELIMINATION OF ROUNDING DISTORTION IN THE CALCULATION OF THE CONTRIBUTION AND BENEFIT BASE AND EARNINGS TEST EXEMPT AMOUNTS

Designates 1994 as the base year to be used in calculating increases in the OASDI contribution and benefit base and earnings test exempt amounts for all years after 1994. (Increases in these amounts will no longer be based on the rounded amounts applicable in the previous year, which can distort the base and exempt amounts over time.) The provision is effective for the contribution and benefit base beginning in 1995 and for earnings test exempt amounts for taxable years ending after 1994.

COMMISSION ON CHILDHOOD DISABILITY

Requires the Secretary to appoint, by January 1, 1995, not less than 9 nor more than 15 experts to a Commission on the "Evaluation of Disability in Children." The Commission, in consultation with the National Academy of Sciences, is to conduct a study on the effect of the current Supplemental Security Income definition of disability as it applies to children under the age of 18 and their receipt of services, including the appropriateness of an alternative definition. The Commission also is to examine the feasibility of providing non-cash benefits to children; the feasibility of prorating Zebley lump sum retroactive benefits or holding them in trust; the extent to which SSA can involve private organizations to increase social services, education, and vocational instruction aimed at promoting independence and the ability to engage in substantial gainful activity (SGA); and the desirability and methods of increasing the extent to which benefits are used to help a child achieve independence and engage in SGA.

The Commission is required to report its results and any recommendations to the House Committee on Ways and Means and the Senate Committee on Finance by November 30, 1995.

REGULATIONS REGARDING COMPLETION OF PLANS FOR ACHIEVING SELF-SUPPORT (PASS) UNDER THE SSI PROGRAM

Requires SSA to revise its regulations to take the needs of an individual into account in determining the time necessary for completion of a PASS. The provision is effective January 1, 1995.

GAO REPORT ON PLANS FOR ACHIEVING SELF-SUPPORT

Although the conference did not agree to a House-passed provision to deem plans for achieving self-support (PASS) approved if they are not disapproved within 60 days, the conferees instructed the GAO to study the PASS provision. GAO's study would include data for the past 5 years on the number and characteristics of individuals who have applied for PASS, the kinds and durations of PASS approved and completed, and the extent to which individuals' PASS have led to their economic self-sufficiency. GAO would include any recommendation for improvements in the PASS provision in its report to the House Committee on Ways and Means and the Senate Committee on Finance.

SSI ELIGIBILITY FOR STUDENTS TEMPORARILY ABROAD

Allows individuals who leave the United States temporarily as part of an educational program that is not available in the United States, that is designed for gainful employment, and that is sponsored by a school in the United States to continue receiving SSI benefits for up to 1 year if they were eligible for SSI the month they left the country. The provision is effective January 1, 1995.

DISREGARD OF COST-OF-LIVING INCREASES FOR CONTINUED ELIGIBILITY FOR WORK INCENTIVES

Continues Medicaid under section 1619(b) for an individual whose Social Security cost-of-living increase otherwise would make them ineligible because of excess unearned income. The provision is effective for eligibility determinations for months after December 1994.

PROVISIONS TO COMBAT OASDI AND SSI PROGRAM FRAUD

Strengthens present law in deterring fraud and abuse in the OASDI and SSI programs by:

Requiring that third-party translators certify under oath the accuracy of their translations, whether they are acting as the applicant's legal representative, and their relationship to the applicant.

Authorizing civil penalties to be imposed against third parties, medical professionals, and OASDI beneficiaries and SSI recipients who engage in fraudulent schemes to enroll ineligible individuals in the OASDI and SSI programs. In addition, medical professionals may be barred from participation in Medicare and Medicaid.

Treating SSI fraud as a felony.

Clarifying SSA's authority to reopen OASDI and SSI cases where there is reason to believe that an application or supporting documents are fraudulent, and to terminate benefits expeditiously in cases where SSA determines that there is insufficient reliable evidence of disability.

Requiring the Inspector General to immediately notify SSA about OASDI and SSI cases under investigation for fraud, and requiring SSA to immediately reopen such cases where there is reason to believe that an application or supporting documents are fraudulent, unless the U.S. Attorney or equivalent State prosecutor determines that doing so would jeopardize criminal prosecution of the parties involved.

Requiring SSA to obtain and utilize, to the extent it is useful, pre-admission immigrant and refugee medical information, identification information, and employment history compiled by the Immigration and Naturalization Service or the Centers for Disease Control when developing SSI claims for aliens.

Requiring SSA to submit an annual report to the House Committee on Ways and Means and the Senate Committee on Finance on the extent to which it has reviewed OASDI and SSI cases, including the extent to which the cases reviewed involved a high likelihood or probability of fraud.

The provisions are effective October 1, 1994.

DISABILITY REVIEWS FOR SSI RECIPIENTS

Requires SSA, in each of fiscal years 1996, 1997, and 1998, to perform CDRs for a minimum of 100,000 SSI recipients and one-third of all childhood SSI recipients who are between age 18 and age 19. The latter provision applies to individuals who attain age 18 in or after the 9th month after enactment. Requires SSA to report its findings on these two provisions to the House Committee on Ways and Means and the Senate Committee on Finance no later than October 1, 1998.

EXEMPTION FROM ADJUSTMENT IN PASSALONG REQUIREMENTS

Allows States the option of exempting Zebley-related retroactive State supplementary payments from the annual supplementary payments expenditure amount that a State must maintain in the following year in order to meet the passalong requirement. Effective before, on, and after date of enactment.

LABOR, HHS AND EDUCATION APPROPRIATIONS, FY 1995 (H.R. 4606), P.L. 103–333, SIGNED ON SEPTEMBER 30, 1994

Provides FY 1995 funding for SSA's Limitation on Administrative Expenses (LAE) account of $5.577 billion, including disability investment funding of $320 million and automation investment funding of $97 million.

In addition, the overall appropriations Act reduces SSA's funding for 1995 for procurement reform, rent savings and performance awards. These reductions total about $37 million for SSA, reducing the total appropriations to $5.540 million.

Reports

Directs SSA to prepare a report by February 1, 1995, addressing concerns raised by Appropriations Committee members and to include information on short and long term costs and performance goals of planned automation initiatives.

Urges SSA to consider establishing a Chronic Fatigue Syndrome (CFS) Surveillance advisory committee and to provide a report to the Committee on this project, including the Agency's efforts to investigate the obstacles to disability benefits for persons with CFS.

SOCIAL SECURITY DOMESTIC EMPLOYMENT REFORM ACT OF 1994 (H.R. 4278), P.L. 103–387, SIGNED ON OCTOBER 22, 1994

SIMPLIFICATION OF EMPLOYMENT TAXES ON DOMESTIC SERVICE

Raises the threshold for coverage of domestic employees' earnings paid per employer from $50 per calendar quarter to $1,000 for calendar year 1994. In calendar years after 1995, this amount will increase in $100 increments as average wages increase.

In cases where domestic employees were paid $50 or more but less than $1,000 in 1994, their employers must report the earnings on form W–2 and the employees will receive credit under Social Security for the wages. (However, no Social Security taxes are payable on these wages.) If total earnings on the worker's record equal $620 or more, but less than $1,000, only one quarter of coverage is credited.

Instead of being treated as agricultural employees, domestic employees no farms operated for profit are treated like other domestic employees and their earnings are subject to the new threshold instead of the threshold applicable to agricultural employees. (Effective in 1994.)

Beginning with calendar year 1995, domestic employees will no longer be covered under Social Security in any year in which they are under age 18 unless their principal occupation is household employment.

In cases where the employer has only domestic employees, wages paid to those employees will be reported annually, rather than quarterly, on the employer's personal income tax return, and Social Security employer and employee taxes will be subject to quarterly estimated tax payment requirements. (Effective January 1995.)

ALLOCATIONS TO THE DISABILITY INSURANCE (DI) TRUST FUND

Allocates a greater portion of the OASDI tax rate (0.94 percent instead of 0.60 percent) to the DI Trust Fund for 1994 through 1996. For 1997 through 1999, the DI reallocation will be increased from the currently scheduled 0.60 percent to 0.85 percent. Beginning with 2000, the DI Trust Fund allocation will be 0.90 percent instead of the currently scheduled 0.71 percent.

These provisions are effective with respect to wages paid after December 31, 1993, and self-employment income for taxable years beginning after such date.

NONPAYMENT OF BENEFITS TO INDIVIDUALS FOUND NOT GUILTY BY REASON OF INSANITY

Extends the current prisoner nonpayment provision to all individuals confined to a jail, prison, or other penal institution or correctional facility pursuant to a conviction of a crime punishable by imprisonment for more than 1 year (regardless of the actual sentence imposed). Suspension will also apply to beneficiaries confined by court order in an institution at public expense in connection with a finding that the individual is: guilty but insane, with respect to an offense punishable by imprisonment for more than 1 year; not guilty of such an offense by reason of insanity or by reason of similar factors (such as a mental disease, a mental defect, or mental incompetence); or incompetent to stand trial for such an offense.

Also provides that an individual shall not be considered to be confined in a jail, prison, or other penal institution or correctional facility if he is residing outside the institution at no expense (other than the cost of monitoring) to the institution or the penal system or to any agency to which the penal system has transferred jurisdiction over the individual.

These provisions are effective with respect to benefits for months beginning after 90 days after enactment.

ADDITIONAL DEBT COLLECTION PRACTICES

Authorizes SSA to use certain delinquent debt collection procedures available to other Federal agencies, but not to SSA, under the Debt Collection Act of 1982. The procedures include reporting delinquent debtors to credit agencies, contracting with private debt collection agencies, and recovering debts by administrative offset of other Federal payments to which the debtor may be entitled. The procedures may be applied only if the overpayment was paid to a person after he or she attained age 18, the debt is not recoverable by other means provided by the Social Security Act, and the debtor is no longer a beneficiary.

The provision is effective with respect to collection activities begun on or after enactment and before October 1, 1999.

NURSING HOME NOTIFICATION

Requires nursing homes to notify SSA within 2 weeks after they admit SSI recipients (effective October 1, 1995).

Report

Requires SSA to conduct a study on the rising costs payable from the Disability Insurance (DI) trust fund. In conducting the study, SSA must determine the relative

importance of the increased number of applications, higher allowance rates and decreased benefit termination rates in increasing the DI program costs. The results of the study must be reported to the House Committee on Ways and Means by October 1, 1995.

SOCIAL SECURITY ACT AMENDMENTS OF 1994 (H.R. 5252) P.L. 103–432, SIGNED ON OCTOBER 31, 1994

DEFINITION OF DISABILITY FOR CHILDREN UNDER AGE 18 APPLIED TO ALL INDIVIDUALS UNDER AGE 18

Provides that the criteria used for determining disability of children who are under age 18 would apply to any individual who is under age 18 (i.e., individuals who do not meet the SSI definition of a child because they are married or the head of a household). Effective for determinations made on or after October 31, 1994.

QUALIFIED MEDICARE BENEFICIARY OUTREACH

Requires the Secretary of HHS to establish and implement within one year after date of enactment a method for obtaining information from newly eligible Medicare beneficiaries that may be used to determine whether they may be eligible as Qualified Medicare Beneficiaries and for transmitting this information to the States in which they live.

INDICATORS/PREDICTORS OF DEPENDENCY ON WELFARE RECEIPT

Requires the Secretary of HHS to develop (1) indicators of the rate at which and degree to which families depend on welfare receipt and (2) predictors of welfare to assess the data needed to report annually on the indicators and predictors, to provide an interim report to congressional committees by October 31, 1996, on conclusions resulting from such development and assessments, and to report annually thereafter, covering AFDC, SSI, food stamps, and general assistance programs administered by State and local governments.

MINOR AND TECHNICAL SSI PROVISIONS

Makes a number of technical corrections in previously enacted legislation.

VOLUNTARY INCOME TAX WITHHOLDING FROM SOCIAL SECURITY BENEFITS

Permits a person to request voluntary withholding from certain Federal payments, including Social Security benefits, for income tax purposes. Withholding will be in accordance with specified percentages as permitted by the IRS and requested by the person. Effective with respect to payments made after December 31, 1996.

TAX ON NONRESIDENT ALIEN INDIVIDUALS

Increases from 50 to 85 percent the amount of Social Security benefits which are subject to mandatory Federal income tax withholding because they are paid to nonresident aliens. Applies to benefits paid in taxable ending after December 31, 1994.

TAXPAYER IDENTIFICATION NUMBER (TIN) REQUIRED TO CLAIM DEPENDENCY EXEMPTION

Requires that, in order to claim a dependency exemption for Federal income tax purposes, a taxpayer must include the TIN/SSN for that dependent on his or her return, regardless of age. (Current law requires the TIN/SSN for claimed dependents who are at least 1 year old). Effective for taxable years beginning after December 31, 1994; with the exception that it does not apply to returns for taxable years beginning in 1995 with regard to individuals born after October 31, 1995, or to returns for taxable years beginning in 1996 for individuals born after November 30, 1996.

MODIFICATION OF MAXIMUM GUARANTEE FOR DISABILITY BENEFITS

Amends the Employee Retirement Income Security Act of 1974 by modifying the maximum guaranteed pension benefit payable in disability cases to participants in terminated employee pension benefit plans, i.e., plans which have been terminated and whose participants are receiving payments from the Pension Benefit Guaranty Corporation. Under this provision, the maximum guaranteed benefit shall not be reduced because of the age of the participant if the participant demonstrates that SSA has determined that he/she meets the definition in the Social Security Act.

ITEM 7. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

U.S. HOUSING FOR THE ELDERLY—FISCAL YEAR 1994

The Department of Housing and Urban Development is committed to providing America's elderly with decent affordable housing appropriate to their needs. The elderly, who are the fastest growing segment of our nation's population, are often frail and in need of supportive services to help them remain in their homes. The Department's goal is to provide a variety of approaches so that older Americans may be able to maintain their independence, remain as part of the community, have access to supportive services, and live their lives with dignity and grace. To meet this goal, HUD has sought to expand its ability to link housing and appropriate services for the elderly.

I. HOUSING

A. SECTION 202 CAPITAL ADVANCES FOR SUPPORTIVE HOUSING FOR THE ELDERLY AND SECTION 811 SUPPORTIVE HOUSING FOR PERSONS WITH DISABILITIES

The National Affordable Housing Act of 1990 authorized a restructured Section 202 program while separating out and creating the new Section 811 program for Housing for Persons with Disabilities. Funding for both programs is provided by a combination of interest-free capital advances and project rental assistance. Project rental assistance replaces Section 8 rent subsidies. The annual project rental assistance contract amount is based on the cost of operating the project. The 30 percent maximum tenant contribution remains unchanged.

Since the passage of the National Affordable Housing Act of 1990, there have been 29,317 units approved under the Section 202 program and 8,686 units approved under the Section 811 program. Of those amounts 7,819 Section 202 units and 2,783 Section 811 were approved in Fiscal Year 1994.

B. SECTION 231 MORTGAGE INSURANCE FOR HOUSING FOR THE ELDERLY

Section 231 of the National Housing Act authorized HUD to insure lenders against losses on mortgages used for construction or rehabilitation of market rate rental accommodations for persons age 62 years or older, married or single. Nonprofit as well as profit-motivated sponsors are eligible under this program. The program is largely inactive since most sponsors and lenders prefer to use the Section 221(d)(3) and 221(d)(4) programs.

C. SECTION 221(d) (3) AND (4) MORTGAGE INSURANCE PROGRAM FOR MULTIFAMILY HOUSING

Sections 221(d) (3) and (4) authorized the Department to provide insurance to finance the construction or rehabilitation of market rate rental or cooperative projects. The programs are available to nonprofit and profit-motivated mortgagors as alternatives to the Section 231 program. While most projects under the programs have been developed for families, projects insured under Section 221 may be designed for occupancy wholly or partially for the elderly, and the mobility impaired of any age.

D. SECTION 232 MORTGAGE INSURANCE FOR NURSING HOMES, INTERMEDIATE CARE FACILITIES, AND BOARD AND CARE HOMES, AND ASSISTED LIVING FACILITIES

The primary object of the Section 232 program is to assist and promote the construction and rehabilitation (or purchase or refinance of existing projects) of nursing homes, intermediate care facilities, board and care homes, and assisted living facilities by providing insurance to finance these facilities. The vast majority of the residents of such facilities are elderly.

E. SERVICE COORDINATOR PROGRAM

The National Affordable Housing Act authorized funding for the service coordinator program under the Section 202 program in 1990. Eligibility was expanded to cover Sections 8, 221(d)(3) and 236 projects in 1992.

A service coordinator is a social service staff person who is part of the project's management team. That individual is responsible for ensuring that the residents of the project are linked with the supportive services they need from agencies in the community to assure that they can remain independently in their homes and avoid premature and unnecessary institutionalization as long as possible.

In FY 1994 HUD awarded two rounds of grants, using both FY 1993 and FY 1994 dollars. The Department awarded about $57.1 million to about 350 Section 202 projects and 99 221(d)(3) and 236 projects. Earlier funding (FY 1992) covered an additional 128 202 projects for about $13.2 million.

F. THE CONGREGATE HOUSING SERVICES PROGRAM

The Congregate Housing Services Program (CHSP), initially authorized in 1978 and revised in 1990, provides direct grants to States, Indian tribes, units of general local government and local nonprofit housing sponsors to provide case management, meals, personal assistance, housekeeping and other appropriate supportive services to frail elderly and non-elderly disabled residents of HUD public and assisted housing, and for the residents of section 515/8 projects under the Department of Agriculture's Rural Housing and Community Department Service.

In 1994 HUD made 28 grants for approximately $6.4 million to serve an estimated 900 additional frail elderly and non-elderly disabled residents of eligible housing. The program covers 115 grantees, which serve about 5,000 people.

G. FLEXIBLE SUBSIDY AND LOAN MANAGEMENT SET ASIDE (LMSA) FUNDING

The Flexible Subsidy Program provides funding to correct the financial and physical health of HUD subsidized properties, including those which house the elderly. Flexible Subsidy provides funds for projects insured under Section 221(d)(3), Section 236, and funding under the 202 program (once they have reached 15 years old).

The Loan Management Set Aside (LMSA) Program provides Project-based Section 8 funding to HUD-Insured and HUD-Held projects and projects funded under the 202 Program which need additional financial assistance to preserve the long-term fiscal health of the project.

H. MANUFACTURED HOME PARKS

The Housing and Urban-Rural Recovery Act (HURRA) of 1983 amended Section 207 of the National Housing Act to permit mortgage insurance for manufactured home parks exclusively for the elderly. The program has been operational since the March 1984 publication of a final rule implementing the legislation, although HUD insures very few manufactured home parks.

I. TITLE I PROPERTY IMPROVEMENT LOAN INSURANCE

Title I of the National Housing Act authorizes HUD to insure lenders against loss on property improvement loans made from their own funds to creditworthy borrowers. The loan proceeds are to be used to make alterations and repairs that substantially protect or improve the basic livability or utility of the property. There are no age or income requirements to qualify for a Title I loan.

J. TITLE I MANUFACTURED HOME LOAN INSURANCE

Title I of the National Housing Act authorizes HUD to insure lenders against loss on manufactured home loans made from their own funds to creditworthy borrowers. The loan proceeds may be used to purchase or refinance a manufactured home, a developed lot on which to place a manufactured home, or a manufactured home and lot in combination. The home must be used as the principal residence of the borrower. There are no age or income requirements to qualify for a Title I loan.

K. HOME EQUITY CONVERSION MORTGAGE INSURANCE DEMONSTRATION

The Department has implemented a pilot program to insure Home Equity Conversion Mortgages (HECM), commonly known as "reverse mortgages." The program is designed to enable persons aged 62 years or older to convert the equity in their homes to monthly streams of income and/or lines of credit.

As of Fiscal Year end September 30, 1994, the Department insured 3,362 loans for HECM borrowers. The cumulative number of active insured loans reached 7,800 with a potential maximum claim amount of $787,355,882 million. Approximately 2,000 loans are in the endorsement pipeline with an average of 300 loans being endorsed per month.

One-third of the borrowers are single with an average age of 76. They have lower incomes and higher house values than the general population of elderly homeowners. The median principal limit or the amount that can be made available to the borrower is approximately $46,836.

The Department is publishing final regulations on the HECM program that simplify processing of loans by permitting the use of the Direct Endorsement program.

The volume of loans is expected to significantly increase as more lenders and the general population become more aware of the HECM program.

II. Public and Indian Housing

The Low-Income Public Housing program may be the largest single resource for housing for the elderly in the United States today.

A. SECTION 8 RENTAL CERTIFICATES AND RENTAL VOUCHERS

Section 8 of the U.S. Housing Act of 1937 authorizes housing assistance payments to aid low-income families in renting decent, safe, and sanitary housing that is available in the existing housing market.

PIH estimates that about 20 percent of Section 8 certificate and voucher recipients are elderly. This equates to 350,000 units.

The following statistics are provided for the elderly low income population of public and Indian housing:

Public and Indian Housing	283,406
Public Housing residents	279,108
Indian housing	4,298

B. ELDERLY/DISABLED SERVICE COORDINATORS

Section 673 of the Housing and Community Development Act of 1992 authorized the Department to fund services coordinators in public housing developments to assure the elderly and non-elderly disabled residents have access to the services they need to live independently. The Department published a NOFA on February 27, 1995 to announce the availability of approximately $46 million in FY 1994 and 1995 funds for public housing authorities to submit applications to hire services coordinators for their elderly and non-elderly disabled residents to provide case management and link these needy residents to other supportive services.

(Note: there is no available information on actual number of residents served because the program has not yet begun, but we estimate it could serve approximately 60,000 elderly and non elderly disabled residents.)

C. TENANT OPPORTUNITY PROGRAM

Section 20 of the U.S. Housing Act of 1937 authorized the Tenant Opportunity Program. This program provides training and technical assistance to resident entities to organize their communities and to establish various resident managed initiatives. The program began in 1988 and to date has funded about 550 resident groups. Public and Indian housing developments with elderly residents are eligible to participate and we would estimate a small portion, perhaps, 5 percent are in fact primarily elderly grantees.

D. PUBLIC HOUSING DEVELOPMENT PROGRAM

The Public Housing Development Program was authorized by Sections 5 and 23 of the United States Housing Act of 1937 to provide adequate shelter in a decent environment for families that cannot afford such housing in the private market.

The program has funds for 612 units of elderly housing. These units equal $98.4 million worth of elderly housing. Presently, including the 612 units, there are 2,598 units of elderly housing under construction.

E. SET-ASIDES

Hope for Elderly Independence Grants: $7.7 million assigned in FY 94.

Hope for Elderly Independence Vouchers: $32.1 million (1,186 units) assigned in FY 94.

III. Community Planning and Development

A. COMMUNITY DEVELOPMENT BLOCK GRANT ENTITLEMENT PROGRAM

The Community Development Block Grant (CDBG) Entitlement Program is HUD's major source of funding to large cities and urban counties. The activities funded by it help low- and moderate-income persons and households, eliminate slums or blight, or meet other urgent community development needs. The CDBG program made more than $3.1 billion available to States and communities in the most recent year for which complete information is available on use of CDBG funds.

Approximately $2.2 billion was available to 757 metropolitan cities and 125 urban counties by entitlement, with individual grants determined by formula.

Entitlement communities implemented a wide range of eligible activities in which elderly residents may benefit either directly or indirectly. HUD does not require local communities to collect information and report to HUD on the age of program beneficiaries. For this reason, it is difficult to determine all of the CDBG funds that directly address the needs of the elderly. However, Entitlement communities did spend $49.5 million in the most recent program year for which complete data are available on senior centers ($22.3 million) and for public services for the elderly ($27.2 million). $35 million of that was spent by metropolitan cities and $14.5 million by urban counties.

Entitlement grantees spent the most money on housing-related activities which are primarily rehabilitation of housing. They spent $985 million or 37.8 percent of all program expenditures on these activities. Housing rehabilitation includes major renovations, minor home repairs, and weatherization activities to owner- and tenant-occupied structures. Many local communities directed a portion of the funding for these activities to the elderly.

Significant amounts of CDBG Entitlement spending for neighborhood improvements, public services, and other public works either directly or indirectly benefited the elderly. CDBG Entitlement grantees spent $65.5 million for improvements to and the operation of neighborhood facilities. They also spent $19.7 million for the removal of architectural barriers and $10.7 million for centers for the disabled. These activities provided important benefits to the elderly.

B. CDBG STATE AND SMALL CITIES PROGRAM

The State Community Development Block Grant and HUD-Administered Small Cities programs are HUD's principal vehicles for assisting communities with less than 50,000 in population that are not central cities. States and small cities use the CDBG funds to undertake a broad range of activities and structure their programs to give priority to eligible activities that they wish to emphasize.

As in the CDBG Entitlement program, States are not required to report to HUD the ages of individuals who benefit from the recipients' activities. Consequently, the level of benefits to the elderly cannot be estimated with certainty. The States and the Commonwealth of Puerto Rico allocated approximately $922 million of State CDBG funds to local governments during Fiscal Year 1992, the latest year for which data on program use are available. Approximately $247 million or 27 percent of that portion of funds which are obligated supported housing-related activities such as the rehabilitation of private properties and weatherization services. Some local governments target some of these activities to benefit elderly homeowners and tenants. Approximately $44 million or 5 percent of State Small Cities CDBG obligated funds assisted community centers and public services. Many local governments use the programs to assist senior citizens.

C. HOME INVESTMENT PARTNERSHIP PROGRAM

Title II of the National Affordable Housing Act of 1990 created of HOME Investment Partnerships Program to provide States and local governments with a flexible vehicle to expand the supply of safe and affordable housing. The HOME Program provides annual formula-based allocations to more than 500 participating jurisdictions to assist low-income families and create homeownership and rental housing opportunities. Eligible activities include: acquisition, rehabilitation, new construction, and tenant-based rental assistance.

Since Fiscal Year 1992, the first year for which appropriations were made participating jurisdictions have committed $1.6 billion in HOME funds to projects for 93,713 affordable units. In Fiscal Year 1994 alone, $1.2 billion was committed for 67,546 affordable units.

OTHER ACTIVITIES

FAIR HOUSING AND EQUAL OPPORTUNITY (FHEO)

A. THE FAIR HOUSING ACT

The Fair Housing Act prohibits discrimination in housing based on race, color, religion, sex, national origin, handicap, or familial status. The Act provides an exemption from the requirement of nondiscrimination on the basis of familial status in circumstances where a housing provider offers "housing for older persons." Such housing is exempt under the law if it is intended for and solely occupied by residents 62 years of age and older, or if (a) 80 percent of the units are occupied by at least

one person 55 years of age and older, (b) there exist significant services and facilities specifically designed to meet the physical or social needs of older persons, and the housing is marketed to persons 55 years of age and older.

Section 919 of the Housing and Community Development Act of 1992 required the Secretary of HUD to issue regulations defining "significant facilities and services." The regulations were issued on July 7, 1994. During an extended comment period on the regulations, HUD conducted five public hearings. The comments, both at the hearings and those received in writing, were strongly against the proposed rule. Accordingly, in December 1994 HUD withdrew the rule and announced its intention to issue a new proposed rule early in 1995.

During Fiscal Year 1994 familial status was alleged as a basis of discrimination in 1,088 complaints filed with the Department pursuant to the Act. This represents 22.2 percent of all HUD complaints (4,841) filed during the period. Many of these complaints were filed against housing providers who claimed the "housing for older persons" exemption. All such complaints are investigated and resolved in accordance with the procedures set forth in the Act and the implementing regulations.

B. AGE DISCRIMINATION ACT

During Fiscal Year 1994, the Department received 13 complaints alleging age discrimination in federally-assisted programs. It appears that five of these complaints were filed by persons over 62 years of age. (Age discrimination complaints may be filed by persons of any age.)

OFFICE OF POLICY DEVELOPMENT AND RESEARCH

A. AMERICAN HOUSING SURVEY

The American Housing Survey for the United States, Current Housing Reports H. 150, and the Supplement to the American Housing Survey for the United States, Current Housing Report H. 151, for the years 1985, 1987, 1989 and 1991, contain special tabulations on the housing situations of elderly households in the United States. (Data for 1993 will be available in Spring 1995.) Chapter 7 of the regular report and Chapter 6 of the supplemental report for each year provide detailed demographic and economic characteristics of elderly households, detailed physical and quality characteristics of their housing units and neighborhoods and the previous housing of recent movers, and their opinions about their house and neighborhood. The data are displayed for the four census regions, and for central cities, suburbs, and nonmetropolitan areas, and by urban and rural classification. The non-elderly chapters (total occupied, owner, renter, Black, Hispanic, central cities, suburbs, and outside MSAs) as well as the publications for the 44 largest metropolitan areas individually surveyed over a 4-year cycle, Current Housing Reports H. 170, also contain data on the elderly.

An elderly household is defined as one where the householder, who may live alone or head a larger household, is age 65 years or more. Special information in these publications is provided on households in physically inadequate housing or with excessive cost burdens, and on households in poverty. The supplemental report provides general housing, household, financial characteristics and housing quality measures by family or household type, and neighborhood quality and journey to work by tenure, selected housing characteristics, selected household characteristics, and type of geographic location.

B. EVALUATION OF THE HOPE FOR ELDERLY INDEPENDENCE DEMONSTRATION PROGRAM

The HOPE for Elderly Independence Demonstration Program (HOPE IV) evaluation studies the design, implementation, and impact of the HOPE IV Program. HOPE IV combines Section 8 housing assistance, service coordination, and supportive services to help low-income frail elderly persons remain in their homes and avoid unnecessary institutionalization.

The evaluation focuses on the first round HOPE IV Program sites. Information comes from applications, surveys of grantees, service coordinators, professional assessment committee representatives, and program participants. In addition, the program participants will be compared with a group of frail elderly who are receiving the Section 8 assistance but are not receiving case management and coordinated services. The evaluation began in July 1993 and will be completed in July 1998. Westat is the contractor conducting the evaluation.

The first interim report (now in draft) presents preliminary findings on the Program's first year operation. There are several policy relevant findings.

Successful program start-up depends on how quickly the public housing agencies (PHAs) can form partnerships with the various State and local service

agencies and programs. The State and local agencies help the PHAs prepare program applications, provide matching funds, and contract for service delivery, including service coordination and professional assessments.

Recruiting participants for the Program has been difficult since Section 8 waiting lists had few eligible applicants. Although the PHAs advertised for applicants and the State and local agencies referred their clients, the Section 8 program is difficult for the frail elderly to use without substantial assistance from the PHA staff and others. The program requires the frail elderly to process a great deal of paperwork and has required in some cases (40 percent of the cases in the FY 1994) locating units which meet the housing quality standards.

The Demonstration is not likely to receive additional funding as of FY 1995.

C. EVALUATION OF THE CONGREGATE HOUSING SERVICES PROGRAM

The Congregate Housing Services Program (CHSP) evaluation will provide a comprehensive picture of the new Program. The evaluation will study CHSP implementation and compare its effectiveness in maintaining the independence of the frail elderly with the HOPE for Elderly independence Program.

The evaluation focuses on the first round CHSP grantees. Information comes from applications, annual financial reports, and census data as well as surveys of grantees, service coordinators, professional assessment committee representatives, and residents. The evaluation began in October 1993 and will be completed in October 1998. Research Triangle Institute is the contractor conducting the evaluation.

As of December 1994, 8 of 44 projects have not yet enrolled the number of residents they plan to serve in the facility during the first year of operation and some grantees have not started delivering services to residents. The first interim report was submitted in January 1995.

D. SERVICE COORDINATOR PROGRAM EVALUATION

The Office of Policy Development and Research began an evaluation of the Service Coordinator Program in the Fall 1994. The objectives of this study are to assess the processes by which the Service Coordinator program is established and implemented. More specifically, this 1-year study will describe the start-up and implementation of the program and assess what service coordinators are doing to facilitate service delivery to the elderly residents. Additionally, the study will focus on measuring resident satisfaction with nonhousing services. Data will be gathered through site visits, focus group interviews, and application reviews.

ITEM 8. DEPARTMENT OF THE INTERIOR

DEPARTMENTAL OFFICE FOR EQUAL OPPORTUNITY

INTRODUCTION

The Department of the Interior (DOI) diligently seeks to improve its services and programs for senior citizens and their families by making DOI managed parks, historical sites, wildlife refuges, prairie lands, recreational areas, offices and other facilities more open and easily accessible, and by improving accommodations at these facilities and areas for the older population and for DOI's own senior employees. To assist the Department in meeting its goals for seniors, the Departmental Office for Equal Opportunity (OEO) takes the lead in managing all federally conducted and federally assisted civil rights programs, activities, and functions within DOI. These activities encompass the coordination and management of both DOI employee activities and general public activities associated with the elimination of age related discrimination in DOI employment and the elimination of age discrimination affecting the general public.

TRAINING EQUAL EMPLOYMENT OPPORTUNITY COUNSELORS

In furtherance of these goals, newly appointed DOI Equal Employment Opportunity (EEO) Counselors are given initial training on how to be aware of and sensitive to the needs of older people. All counselors receive pertinent training in order to understand and accurately apply regulations which are related to the issues of age discrimination and its elimination. When age related regulations are up-dated or modified, both newly appointed and experienced EEO Counselors receive briefings, training, or information designed to keep them fully informed about the changes which affect senior citizens. Educational and training texts and classroom materials are specifically designed to reflect and explain all new changes which impact the well-being and health of senior citizens. In regards to complaints about age

discrimination, all offices and bureaus have been given EEO Counselor's Guidebooks and recently up-dated EEO materials which explain the rights of Federal employees, particularly those who are over 40 and who thus have employment rights against age discrimination based upon their age.

INTER-AGENCY INFORMATION SHARING

To further the exchange of information on issues related to senior citizens and issues concerning age discrimination, DOI regularly prepares and transmits quarterly and annual reports to the Department of Justice, the Equal Employment Opportunity Commission, and the Department of Health and Human Services.

DECREASED AGE RELATED COMPLAINTS IN 1994

During Fiscal Year 1994 (FY–94) the number of Federal equal employment complaints filed with DOI in which age discrimination was alleged to be a factor decreased by 19 percent over the number filed in FY–93 (222 cases were filed in FY–94 compared to 265 filed in FY–93). This decrease in cases in FY–94 reverses a trend stated in FY–93 in which age related cases increased 34 percent. This change, in part, may be attributable to a continued emphasis within DOI on training and counseling which has helped to improve the working environment and morale of older DOI employees.

IMPROVED INFORMATION ON COMPLAINT PROCESSING

With respect to age discrimination matters, OEO has provided refresher training and up-dated information for EEO specialists throughout DOI on such subjects as the implementation of guidance in the Code of Federal Regulations (29 CFR 1614). OEO has developed, printed, and distributed a brochure, You and the Federal Sector Employment Discrimination Complaints Process which has proven to be helpful in explaining in a simple, uncomplicated manner the new EEOC regulations to older employees and to older job applicants.

FEDERAL FINANCIAL ASSISTANCE PROGRAMS

In relation to DOI's Federal Financial Assistance Programs, OEO provided leadership and direction for approximately 5,000 civil rights compliance reviews of its federally assisted programs and activities to determine, among other issues, whether they are in compliance with Federal age discrimination requirements. State and local recreation programs, as well as State fish and wildlife activities, were evaluated for inappropriate age distinctions. OEO also provided technical assistance to DOI bureaus and offices and State and local governments regarding the applicability of DOI Federal assistance age discrimination policies. OEO processed numerous inquiries from Federal, State, and local government agencies, private organizations, and citizens regarding DOI polities against age discrimination. During FY–94, OEO processed eight civil rights complaints from the general public that alleged discrimination on the basis of age in programs and activities to which DOI provided Federal financial assistance.

ITEM 9. DEPARTMENT OF JUSTICE

OFFICE OF JUSTICE PROGRAMS

The Office of Justice Programs (OJP) works to form partnerships among Federal, State, and local government officials to address crime and related problems in communities throughout the Nation. OJP is comprised of five major program bureaus: The Bureau of Justice Assistance (BJA); the Bureau of Justice Statistics (BJS); the National Institute of Justice (NIJ); the Office of Juvenile Justice and Delinquency Prevention (OJJDP); and the Office for Victims of Crime (OVC). These five program bureaus:

Support national, State, and local programs to prevent and control crime and improve the criminal justice system;

Collect and analyze statistical justice-related data;

Conduct research to identify emerging criminal justice issues, develop and test promising approaches to address these issues, evaluate program results, and disseminate research findings;

Sponsor research and demonstration programs to test effective methods for preventing and treating juvenile delinquency and improving the juvenile justice system; and

Lead efforts to improve the Nation's response to crime victims and their families.

STATE FORMULA GRANT PROGRAMS

Most OJP funding is awarded to State governments through formula or "block" grant programs. The largest such program is the Edward Byrne Memorial State and Local Law Enforcement Assistance Program, which is administered by BJA. States may use Byrne funds to support a variety of criminal justice programs that affect elderly citizens, including projects to protect senior citizens from physical and mental abuse, prevent consumer fraud directed at them, promote community awareness and crime prevention among the elderly, and provide assistance for elderly victims of crime.

For example, Massachusetts uses Byrne formula funds to support a project by the Massachusetts Attorney General that provides specialized training to police officers to assist them in preventing, reporting, and responding to cases of elder abuse and to protect older citizens from neglect and financial exploitation. The program involves cooperation among law enforcement, prosecutors, and protective service agencies. Its curriculum covers such issues as the myths and facts about aging, elder abuse reporting law, domestic violence and the elderly, mental health, and police response to missing persons with Alzheimer's disease.

OVC also awards funds to the States under two programs authorized by the Victims of Crime Act (VOCA) of 1984. The VOCA programs are funded, not by Congressional appropriations, but by the Crime Victims Fund in the U.S. Treasury. The Fund is comprised of fines and penalties assessed on convicted Federal offenders.

OVC's Victim Assistance Program provides funds to States to support programs that provide direct services for crime victims, such as rape crisis centers, battered women's shelters, and counseling services. States are required to set aside 10 percent of these funds for previously underserved victims of violent crime. A number of States have identified elder abuse victims as a previously underserved group for which they provide additional programs and services. Other States and territories award subgrants from VOCA victim assistance funds to local victim services agencies that aid elderly victims of abuse and crime.

OVC's Victim Compensation Grant Program awards grants to states to support State programs that reimburse violent crime victims and their survivors for expenses related to their victimization. These include medical expenses, including mental health counseling and care, funeral expenses, lost wages, and other costs associated with the crime.

NATIONAL CITIZENS' CRIME PREVENTION CAMPAIGN

OJP's bureaus also directly support a number of innovative initiatives relating to the elderly. These include the National Citizens' Crime Prevention Campaign, which is supported by BJA in cooperation with the National Crime Prevention Council (NCPC), the Advertising Council, Inc., and the Crime Prevention Coalition, which includes such organizations as the American Association of Retired Persons (AARP).

Among other activities, the Campaign provides crime prevention and personal safety information to elderly and other citizens throughout the Nation. The Campaign features "McGruff, the Crime Dog," who asks Americans to help "Take A Bite Out Of Crime" by taking simple precautions, by reporting suspicious activity to the police, and by working with their neighbors, community leaders, law enforcement officials, and others to keep their communities safe from crime and drugs.

Information packets developed by the Campaign and distributed across the country include special crime prevention tips for senior citizens and focus on the special needs, concerns, and vulnerabilities of elderly citizens with regard to crime and victimization. Recent material includes a booklet developed by NCPC and the General Federation of Women's Clubs on crimes against the elderly, as well as several reproducible brochures.

The Campaign also works to enlist senior citizens in the fight against crime and drugs, recognizing them as a valuable resource for community crime prevention programs. Its informational materials and public service advertising encourage older Americans to participate in crime prevention activities in their communities.

TRIAD

BJA, NIJ, and OVC support Triad, a program sponsored by three national organizations—the American Association of Retired Persons, the International Association of Chiefs of Police, and the National Sheriffs' Association. These organizations encourage Triad agreements at the State and local level and monitor the programs' progress.

Under Triad, teams of local law enforcement personnel, elderly volunteers, and victim-service providers work together to prevent crime against senior citizens.

Communities implementing Triad have formed senior advisory councils, sometime known as SALT (Seniors and Lawmen Together) Councils, to ensure dialog between the chief executive officers of law enforcement agencies and the senior citizen community.

In Illinois, a State-level Triad program involves a cooperative effort of the Attorney General's office, the Department of Aging, and Adult Protective Services targeting fraud against the elderly in the financial and health care sectors.

In Orange County, Florida, senior safety seminars offer information on scams, as well as tips on traffic safety and side effects of some over-the-counter and prescription drugs. The seminars also feature an exhibit by the mobile crime prevention unit, a tractor-trailer renovated by an elder by volunteer that displays home safety devices. In addition, senior volunteers provide support for storefront police operations, court services, and crime prevention activities.

In Georgia's Adopt-A-Senior Program, a law enforcement officer visits an individual weekly to assess that person's needs and pass on information to the appropriate service agencies.

With NIJ's support, the sponsoring organizations have published and distributed newsletters on Triad and completed a manual to help sheriffs, police chiefs, and senior leaders implement Triad in their communities. In addition, a videotape describing the program has been produced and distributed to communities seeking to establish their own Triad programs.

ALZHEIMER'S PATIENT ALERT PROGRAM

As directed by Congress, OJJDP's Missing Children Program is providing the third year of funding for the National Alzheimer's Patient Alert Program's "Safe Return" project. Safe Return is designed to facilitate the identification and safe return of missing persons afflicted with Alzheimer's disease and related disorders.

The project supports a national registry of computerized information on memory-impaired persons and a toll-free telephone line to access the registry. It communicates vital information to appropriate law enforcement agencies and has developed an identification system using jewelry and clothing labels with unique numbers to aid in locating and returning missing persons affected by Alzheimer's disease or other memory loss.

During its third year of operation, the program will assist local Area Resource Centers to provide more hands-on services to families and work with law enforcement and emergency service personnel. It also will launch a national public awareness campaign and expand its information and educational materials to include translations into other languages.

UNDERSTANDING CRIME AND THE ELDERLY

As the primary justice statistical agency in the Nation, BJS collects, analyzes, publishes, and disseminates statistical information on crime, criminal offenders, victims of crime, and the operations of criminal justice systems at all levels of government. In March 1994, BJS released Elderly Crime Victims, which reports data from a special analysis of its National Crime Victimization Survey (NCVS). NCVS interviews approximately 100,000 people every 6 months about the crimes they sustained. This includes the violent crimes of rape, robbery, and assault; personal theft; and the household crimes of burglary, household larceny, and motor vehicle theft. Persons age 65 or older comprise about 14 percent of people age 12 or older interviewed in the NCVS. However, the elderly report less than 2 percent of all victimizations. Among the report's findings:

In 1992, people age 65 or older experienced about 2.1 million criminal victimizations.

People age 65 or older are the least likely of all age groups in the Nation to experience crime.

The elderly appear to be particularly susceptible to crimes motivated by economic gain, such as robbery and personal theft, as well as the household crimes of larceny, burglary, and motor vehicle theft. Like the general population, the elderly are most susceptible to household crimes and least susceptible to violent crimes.

Injured elderly victims of violent crime are more likely than younger victims to suffer a serious injury. Violent offenders injure about a third of all victims. Among the violent crime victims age 65 and older, 9 percent suffer serious injuries such as broken bones and loss of consciousness. By comparison, 5 percent of younger victims suffer serious injuries.

Elderly violent crime victims are more likely than younger victims to face assailants who are strangers.

Elderly victims of violent crime are almost twice as likely as young victims to be raped, robbed, or assaulted at or near their home. Half of the elderly victims of violence and a quarter of those under age 65 are victimized at or near their home.

About 38 percent of elderly victims of violent crime and 35 percent of younger victims report facing an armed offender.

Among the elderly, certain groups were generally more likely to experience a crime than others:

Elderly men generally have higher victimization rates than elderly women. Elderly women, however, have higher rates of personal larceny with contact such as purse snatching.

The elderly age 65 to 74 have higher rates of victimization than those age 75 or older.

Elderly blacks are more likely than elderly whites to be crime victims. However, rates of personal larceny that did not involve contact between the victim and offender were greater for whites.

Elderly with the lowest incomes experienced higher violence rates than those elderly with higher family incomes. Those elderly with the highest family income have the highest rates of personal theft or household crime.

BJS also analyzes data collected through its 1992 National Corrections Reporting Program. These data show that among offenders entering prison, older offenders are more likely than younger offenders to have been convicted of a violent offense.

Of the total persons age 55 of older entering prison, 43.7 percent were convicted of violent offenses, compared to 26 percent for 25–29 year olds and 24.5 percent for 30–34 year olds. Of the total persons age 55 or older entering prison, the survey found that 7.4 percent were convicted of rape and 17.8 percent were convicted for other sexual assault.

Another BJS survey, the 1992 National Judicial Reporting Program, found that 3 percent of persons convicted of felonies in state courts were age 50–59. One percent was age 60 or older. Three percent of all persons convicted of violent felonies were age 50–59, while 2 percent were age 60 or older.

NIJ supported Research on Managing Elderly Offenders begun in late 1993 by Northwestern University. The study is examining management, supervision, and treatment of elderly inmate populations in the Nation's prisons and jails. Researchers will conduct a comprehensive literature review on related topics such as management issues concerning elderly inmates, elderly offender needs and problems, and existing programs for elderly offenders. A survey of State and Federal prison systems, as well as local jails, will be conducted to compile information on their current policies, programs, management strategies, housing, classification, and medical services. Researchers will also conduct site visits to jurisdictions to document promising programs and practices.

Early results from the study indicate that, among three states (Georgia, Illinois, and Michigan) that have studied elderly inmates in their systems, findings are strikingly similar:

Most older inmates are serving time for violent or sex crimes.

Most elderly offenders are classified as medium security inmates or less.

Elderly inmates have few disciplinary problems.

The study also found that in Georgia, 1 in 5 elderly offenders had major medical problems. Michigan categorized about 20 percent of its elderly inmates as having bad health. In Illinois, the cost of care for geriatric inmates is estimated at $24,000 annually, compared with $16,000 for inmates in the general population.

TRAINING AND TECHNICAL ASSISTANCE

OVC uses a small but growing share of the Crime Victims Fund to award grants to eligible crime victim assistance programs for training and technical assistance services. OVC's national-scope training and technical assistance programs have focused on providing training for criminal justice personnel, volunteers, professionals, clergy and other service providers who play a critical role in responding to victims of crime.

During 1994, OVC completed a project with the Police Executive Research Forum that developed a curriculum on elder abuse for law enforcement agencies. The curriculum is designed to provide law enforcement policymakers and officers information on the most effective procedures and policies for responding to incidents of family violence involving elderly people. OVC, NIJ, and BJA are working with AARP, the National Sheriffs' Association, and the Department of Health and Human Services' Administration on Aging to sponsor regional training seminars using the curriculum.

Grant and program information is available by calling the Department of Justice Response Center at 1–800–421–6770. Copies of research and statistical reports and other information published by the Office of Justice Programs is available by calling the National Criminal Justice Reference Service toll-free on 1–800–851–3420. From metropolitan Washington, D.C., and Maryland, call 301–251–5500.

Other inquiries should be addressed to the: Office of Congressional and Public Affairs, Office of Justice Programs, 633 Indiana Ave., N.W., Washington, D.C. 20531, Telephone: 202–307–0703.

ITEM 10. DEPARTMENT OF LABOR

The welfare of our Nation's older citizens is a matter of substantial concern to the Department of Labor. The Department of Labor is therefore pleased to provide this summary of the programs it administers which can provide helpful assistance to older citizens. These include—job training and related assistance, disclosed worker assistance, and other employment service assistance, under programs administered by the Department of Labor's Employment and Training Administration; a public information and assistance program on matters relating to certain pension and welfare plans, under programs administered by the Pension and Welfare Benefits Administration; statistical programs providing employment and unemployment data for older persons, under programs administered by the Bureau of Labor Statistics; protection for certain employees to take unpaid, job-protected leave to provide care for sick, elderly parents, under a program administered by the Employment Standards Administration; and, a Clearinghouse which provides information and resources to employees and employers interested in developing or implementing family friendly policies such as elder care and child care, under a program administered by the Women's Bureau. These matters are addressed more fully in the following discussion.

EMPLOYMENT AND TRAINING ADMINISTRATION

INTRODUCTION

The Department of Labor's Employment and Training Administration (ETA) provided a variety of training, employment and related services for the Nation's older individuals during Program Year 1993 (July 1, 1993–June 30, 1994) through the following programs and activities: the Senior Community Service Employment Program (SCSEP); programs authorized under the Job Training Partnership Act (JTPA); and the Federal-State Employment Service system.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The Senior Community Service Employment Program (SCSEP), authorized by Title V of the Older Americans Act, employs low-income persons age 55 or older in a wide variety of part-time community service activities such as health care, nutrition, home repair and weatherization programs, and in beautification, child care, conservation, and restoration efforts. Program participants work an average of 20 hours per week in schools, hospitals, parks, community centers, and in other government and private, nonprofit facilities. Participants also receive personal and job-related counseling, annual physical examinations, job training, and in many cases referral to regular jobs in the competitive labor market.

Over 66 percent of the participants were age 60 or older, and over 37 percent were age 65 or older. Over two-thirds were female; about one-third had not completed high school. All participants met low-income guidelines.

Table 1 below shows SCSEP enrollment and participant characteristics for the program year July 1, 1993, to June 30, 1994.

TABLE 1.—Senior Community Service Employment Program (SCSEP): Current Enrollment and Participant Characteristics—Program Year July 1, 1993, to June 30, 1994

Enrollment:	
Authorized positions established	65,107
Unsubsidized placements	17,776
Characteristics Cumulative Starts (Percent):	
Sex:	
Male	33
Female	67
Educational status:*	
8th grade and less	15.3

9th grade through 11th grade	17.5
High School graduate or equivalent	40.2
1–3 years of college	18.3
4 years of college or more	8.6
Veterans	16
Ethnic Groups:*	
White	62.6
Black	22.4
Hispanic	9.7
American Indian/Alaskan Native	1.7
Asian/Pacific Island	3.5
Economically disadvantaged	100
Poverty level or less	77.5
Age groups:*	
55–59	33.8
60–64	28.8
65–69	20.9
70–74	11.3
75 and over	5.1

* Figures do not add to 100% due to rounding.

Source: U.S. Department of Labor, Employment and Training Administration (Preliminary Data).

JOB TRAINING PARTNERSHIP ACT (JDTA) PROGRAMS

The Job Training Partnership Act (JTPA) provides job training and related assistance to economically disadvantaged individuals, dislocated workers, and others who face significant employment barriers. The ultimate goal of JTPA is to move program participants into permanent, self-sustaining employment. Under JTPA, Governors have the approval authority over locally developed plans and are responsible for monitoring local program compliance with the Act. JTPA functions through a public/private partnership which plans, designs and delivers training and other services. Private Industry Councils (PICs), in partnership with local governments in each Service Delivery Area (SDA), are responsible for providing guidance for and oversight of job training activities in the area.

JTPA was amended most recently in 1992, to target program services to those with serious skill deficiencies; and individualize and intensify the quality of services provided. Five percent of the funds appropriated for the new adult program (Title II–A) must be used by States in partnership with SDAs for older workers. The Governors must ensure that services under the adult program are provided to older workers on an equitable basis.

BASIC JTPA GRANTS

Title II–A of JTPA authorizes a wide range of training activities to prepare economically disadvantaged youth and adults for employment. Training services available to eligible older individuals through the basic Title II–A grant program include vocational counseling, jobs skills training (either in classroom or on-the-job), literacy and basic skill training, job search assistance, and job development and placement. Table 2 below shows the number of persons 55 years of age and over who terminated from the Title II–A program during the period July 1, 1993 through June 30, 1994. (The data do not include the 5 percent set-aside for older individuals, which is discussed separately.)

TABLE 2—JTPA ENROLLMENT JULY 1, 1993—JUNE 30, 1994

[Title II–A]

Item	Number Served	Percent
Total Adult Terminees:		
(22 and older)	210,640	100
55 years and over	5,088	2.4
Entered Unsubsidized Employment	2,393	(1)
Received Training	2,517	(1)

[1] N/A.

Source: U.S. Department of Labor, Employment and Training Administration (December, 1994 Preliminary Data).

SECTION 124 SET-ASIDE

Section 124 of JTPA mandates that 5 percent of the Title II–A allotment of each State be made available for the training and placement of older individuals in private sector jobs. Only economically disadvantaged individuals who are 55 years of age or older are eligible for services under this set-aside.

Governors have wide discretion regarding use of the JTPA 5 percent set-aside. Two basic patterns have evolved. One is adding set-aside resources to Title II-A to ensure that a specific portion of older persons participates in the basic Title II-A program. The other is using the resources to establish specific projects targeted to older individuals which operate independently of the basic program. Likewise, States are required to provide "equitable services to older individuals throughout the State, taking into consideration the incidence of such workers in the population." Some States distribute all or part of the 5 percent set-aside by formula to local SDAs; other States retain the resources for State administration and/or model programs.

In keeping with the requirements of the amendments, Governors are expected to coordinate services as much as possible with the services provided under Title V of the Older Americans Act—Senior Community Service Employment Program. There are two separate provisions for older individual programs as they relate to Title V of the Older Americans Act. Under the Title II-A program, up to 10 percent of the participants may be individuals who are not economically disadvantaged; under this 10 percent "window," those who meet Title V criteria and have a serious barrier to employment may qualify. In addition, when an SDA and Title V sponsor establish joint projects, individuals eligible under Title V of the Older Americans Act "shall be deemed to satisfy the requirements" of JTPA. SDAs may enter into joint programs with Title V programs, including co-enrollment of Title V participants in Title II–A. Joint programs must have a written agreement, which may be financial or nonfinancial in nature, and may include a broad range of activities. For Program Year 1993 (July 1, 1993, through June 30, 1994) preliminary data indicate that over 16,846 terminees went through the set-aside program for economically disadvantaged individuals 55 years of age and older.

PROGRAMS FOR DISLOCATED WORKERS

Title III of JTPA authorizes a State and locally-administered dislocated worker program which provides training and related employment assistance to workers who have been, or have received notice that they are going to be, laid off from their jobs, and are unlikely to return to their previous industries or occupations. This includes workers who lose their jobs because of a permanent closing of a plant or facility or mass layoffs; long-term unemployed with little prospect for local employment or reemployment; and farmers, ranchers, and other self-employed persons who become unemployed due to general economic conditions.

Those older workers eligible for the program may receive such services as job search assistance, retraining, pre-layoff assistance and relocation assistance. During the period July 1, 1993, through June 30, 1994, approximately 13,000 individuals 55 years of age and over completed their participation in the program (8 percent of the program terminations), based on preliminary data.

THE FEDERAL-STATE EMPLOYMENT SERVICE SYSTEM

The State-operated public employment service offices (ES) offer employment assistance to all jobseekers, including middle-aged and older persons. A full range of basic labor exchange services are provided, including counseling, testing, job development, job search assistance and job placement. In addition, labor market information and referral to relevant training and employment programs are also available.

Federal reporting requirements for State employment service agencies (SESAs) were revised effective July 1, 1992, to capture additional information on applicant characteristics, including data on the age of all ES applicants and those placed in employment. During the period July 1, 1993, through June 30, 1994, over 1,300,000 ES applicants were age 55 and over. Approximately 97,500 of the ES applicants age 55 and over were placed in jobs during this period.

PENSION AND WELFARE BENEFITS ADMINISTRATION

INTRODUCTION

The Pension and Welfare Benefits Administration (PWBA) is responsible for enforcing the Employee Retirement Income Security Act (ERISA). PWBA's primary responsibilities are for the reporting, disclosure, and fiduciary provisions of the law.

Employee benefit plans maintained by employers and/or unions generally must meet certain standards, set forth in ERISA, designed to ensure that employees actually receive promised benefits. Employee benefit plans exempt from ERISA include church and Government plans.

The requirements of ERISA differ depending on whether the benefit plan is a pension plan or a welfare plan. Pension plans provide retirement benefits, and welfare plans provide a variety of benefits, such as employment-based health insurance and disability and death benefits. Both types of plans must comply with provisions governing reporting and disclosure to the Government and to participants (Title I, Part 1) and fiduciary responsibility (Title I, Part 4). Pension plans must comply with additional ERISA standards (contained in both Title I, Parts 2 and 3, and Title II), which govern—membership in a plan (participation); nonforfeitability of a participant's right to a benefit (vesting); and financing of benefits offered under the plan (funding). Welfare plans providing medical care must comply with ERISA continuation of coverage requirements and medical child support orders (Title I, Part 6).

The Departments of Labor and the Treasury have responsibility for administering the provisions of Title I and Title II, respectively, of ERISA. The Pension Benefit Guaranty Corporation (PBGC) is responsible for administering Title IV, which established an insurance program for certain benefits provided by specified ERISA pension plans. On a regular basis, PWBA meets and coordinates closely with the Internal Revenue Service (IRS) and the PBGC on matters concerning pension issues.

In FY 1994, PWBA participated in legislative efforts for comprehensive reform of America's health care system. No legislation was enacted, but problems in this area are expected to demand PWBA's continuing attention.

PWBA also supported enactment of a Congressional proposal to make remedies available to former participants and beneficiaries under certain pension plans that had purchased annuity contracts from Executive Life Insurance Company and several other insolvent insurers. The "Pension Annuitants Protection Act of 1994" was signed into law as Public Law 103–401 on October 22, 1994. PWBA had sought broader legislation to restore the full range of potential remedies to participants and beneficiaries who sue third parties that knowingly and actively assist fiduciaries in breaching their duties under ERISA, and to give standing to former participants to sue wrongdoers for actions taken while they were active participants. As enacted, Public Law 103–401 provides standing and fuller remedies for participants who lose benefits due to improper purchases of pension annuities, but not for other violations of ERISA.

PWBA also supported the "Retirement Protection Act of 1994," a bill to strengthen funding in underfunded pension plans. Legislation based on the Administration's bill was enacted as part of Public Law 103–465 on December 8, 1994. Public Law 103–465 also modified and extended provisions which allow the transfer of excess pension assets to pay for retiree health expenses.

The 100th Congress amended ERISA to impose penalties of up to $1,000 per day for filing late or deficient annual reports. Because these penalties could impose substantial burdens, the Department provided plan administrators a "grace period" ending December 31, 1993. Plan administrators filing overdue annual reports in the grace period were assessed $1,000 regardless of how many days the report was actually in arrears. During this grace period, over 41,000 filings were submitted to bring plans into compliance with ERISA. The Department collected over $35 million in penalty fees from the grace period.

PWBA published an interpretive bulletin on fiduciary standards for proxy voting on July 29, 1994, with guidance on the responsibilities of ERISA plan fiduciaries in voting shares held by the plan, and encouraged plan officials to adopt written statements of investment policy. An interpretive bulletin on economically targeted investments was published June 23, 1994. This bulletin clarified the DOL position on ERISA's fiduciary standards for investing plan assets in economically targeted investments with risk-adjusted returns no lower than alternative investments. To make previous guidance widely available in the code of Federal Regulations, the bulletin reiterated positions taken in earlier DOL advisory letters. The bulletin stresses that any ETI must be made for the exclusive benefit of participants and beneficiaries, and all other ERISA requirements must be satisfied.

In fiscal year 1994 PWBA continued its program of research directed toward improving the understanding of the employment-based pension and health benefit systems. The key component of this program is the project with the National Academy of Sciences to improve retirement income modeling. PWBA sponsored a conference on this important work on September 29–30, 1994. The agency also published "Pension and Health Benefits of American Workers" in fiscal year 1994, with findings and data from the Census Bureau's April 1993 survey of 30,000 households on employee benefits; and "Pension Coverage Issues for the 90's," containing articles on new studies in this area.

INQUIRIES

PWBA publishes literature and audio-visual materials which, in some depth, explain provisions of ERISA, procedures for plans to ensure compliance with the Act and the rights and protections afforded participants and beneficiaries under the law. In addition, PWBA maintains a public information and assistance program, which responds to many inquiries from older workers and retirees seeking assistance in collecting benefits and obtaining information about ERISA. Among the publications disseminated, the following are designed exclusively to assist the public in understanding the law and how their pension and health plans operate:

Health Benefits Under the Consolidated Omnibus Budget Reconciliation Act (COBRA); What You Should Know About the Pension and Welfare Law; Know Your Pension Plan; How to File a Claim for Benefits; and Often Asked Questions About ERISA;

How to Obtain Employee Benefits Documents From the Labor Department; and

Simplified Employee Pensions: What Small Business Needs to Know.

BUREAU OF LABOR STATISTICS

The Department of Labor's Bureau of Labor Statistics (BLS) regularly issues a wide variety of statistics on employment and unemployment, prices and consumer expenditures, compensation including wages and benefits, productivity, economic growth, and occupational safety and health. Data on the labor force status of the population, by age, are prepared and issued on a monthly basis. Data on consumer expenditures, classified by age groupings, are published annually. In 1994 BLS published the first results of the redesigned survey of occupational injuries and illnesses; these data will now be available by age, race, and gender, providing important new information on this aspect of the labor market experiences of older Americans. In addition to regularly recurring statistical series, BLS undertakes special studies as resources permit. In May 1994 BLS published a report on an experimental Consumer Price Index for older Americans. This report updates a portion of a study originally performed by BLS in response to the Older Americans Act Amendments of 1987.

WOMEN'S BUREAU

The Women's Bureau Clearinghouse, established in 1989, is a computerized database and resource center responsive to dependent care and women's employment issues. Services help employers and employees make informed decisions about which programs and services best serve their needs. The Clearinghouse offers information and guidance in five broad option areas for child care and elder care services: direct services, information services, financial assistance, flexible leave policies, and public-private partnerships. The Clearinghouse has also been expanded to include information on the Family and Medical Leave Act (FMLA), pregnancy discrimination, and sexual harassment. Within each of these areas customers can be provided with model programs from other companies, implementation guides, national and State information sources and bibliographic references.

In 1994, the Clearinghouse continues to receive requests for information on worksite elder care program options. Information provided included flexible work schedules, respite care services, information and referral, adult day care, parent seminars, case management, as well as transportation services.

The Clearinghouse can be accessed through 1–800–827–5335.

EMPLOYMENT STANDARDS ADMINISTRATION

The Family and Medical Leave Act of 1993 became effective on August 5, 1993, for most employers. This statute provides potential benefit to the elderly in that it empowers eligible employees of covered employers to take up to 12 weeks of unpaid,

job-protected leave in any 12-month period to provide care for a parent who has a serious health condition. In the past, the employee had to make a decision in many instances of whether or not to give up their job to provide care to a sick, elderly parent.

ITEM 11. DEPARTMENT OF STATE

SUMMARY OF PROGRAMS FOR CIVIL SERVICE EMPLOYEES AND FOREIGN SERVICE PERSONNEL

Dependent Parents Residing at Post.—A number of Foreign Service personnel choose to have elderly family members accompany them on overseas assignments. The Department of State will place parents who qualify as "dependents" on the employee's travel orders. To qualify, a parent must be at least 51 percent financially dependent upon either the employee or his/her spouse. The parent then becomes eligible: to travel on a diplomatic passport; for official travel to post at government expense; for criminal, civil and administrative immunity in the country of assignment; and to evacuation in times of civil unrest or natural disaster. In addition, the family may qualify for larger housing due to increased family size. The one benefit for which older family members are not automatically eligible is medical benefits; accompanying parents are urged to carry private insurance to cover their medical expenses, including coverage in case of a medical evacuation. The Employee Consultation Service (ECS), a confidential counseling service in the Office of Medical services, provides information to departing employees regarding insurance. (Medicare does not cover overseas expenses and very few private companies will protect those over the age of 70.) Only if no adequate care is available in the host country will the medical unit at post attempt to meet the needs of an older relative. If these medical needs are more than routine, however, it may be difficult for post medical personnel to provide that care.

Dependent Parents Unable to Reside at Post.—Because of assignment to an unaccompanied post, medical concerns, or personal need, a dependent parent may decide not to reside at the employee's post of assignment. If the parent has previously accompanied the employee on an overseas assignment, s/he may request to be placed on a Separate Maintenance Allowance, a special allowance which alleviates some of the additional expenses of maintaining two households. When parents suffer a health crisis in the United States, the Employee Consultation Service provides a resource locator service for Foreign Service employees abroad. This service researches and identifies the best medical and support services in the parent's community. In addition, ECS staff members will visit nursing homes, hospices, and hospitals in the Washington area, if requested, to assess the degree of care being provided. This service is now limited, however, due to down-sizing.

Parents Not Residing at Post.—Most parents do not qualify as dependents and do not accompany their Foreign Service family members on overseas assignments. When personnel are assigned abroad the issue of caring for elderly parents can be particularly challenging. Long-distance decisionmaking is difficult at best, impossible at times. The ECS resource locator service is available to Foreign Service employees and staff members will visit care providers as described in the previous section. Finally, ECS provides individual counseling for those dealing with eldercare concerns. A paper entitled "Caring for Elderly Parents," prepared by the Family Liaison Office (FLO), is available to all employees and family members, and several books on eldercare have been provided to embassies and consulates by FLO. In the case of a life-threatening illness or the death of a parent, visitation travel at government expense is permitted for either the employee or a family member.

Retirement Programs.—The Department is committed to assisting employees as they make the transition to retirement. A 1-week seminar followed by a 30-day (Civil Service) or 90-day (Foreign Service) job-search program with full pay is available to every employee. Topics covered in the seminar include financial planning, estate planning, retirement living, long-term healthcare, nursing home insurance, and more. Spouses often attend this seminar along with the employee and the Overseas Briefing Center offers a 2-day course specifically tailored to spousal concerns. The course, entitled "Life After the Foreign Service," is professionally-led and provides discussion, papers, and a reading list on issues facing older Americans.

Retired Employees.—The Department of State's commitment to assist Foreign Service employees does not end at retirement. The Employee Consultation Service will consult with former employees and family members to provide guidance on medical and mental health alternatives which are available to them.

American Foreign Service Protective Association (AFSPA).—AFSPA offers medical insurance to all Foreign Service personnel and their family members. Recently they

initiated a long-term care policy (LTCare) which will assist older members to meet their need for additional care. Parents under the age of 80 at the time of enrollment may be included on a member's policy.

Programming for Civil Service Employees and Foreign Service Personnel Assigned to Washington.—The Employee Consultation Service provides both programs and services to assist older Americans and their families. For 5 years ECS has offered weekly support groups for those providing care for elderly relatives. In addition, they counsel employees on retirement options in the Washington area and throughout the United States, they consult with parents experiencing difficulty when family members move overseas, they meet with managers concerned about workplace performance of elderly employees, and they provide private short-term counseling.

Programs for older Americans are vitally important; I am pleased to have this opportunity to inform you of those offered by the Department of State.

I hope this report is useful to you. Please do not hesitate to contact me if we can be of further assistance.

Sincerely,

WENDY R. SHERMAN,
Assistant Secretary Legislative Affairs.

ITEM 12. DEPARTMENT OF TRANSPORTATION

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 calendar year 1994 to improve transportation for elderly persons.[2]

POLICIES

FEDERAL RAILROAD ADMINISTRATION (FRA)

The National Railroad Passenger Corporation (Amtrak) continued throughout calendar year 1994 to provide elderly and disabled passengers with discounted fares, accessible accommodations, and special services, including assistance in arranging travel. These passengers continue to represent a substantial part of Amtrak's ridership—in recent years, 28 percent of long-distance passengers were 62 or older.

Discounted Fares.—Amtrak has a systemwide policy of offering to elderly persons and persons with disabilities a 25 percent discount on one-way ticket purchases. This 25 percent discount to senior citizens and passengers with disabilities cannot be combined with any other discounts.

Accessible Accommodations.—Amtrak provides accommodations that are accessible to elderly and disabled passengers, including those using wheelchairs, on nearly all of its trains. Long-distance trains include accessible sleeping rooms. Short-distance trains, including Northeast Corridor trains, have accessible seating and bathrooms in food service cars. Many existing cars are being modified to provide more accessible accommodations and all new cars will provide enhanced accessibility for passengers with mobility and other types of disabilities.

Mechanical lifts operated by train or station staff provide passengers with access to single-level trains from stations with low platforms and short plate ramps provide access to bi-level equipment. An increasing number of Amtrak stations are fully accessible, particularly among key intermodal stations that provide access to commuter trains and other forms of transportation.

Special On-Board Services.—Amtrak continues to provide special on-board services to elderly and disabled passengers needing such assistance, including aid in boarding and deboarding, special food service, special equipment handling, and provisions for wheelchairs. Amtrak has also improved training of its employees to better enable them to respond knowledgeably to passengers with special needs. It is always advisable for passengers to advise Amtrak of any special needs they may have.

Assistance in Making Travel Arrangements.—Persons may request special services by contacting the reservations office at 1–800–USA–RAIL. This office is equipped

[1] "Prepared for the U.S. Senate Special Committee on Aging—December 1994.

[2] Many of the activities highlighted in this report are directed toward the needs of handicapped persons. However, one-third of the elderly are handicapped and thus will be major beneficiaries of these activities.

with facilities for taking reservations from hearing impaired persons. To ensure that passengers receive the assistance they need, Amtrak maintains a Special Services Desk which supports its reservations agents 7 days a week. This desk completed successful responses to nearly 100,000 requests for special services last year. Passengers may also inform their travel agent or the station ticket agent of their special needs when making travel reservations.

FEDERAL TRANSIT ADMINISTRATION (FTA)

The Federal Transit Administration is the lead agency in an interdepartmental working relationship between the Department of Transportation (DOT) and the Department of Health and Human Services (DHHS). Under the terms of the interagency agreement, a staff working group has been established, and a formal executive level DOT/DHHS Transportation Coordinating Council has been formed. The council, which meets quarterly, has directed that regional initiatives be undertaken in each Federal region. Federal regional staff from both departments have worked with state program administrators to identify barriers to coordination in Federally supported programs and to encourage State and local efforts to coordinate funding for specialized transportation services. Liaison between these two departments will increase the mobility of elderly Americans by improving the coordination and effective use of transportation resources of both departments. The FTA and DHHS are negotiating with the Departments of Housing and Urban Development, Labor, Education, and Agriculture and the Veterans Administration to join the council.

In a continuing project of the council, the Administration on Aging and FTA have developed a Volunteer Van Transportation Program in the State of Oklahoma for Native Americans who do not live on reservations. This joint program provides vans, insurance, and maintenance for a period of 4 years to develop a community-based transportation program where no public transportation exists. The project is currently purchasing additional vans to enhance the expansion of this project. A significant segment of those being served by this program is elderly.

CAPITAL AND OPERATING ASSISTANCE

FEDERAL TRANSIT ADMINISTRATION

Under 49 USC 5310 (formerly Section 16 of the Federal Transit Act, as amended), the FTA provides assistance to private nonprofit organizations and certain public bodies for the provision of transportation services for elderly persons and persons with disabilities. In FY 1994, over $58.6 million was used to assist in the purchase of 1,895 vehicles for the provision of transportation services for the elderly and individuals with disabilities. Besides providing transportation service, vehicles purchased with these funds may also be used for meal delivery to the homebound, as long as this purpose does not interfere with the primary purpose of the vehicles.

Under 49 USC 5211 (formerly Section 18 of the Federal Transit Act, as amended), the FTA obligated $137.1 million to States in FY 1994. These funds were used for capital, operating, and administrative expenditures by State and local agencies, nonprofit organizations and operators of transportation systems to provide public transportation services in rural and small urban areas under 50,000 population. The rural program funds are also used for intercity bus service to link these areas to larger urban areas and other modes of transportation. An estimated 36 percent of the ridership of nonurbanized systems is elderly, which represents nearly three times their proportion of the rural population.

Under Section 9 of the Federal Transit Act, as amended, the FTA obligated $2.3 billion in 1994. These funds were used for capital and operating expenditures by transit agencies to provide public transportation services in urbanized areas. While these services must be open to the general public, a significant number of passengers served are elderly.

RESEARCH AND TECHNICAL ASSISTANCE

FEDERAL AVIATION ADMINISTRATION (FAA)

Over the past year, the Office of Aviation Medicine's Civil Aeromedical Institute has contributed to the following research related to the needs/concerns of the aging population in aviation transportation.

Cataract Therapy Implications for Airmen.—The prevalence of aphakia (no natural lens in the eye) and the use of operatively placed intraocular lenses by pilots was determined; concurrently, the aircraft accident rate associated with the aphakic condition was determined. Although not all intraocular lens implants are necessitated by conditions directly related to age, many are carried out because of the

development of senile cataracts, which are typically related to age. Thus the findings of the research assist aeromedical certification personnel and pilots in assessing both the need for the efficacy of surgical correction for a category of visual defect increasingly prevalent in the aging pilot.

Aircraft Evacuation Study.—The influence of age on evacuation performance was studied. Test subjects were divided into two groups, age 40 and under and over age 40, and asked to perform a simulated emergency evacuation from a single-aisle airliner through the overwing exits. The more elderly group was found to take significantly longer to evacuate the passenger cabin in simulated emergency conditions. In 1994, the data were analyzed, and relationships correlating age and evacuation speed were developed and presented to a scientific meeting.

Cognitive Function Test.—An automated cognitive function test was developed to permit the more sensitive and specific evaluation of pilots after brain injury or disease. This test was not specifically developed to assess fitness to perform flying duties in relation to the age of the subject being evaluated. However, this screening test was proven useful in assisting both aeromedical certification personnel and the involved pilot in assessing the level of cognitive capability for tasks proven to be key components in the job of piloting an aircraft; and since some cognitive loss is related to age, this test helps to assess if the degree of loss (independent of brain injury and disease) has progressed to levels usually associated with brain disease or injury. Thus, this test has been incorporated in batteries of tests used by some employers, as a part of EEOC settlements, to permit certain categories of commercial pilots to fly past age 60.

"Age 60 Rule".—The "Age 60" Rule of the Federal Aviation Regulations, Part 121, prohibits any person who has reached the age of 60 from serving as a pilot in air carrier operations. This rule has generated controversy since its adoption by the FAA in 1959. The rule has been challenged in court. Both Federal and private organizations have been tasked with developing specialized informational reports concerning the issue, and Congress has sought to develop specialized legislation. Recent challenges call into question the validity of the rule. In 1990, a contract was awarded to Hilton Systems, Inc. Under the contract, Hilton Systems conducted a statistical analysis on historical data to investigate the relationship between pilot age and accident rates. The results present a converging body of evidence which fails to support a hypothesis that the pilots of scheduled air carriers had increased accident rates as they neared the age of 60. Analyses give a hint, and a hint only, of an increase in the accident rate for medical Class III (private) pilots older than 63 years of age. Additional research will continue on this issue.

FEDERAL HIGHWAY ADMINISTRATION (FHWA)

The following FHWA supported studies have been completed in fiscal year 1994:

Relative Visibility of Increased Legend Size vs. Brighter Materials studied the effects of highly retroreflective sheeting on current stroke-width standards; compared older driver responses to these brighter signs, as compared with their response to larger signs; and evaluated other legend characteristics (font, spacing, and capitalization). Findings show that sign material did not have a significant effect on legibility, and imply that increases in letter height beyond 16 inches may not produce expected increases in legibility distance.

Older Driver Perception-Reaction Time for Intersection Sight Distance and Object Detection evaluated the perception-reaction time of older drivers in a variety of intersection, stopping, and decision sight-distance situations. Alternate models for intersection sight distance were identified and evaluated. Findings show that in most cases, older drivers are not significantly slower than their younger counterparts, although the distributions of reaction time do appear to vary for different age groups.

Symbol Signing Design for Older Drivers investigated the use of symbol signs for older drivers, made recommendations on changes to current signs, and developed guidelines for design of future symbol signs. Findings show that mechanisms exist to optimize symbol signs, particularly the application of Fourier analyses during sign design.

Traffic Operations Control for Older Drivers investigated many operational aspects of intersections in light of older driver and pedestrian capabilities. Findings show that pedestrians do not often read educational placards and that older drivers are more likely than younger drivers to stop on the amber phase of a signal. Overall, drivers do not show adequate comprehension of the protected/permissive left turn signal, and older drivers in particular tended to interpret the permissive phase as giving them right-of-way.

Design Characteristics of Older Adult Pedestrians used analytical and empirical methods to determine the capabilities and limitations of older pedestrians and to recommend changes in design to accommodate the population. Findings show that vehicles making a right turn on red are considered particularly hazardous by older pedestrians, and that pedestrians tend to walk faster when a pedestrian signal is present.

Older and Younger Drivers' Reactions to Emergency Events was conducted on the HYSIM (Highway Driving Simulator) to investigate the driving performance of older and younger drivers. During the test session, subjects performed four evasive emergency maneuvers. Findings show no significant difference in older and younger drivers response times to emergency events, but do show that older drivers tend to drive further to the right in their lanes.

Design Characteristics of Older Pedestrians developed walking speed distributions for pedestrians 65 and older as compared with walking speed distributions for pedestrians less than 65 years old. The comparisons are intended for use in highway design and operations.

ONGOING FHWA SUPPORTED STUDIES

Pavement Markings and Delineation for Older Drivers is using simulator and field techniques to investigate the use of improved pavement marking and delineation systems to enhance their value for older drivers. Preliminary findings show that delineation treatments that include both an edgeline and an off-road element (post mounted delineators, chevron signs) have the best recognition distance, for both older and younger drivers.

Intersection Geometric Design for Older Drivers and Pedestrians is using laboratory and field methodologies to investigate the geometric needs of older road users at intersections, an area where older drivers experience a large number of accidents.

Investigation of Older Driver Freeway Needs and Capabilities is a preliminary investigation to assess the extent of older driver usage of, and difficulties with, freeways.

Traffic Control Device Design and Placement to Aid the Older Driver is investigating, in predominantly field settings, issues related to the design and placement of signs to aid older drivers in terms of detection, comprehension, recognition, and response time. This study is being conducted under the auspices of the National Cooperative Highway Research Program.

Synthesis of Research Findings on Older Drivers will review and synthesize all the research findings in the High Priority National Area for older driver research, as well as other relevant research, in a format compatible for later inclusion in a driver handbook. Implementation plans will be developed and future research needs identified.

Delineation of Hazards for Older Drivers is evaluating the utility of object markers in terms of conspicuity, recognizability, and comprehension through a series of laboratory and field studies.

Human Factors Study of Traffic Control in Construction and Maintenance Zones is the subject of a projected 1995 FHWA supported study that will evaluate, through laboratory studies and field verification, the traffic control devices and operational aspects of construction and maintenance zones. Drivers of all ages will be studied, but older driver needs and capabilities will be emphasized. Specific problems will be identified, followed by the development and testing of countermeasures.

NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION (NHTSA)

The agency continues its on-going research and programs designed to improve the safety and mobility of older persons. During 1993, the agency updated its long-term research and development program, published as the Traffic Safety Plan for Older Persons. Geared toward enhancing older person safety on the nation's streets and highways, it includes cooperative research between the private and public sectors on older drivers, vehicle occupants, and pedestrians.

Older Driver Safety.—Analyses continue to show that older people are increasingly dependent on driving for their mobility, and that this mobility is essential for maintaining quality of life. Analyses also show that older drivers have fewer crashes per vehicle mile driven than do other drivers, but, due to their physical frailty, are more likely to die when involved in a crash than a younger person involved in the same crash.

Research currently underway is refining the impact of specific medical conditions and functional ability on driving patterns and crash involvement. Early findings indicate that most older drivers with functional disabilities curtail or limit their driving and pedestrian practices in urban and rural areas, with a concurrent reduction

in their ability to meet their transportation needs. More recent findings seem to indicate that those with arthritis are more likely to continue to drive and those with low back pain who take non-steroidal medications may be at higher risk of having a crash.

A Cooperative Agreement currently in place with the State of California is developing driver license assessment techniques that will identify older drivers who have dementia or other unsafe cognitive conditions. Results from this work are not yet available.

A study was also initiated in 1994 to understand the difficulties older drivers have in negotiating intersections—an area where they are over-involved in crashes. Studies have also been undertaken to evaluate the mobility consequences of stopping driving and to determine how society can assist older people to better regulate their driving. In addition, two projects have been initiated to update the medical condition/functional assessment guidelines for use by State motor vehicle administrators. The results of this work would also provide guidelines for license examiners in spotting driver license applicants who need more extensive examination before being granted a license.

The Transportation Research Board's Committee on the Safety and Mobility of Older Persons, chaired by a NHTSA employee, continues to provide coordination of research and development activities across the private and public sectors. It serves a multi-disciplinary constituency, directing research attention to those areas most in need, helping to avoid unnecessary duplication of effort, and disseminating information about the latest findings in the field. It's chair also serves as an advisor on the Administration on Aging's Eldercare Institute on Transportation.

Occupant Protection.—As people age, their vulnerability to injuries and fatality increases dramatically. NHTSA is continuing two major activities begun in 1993 that will better understand and increase the survivability of older vehicle occupants who are involved in a crash. Work is continuing under a grant awarded to the William Lehman Injury Research Center at the Ryder Trauma Center, Jackson Memorial Hospital in Miami, Florida. This will develop an Automobile Trauma Care and Research Facility, and establish an information system that will advance both the delivery of trauma care and the detailed data for research on automobile injuries, treatments, outcomes, and costs. The availability of an older population of automobile injury victims in the Miami area is providing information on the prevention of restrained occupant injuries that will be of increasing national importance as the population ages and the use of occupant restraints (air bags and automatic and manual belts) grows.

NHTSA is also continuing research with the Transportation Systems Center using computer simulation and experimental work to improve belt/air bag systems for vehicle occupants. Particular attention is being paid to possible approaches to improving alternate restraint designs or requirements for elderly vehicle occupants. It is expected that this work will be of particular value to older vehicle occupants and to women who, due to their more fragile bone structure, can benefit most from improved belt/air bag designs.

In addition, NHTSA's new side impact standard provides a higher level of protection to older occupants in vehicles meeting the standard. The new standard is based on a dynamic crash test which incorporated age effects for the first time and, thus, will provide better protection to older vehicle occupants. Manufacturers are required to incrementally apply the standard to 25 percent of cars manufactured after September 1, 1994, 40 percent after September 1, 1995, and 100 percent after September 1, 1996.

Vehicle Design Practices to Enhance Older Driver Crash Avoidance.—NHTSA's crash avoidance research program on the older driver will emphasize the evaluation of vehicle design practices—e.g., instrument panel features, forward lighting, collision warning systems—that influence driving safety. NHTSA will analyze the traffic crash experience of older drivers, assess their capabilities and limitations as drivers, and identify vehicle design features that will ensure safety while accommodating mobility needs.

Such design features may be conventional vehicle components, such as lights and mirrors, which can be modified to enhance older driver performance. Or, they can be advanced technology countermeasure systems such as those under study as part of NHTSA's Intelligent Vehicle Highway System (IVHS) research program. Indeed, a major goal in NHTSA's IVHS program is to determine the safety improvements (and, hence, mobility-enhancements) that IVHS technologies can provide to the older driver.

It is recognized that IVHS may be a "double-edged sword" for the older driver. Selected IVHS technologies clearly provide opportunities for safety improvements. However, other IVHS applications have the potential to further degrade older driver

safety by confusing or distracting the older driver with an overload of information or decision-making workload. The types and amounts of information and the methods of presenting it must be carefully studied to ensure that older driver safety and mobility are enhanced rather than degraded.

Whether the focus is on conventional or high-technology solutions, NHTSA addresses the older driver issue in two fundamental, mutually-reinforcing ways. First, NHTSA considers the older driver in the context of virtually all ongoing research on specific driver-vehicle interaction issues (e.g., crash types, proposed countermeasures, safety concerns regarding mobility-enhancing systems). Here, the older driver is treated as part of the overall distribution of driver traits and behaviors. For example, a new study on Head-Up Displays (HUDs)—small windshield projected displays of information that might otherwise show on a dashboard—is assessing any potential distraction that might effect driver performance. In this case questions are being examined about whether the HUDs might adversely impact driver performance by distracting driver attention, particularly older driver attention, away from the driving task.

Secondly, crash avoidance and the older driver is being addressed specifically to identify vehicle design practices likely to enhance (or degrade) the driving safety performance of older drivers. In 1994 the agency completed an assessment of research needs and targets of opportunity relating to older driver traffic safety, with emphasis on vehicle design practices and potential countermeasures. Based upon the results of this work, the agency will further refine work on the effect of vehicle design and older driver crash involvement, and will identify recommended vehicle design practices, including crash avoidance countermeasures, of benefit to the older driver.

Pedestrian Safety.—NHTSA and FHWA are continuing field research aimed at preventing older pedestrian accidents. The work is ongoing in Phoenix and Chicago, and involves a demonstration program of behavioral safety information combined with traffic engineering applications in selected "zones" of the cities that have been shown to have a high incidence of older pedestrian accidents. Elderly pedestrian safety will also be addressed in NHTSA's "Pedestrian Safety Awareness" *Project.* There is little awareness of the dangers faced by the walking public and older adults are more likely to be killed in pedestrian accidents than any other age group. This project seeks to form a public/private coalition to develop and initiate a national awareness campaign.

FEDERAL TRANSIT ADMINISTRATION

In FY 1994, under FTA's University Research and Training Program, the University of Kentucky completed a research project to examine the travel behavior and transportation needs of the elderly in rural areas. The major objective of the project is to evaluate existing systems of transport and to suggest how these systems may be managed, modified, reorganized, and/or enhanced to improve mobility and provide better service to the elderly. The draft project report suggests that an organized, institutional volunteer system might be considered to assist in meeting the transportation needs of the elderly in the rural Kentucky community in which the study was conducted. The final report on this project will be provided to FTA by the end of December 1994.

A project by the University of Arizona was undertaken in FY 1994 to draw together and synthesize operating experiences of American and European transit operators who have implemented, provided, or evaluated service routes, deviation on fixed route services, group services, and accessible feeder services. The study will focus primarily on how each of these service options is synchronized with current system operational patterns, in conformity with requirements of the Americans with Disabilities Act of 1990 (ADA), and consistent with the system's ADA eligibility criteria and screening processes. Based on preliminary data collected from paratransit providers, it is estimated that approximately 50 percent of ADA paratransit riders are elderly. The final report will be submitted to FTA by March 1995.

The Rural Transit Assistance Program (RTAP), in its seventh year, obligated $5.2 million in FY 1994. The program provides funding for training, technical assistance and research, and related support activities in rural areas. The RTAP National Program supports, among other initiatives, a National RTAP Resource Center, an Electronic Bulletin Board, regional outreach initiatives, and the development of training modules for use by rural transit operators. The RTAP National Program produces a wide range of initiatives for the elderly and individuals with disabilities living in rural areas.

The National Easter Seal Society's Project ACTION (Accessible Community Transportation in Our Nation) is a $2 million research and demonstration grant

program. National and local organizations representing public transit operators, the transit industry, and persons with disabilities are involved with the development and demonstration grant program now in the final implementation phase. National and local organizations representing public transit operators, the transit industry, and persons with disabilities are involved with the development and demonstration of workable approaches to promote access to public transportation services for persons with disabilities. A large number of elderly persons with disabilities will benefit from this project. Project ACTION has identified the following six priority areas through a Request for Proposal process, has completed 57 projects in the six priority areas.

1. Clarify disability problems in the community;
2. Outreach and marketing strategies for people with disabilities;
3. Training programs for transit providers;
4. Training programs for persons with disabilities;
5. Technology to solve critical barriers to transportation and accessibility; and
6. Development of a Resource Center on Transit Access Activity.

Project ACTION also assists in the implementation of the Americans with Disabilities Act by investigating what training is necessary to sensitize transit drivers to the needs of people with various disabilities. Tie-down and securement difficulties, especially for the three-wheeled motorize wheelchairs, have been identified for research. Project ACTION has also targeted other model projects to be refined and replicated throughout the Country. Congress mandated an additional $2 million per year to continue this program for the next 3 years.

RESEARCH AND SPECIAL PROGRAMS ADMINISTRATION (RSPA)

Several schools participating in the Department of Transportation University Transportation Centers Program are conducting research that relate to improving mobility of older Americans. Title and summaries of the most relevant projects are as follows:

Accommodating the Elderly to Accellerative Forces in Transit Vehicles takes into consideration that public transportation vehicles must meet tight schedules. Boarding and exiting vehicles can pose significant risks to elderly persons, giving rise to the perception that public transit is hazardous, and thus reducing the frequency of usage. Large accelerative and decelerative forces are present in public transit vehicles, especially buses, shortly before and after stops. The elderly, because of decreased motor strength, motor coordination, sensory capabilities, and increased skeletal brittleness, are at far higher risk for serious injury than younger transit users in response to these forces. Possibly, the *fear of this hazard* deters many from taking full use of public transit. This project will measure the magnitude of *accelerating forces* in buses in a typical urban transit system during the boarding and exiting epochs. During these epochs, transit users who are manifestly old, will be observed during the times they are not seated, to correlate measured accelerative forces with the associated duration of exposure.

Design of Communications Network to Support Mobile Health System was identified as a need in a study by the Mack-Blackwell Transportation Center. In that study concept of the integration of a mobile health system to deliver routine medical care to patients living in the rural areas was analyzed. The mobile health system was envisioned as hospital based and provided medical services, chronic and short term, acute care on an outpatient basis. For a mobile medical facility to operate effectively, the ability to transmit/receive patient information between doctors at the hospital and the medical personnel at the mobile unit is a requirement that must be addressed. A study is being conducted that will analyze the design of communication networks to support a mobil health system.

A Feasibility Study for the Application of Advanced Public Transportation System Technology will study the use of advanced communications equipment in paratransit service. Specifically, the project will determine whether an investment in this technology is cost effective. The project will also involve a study of the state-of-the-art in current communications and automatic vehicle location AVL technology that would be appropriate for paratransit operations, develop a test methodology and protocol, undertake pilot and field tests to measure the changes in service as a result of the use of communications technology, do post test analysis, and document the results for managers to make decisions on the implementation of this technology for regular operations.

Development of Transportable Wheelchair Standard is an important objective because providing occupant protection for persons seated in wheelchairs during travel in motor vehicles is a system problem that involves the wheelchair securement equipment, the occupant restraints, the wheelchair, the occupant, and the vehicle.

Failure to adequately deal with and consider each of these system components can result in ineffective occupant protection. A study is underway that will develop a standard on "Wheelchairs and Transportation" that will provide general design guidelines and will specify test conditions and performance requirements for wheelchairs that can be considered to offer safe and effective seating to occupants of motor vehicles.

Optimum Size of an Effective and Efficient Transit Agency in Rural or Non-Metropolitan Areas is important because one of the principal customer groups for rural transit services is elderly rural residents. Providing transit services in the most cost-effective manner while increasing the quantity and improving the quality of service is a long-term goal of the U.S. Department of Transportation and the Department of Health and Human Services. Several studies have attempted to measure the effectiveness and efficiency of transit agencies. However, no studies have indicated the optimum size a transit system should be in order to operate in the most cost-efficient and effective manner within the rural and non-metropolitan regions. A study is underway that will investigate the optimum size a rural or non-metropolitan transit system should reach in order to maximize efficiency and effectiveness.

Paratransit and Land Use: Facility Siting Considerations will use 10 to 15 local-area (e.g., city or county) case studies to describe the types of facilities that are major attractors and producers of paratransit trips and to describe the types of transportation services provided to the clients of these facilities. The decisionmaking process for the location of these facilities will also be described. These facilities include sheltered workshops, congregate dining facilities, and senior centers, among others. Often these types of facilities are located without regard to the service areas and patterns of local transit and paratransit services, which can result in poor public transportation service to the facilities and/or substantially increased costs for the providers of service. When facilities are located in areas easily served by paratransit or on existing transit routes, and when complementary facilities and services are located next to each other so that one trip can meet more than one need, the efficiency of public transportation services is increased. This study will develop a classification methodology for these types of facilities that will describe their relative dependence on paratransit services and the relative impacts of transportation considerations on their location decisions.

Potential for Advance in-Vehicle Systems to Increase the Mobility of Elderly Drivers will assess the feasibility of applying advanced in-vehicle information and warning devices for increasing the mobility of the elderly. Such devices have the potential, if specifically designed to enhance the weaknesses of the elderly driver, to allow the elderly to drive more efficiently, comfortable, and safely for a longer period of time. The criticality of exploring methods to maintain the mobility of older drivers cannot be over emphasized, particularly given the changing demographics of the population in the United States. The elderly populations of the United States could benefit greatly from the development of such systems.

The Role of Transportation in Service Access for Rural Elderly is the title of a study that focuses on improving transportation access to health services in rural areas. The project will provide the knowledge base to examine this conclusion and suggest methods for improving health care access for rural elderly within the state of Arkansas. The rural nature of the State of Arkansas combined with the relatively high numbers of elderly within the State, present a special challenge in the provision of health care and other formal services essential in the maintenance of personal independence. At 15 percent, the percentage of the population over the age of 65 years is higher than the 12.2 percent national average. A majority of the elderly of the State live in rural counties where transportation limitations hinder their access to medical and other needed services.

Transportation and the Elderly: Coping with Loss of Mobility is an important study because the population of elderly people in the United States is growing, and most of this growth is occurring in suburban areas. Because private automobiles are the number one source of transportation for the suburban elderly, it is important to understand the effects of mobility restrictions when they face the loss of access to private automobiles. The main objective of a study entitled is to examine the process of adaptation that occurs during the transition from autonomy through private automobile use to dependency on public transit and other sources of transportation. Although planners and designers have focused on issues concerning the elderly for some time, the psychological adaptation process to mobility loss is important yet little studied.

INFORMATION DISSEMINATION

FEDERAL RAILROAD ADMINISTRATION

Information about Amtrak special services and accessible stations is available to senior citizens and passengers with disabilities in a brochure entitled "Amtrak Travel Planner" which can be obtained in stations, local sales offices, and through travel agencies. Amtrak also works directly with a number of organizations each year on large special moves of passengers needing assistance.

NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION

In 1993, NHTSA completed production on a video "Walking Through the Years." The video illustrates the problems facing older pedestrians and presents safety advice for preventing pedestrian crashes. The American Automobile Association has adapted "Walking Through the Years" materials as a program to help older adults recognize pedestrian hazards and safer walking behaviors. They have agreed to market a flyer, brochure and scripted slide presentation through its network of 1,000 clubs. To ensure that this effective material reaches the widest audience possible, the video presentation is being distributed through the National Safety Council.

In an effort to address the elderly pedestrian problem in the Hispanic communities, NHTSA is preparing an Hispanic version of "Walking Through the Years." A focus group will assist in the translation of the program, with attention given to distinct cultural factors that may affect Hispanic behavior.

NHTSA and FHWA recently revised the "Walk Alert Manual," a national pedestrian safety concept. Special attention is given to elderly pedestrian issues in this program. A marketing plan, centered around the "Walk Alert" concept, is being developed to increase community leaders' awareness of pedestrian safety issues and problems.

RESEARCH AND SPECIAL PROGRAMS ADMINISTRATION

Because of continuing interest in State and local governments and throughout the transportation community, the following products dealing with mobility of the elderly were distributed through RSPA's Technology Sharing program.

Improving Bus Accessibility.—RSPA and the Federal Transit Administration (FTA) cooperated in distributing the report "Improving Bus Accessibility Systems for Persons with Sensory and Cognitive Impairments." This study, conducted by the Transportation Research Institute of Oregon State University, focused on meeting the transportation needs of the visually-impaired, the hearing-impaired, and cognitive problems resulting from age, heredity, or injury.

Vehicle Emergency Response.—RSPA and FTA cooperated in distributing the report "Evacuating Elderly and Disabled Passengers from Public Transportation Vehicle Emergencies" (DOT–T–94–16). This training package, developed by Senior Services of Snohomish County under FTA funding, is a detailed overview of evacuation techniques which can be used to extricate people with mobility limitations from transit vehicles involved in breakdown, accident, or fire situations.

Advance Public Transportation Systems (APTS).—Applications of advanced electronics and computer technology to bus routing, scheduling, and operations hold the promise of making transit easier for a variety of groups, including the elderly, to use. RSPA and FTA collaborated on making the following products on the potential of the technology available to the transit industry and transportation decision-makers:

"Advanced Public Transportation Systems: The State of Art, Update" '94 (DOT–T–94–09)

"Advanced Public Transportation Systems: Evaluation Guidelines" (DOT–T–94–10)

"Advanced Vehicle Monitoring and Communication Systems for Bus Transit: Benefits and Economic Feasibility" (DOT–T–94–03)

Telecommuniting Programs.—Although the link between telecommuting activities and the elderly has not been highlighted, the availability of telecommuting programs will enable many of the elderly to continue productive lives by working at home connected to their workplace electronically. RSPA and the Office of the Secretary issued the following two publications describing the potential of the technology:

Orientation to Telecommuting
Implementing Telecommuting

ITEM 13. DEPARTMENT OF THE TREASURY

TREASURY ACTIVITIES IN FISCAL YEAR 1994 AFFECTING THE AGED

The Treasury Department recognizes the importance and the special concerns of older Americans, a group that will comprise an increasing proportion of the population in decades ahead.

The Secretary of the Treasury is Managing Trustee of the social security trust funds. The short- and long-run financial status of these trust funds is presented in annual reports issued by the Trustees. The 1994 reports concluded that combined Old-Age and Survivors Insurance and Disability Insurance (OASDI) benefits can be paid on time well into the next century. Legislation enacted in 1994 resolved the impending exhaustion of the DI Trust Fund. As reflected in the past several reports, the financial outlook for Medicare, in particular Hospital Insurance (HI), will become troublesome shortly after the turn of the century. Although legislation enacted in 1993 has provided additional breathing space for the HI Trust Fund, further action may be required before the end of the century. During 1994, the OASDI cost-of-living increase was 2.6 percent. The taxable base for OASDI was increased to $60,600 for 1994 and the HI taxable base was changed to include all earnings. The amount a 65- to 69-year-old beneficiary could earn before his or her OASDI benefits were reduced was $11,160 per year.

With respect to the personal income tax, in 1994 the width of the income tax brackets and the sizes of personal exemptions and of the standard deductions were increased by approximately 3.1 percent to reflect the effects of inflation which occurred during the preceding year. The personal exemption increased by $100 to $2,450 for each taxpayer and dependent.

Taxpayers aged 65 or over (and taxpayers who are blind) are entitled to larger standard deductions than other taxpayers. For 1994, each taxpayer who is single and who is at least 65 years old is entitled to an extra $950 standard deduction. Each married taxpayer aged 65 or over is entitled to an extra $750 so that a married couple, both of whom are over age 65, are entitled to an extra $1,500. Including these extra standard deduction amounts and the basic standard deduction amounts, taxpayers over age 65 are entitled to the following standard deductions for tax year 1994: $4,750 for a "single" taxpayer; $6,550 for a taxpayer entitled to claim "unmarried head of household" status; $7,100 for a married couple filing a joint tax return, only one of whom is 65 or older; and $7,850 for a married couple filing jointly if both are age 65 or older. The corresponding amounts for tax year 1993 were: $4,600 for a "single" taxpayer; $6,350 for a taxpayer entitled to claim "unmarried head of household" status; $6,900 for a married couple filing a joint tax return, only one of whom was 65 or older; and $7,600 for a married couple filing jointly if both were age 65 or older.

Two other special provisions for the elderly continue: the tax credit for the elderly (and permanently disabled); and the one-time exclusion of the first $125,000 of profit from the sale of the personal residence of a taxpayer age 55 or older.

As the result of the Omnibus Reconciliation Act of 1993 (OBRA 1993), the taxation of social security benefits and the portion of Tier 1 of Railroad Retirement benefits treated as social security benefits changes for 1994. Prior to 1994, taxpayers with Modified Adjusted Gross Income (AGI) exceeding threshold amounts were required to include in AGI the lesser of 50 percent of social security benefits or 50 percent of the amount by which Modified AGI exceeded the threshold. Modified AGI is the sum of items of income included in AGI (except any includable social security benefits) plus tax-exempt state and local bond interest plus *one-half* of social security benefits. The Modified AGI threshold was $25,000 for single taxpayers and $32,000 for married taxpayers filing joint returns. Taxpayers with Modified AGI below these thresholds do not pay taxes on *any* of their social security benefits. For 1994 and future years, a second Modified AGI threshold was added: $34,000 for single taxpayers and $44,000 for married taxpayers filing joint returns. Fro those with Modified AGI below these new, secondary thresholds, the taxation of social security benefits did not change at all. Beginning in 1994, taxpayers with Modified AGI over the secondary threshold are required to include in AGI the lesser of 85 percent of social security benefits or the sum of $4,500 ($6,000 on a joint return) and 85 percent of the amount by which Modified AGI exceeds the secondary threshold. All of the revenue from the additional taxation of social security benefits is allocated to the Hospital Insurance (HI) trust fund.

INTERNAL REVENUE SERVICE ACTIVITIES AFFECTING THE AGED

The Internal Revenue Service (IRS) recognizes the importance and special concerns of older Americans, a group that will comprise an increasing proportion of the

population in the years ahead. Major programs and initiatives of the Office of the Assistant Commissioner (Taxpayer Services) and the Office of Strategic Planning and Communications that are of interest to older Americans and to others are described below.

The following publications, revised on an annual basis, are directed to older Americans:

Publication 523, *Selling Your Home,* sets forth the rules regarding the once in a lifetime exclusion of $125,000 of the gain on the sale of a personal residence of a person 55 years of age or older.

Publication 524, *Credit for the Elderly or the Disabled,* explains that individuals 65 and older may be able to take the Credit for the Elderly or Disabled, reducing taxes owed. In addition, individuals under 65 who retire with a permanent and total disability and receive taxable disability income from a public or private employer because of that disability may be eligible for the credit.

Publication 554, *Tax Information for Older Americans,* explains that single taxpayers aged 65 or older are generally not required to file a federal income tax return unless their gross income for 1994 is $7,200 or more (as compared to $6,250 for single taxpayers under age 65). Married taxpayers who can file a joint return are generally not required to file unless their joint gross income for 1994 is $12,000 or more if one of the spouses is 65 or over, or $12,750 if both spouses are 65 or older.

Publication 721, *Tax Guide to U.S. Civil Service Retirement Benefits,* and Publication 575, *Pension and Annuity Income,* provide information on the tax treatment of retirement income.

Publication 907, *Tax Highlights for Persons with Disabilities,* covers tax issues of particular interest to persons with handicaps or disabilities and to taxpayers with disabled dependents.

Publication 915, *Social Security Benefits and Equivalent Railroad Retirement Benefits,* assists taxpayers in determining the taxability, if any, of benefits received from Social Security and Tier I Railroad Retirement.

All publications are available free of charge. They can be obtained by using the order forms found in the tax forms packages or by calling 1–800–TAX–FORM (1–800–829–3676). Many libraries, banks and post offices stock the most frequently requested forms, schedules, instructions and publications for taxpayers to pick up. Also, many libraries stock a reference set of IRS publications and a set of reproducible tax forms.

Most forms and some publications are on CD–ROM, available in some larger libraries and on sale to the general public through the Government Printing Office's Superintendent of Documents. Information about ordering can be obtained by calling (202) 512–1800. Also, most forms and some publications may be downloaded through the FedWorld electronic bulletin board system. FedWorld can be reached by modem (dial-up) at (703) 321–8020, or by Internet (Telnet to fedworld.gov (192.239.93.3)).

Outreach and taxpayer education programs include:

The *Tax Counseling for the Elderly (TCE) Program,* which provides free tax assistance to persons 60 and older. The IRS enters into cooperative agreements with public and private nonprofit organizations (sponsors) whose members will be trained by IRS to act as volunteer tax assistors at selected sites identified by the sponsors. Sponsors also now have the option to operate telephone answering sites to assist the elderly with tax questions, help with forms, or schedule appointments. IRS assistance to older Americans through the TCE program has been growing since the program began in 1980. Some 35,000 volunteers helped 1.6 million persons during the past filing period.

The *Volunteer Income Tax Assistance (VITA) Program* provides tax assistance to targeted groups including low income persons, non-English speaking persons, and the elderly. The IRS trains volunteers who offer their services to taxpayers needing assistance. This service is free and many VITA volunteers also help the elderly in preparing their State and local returns and answering their questions. In addition, volunteers helped elderly taxpayers compute their estimated tax for the current tax year. The training that is available was developed in response to a study that included evaluations by educational authorities and surveys of volunteers and IRS employees involved in VITA and TCE. In fiscal year 1994, over 51,000 volunteers assisted over 1.5 million taxpayers through the VITA Program.

The *Small Business Tax Education (STEP) Program* provides information about business taxes and the responsibilities of operating a small business. Through a partnership between IRS and over 1,600 community colleges, universities, and business associations, small business owners and other self-employed persons have an opportunity to learn what they need to know about business taxes. Assistance is of-

fered at convenient community locations and times. Many elderly persons, such as those beginning second careers, avail themselves of this program.

As part of the *Banks, Post Offices, and Libraries (BPOL) Programs,* the IRS supplies 12,000 libraries with free tax aids such as reproducible tax forms, reference publications, and audio-visual materials that can assist older Americans in preparing Forms 1040EZ, 1040A, 1040 and related schedules. Also, banks and post offices distribute the Form 1040 family and other forms.

The Community Outreach Tax Education Program provides individuals with group income tax return preparation assistance and tax education seminars. IRS employees and trained volunteers conduct these seminars, which address a variety of topics. They are tailored for groups and individuals with common tax interests, such as groups of older Americans. These seminars are conducted at convenient community locations.

The 1990 tax year was the first year older Americans could use the expanded Form 1040A to report income from pensions and annuities, as well as other items applicable to older Americans such as estimated tax payments and the credit for the elderly or the disabled. More than half of the potential filing population eligible to use this simpler, shorter form rather than the much longer Form 1040 made the switch.

Responding to requests from the public for such a product, the Tax Forms and Publications Division developed large-print versions of the Form 1040 and Form 1040A packages earmarked for older Americans. These packages (designated as Publications 1614 and 1615, respectively) are newspaper-size and contain both the instructions and the forms (for use only as worksheets, with the amounts to be transferred to regular-size forms for filing).

The Tax Forms and Publications Division reviews *Protecting Older Americans Against Overpayment of Income Taxes,* a publication from the Senate Special Committee on Aging.

OTHER TREASURY ACTIVITIES AFFECTING THE AGED

Other agencies of the Treasury also have an impact on the elderly as part of their specific functions. Developments during 1994 are summarized below.

FINANCIAL MANAGEMENT SERVICE

The Financial Management Service makes over 600 million Social Security, Supplemental Security Income, and Veteran payments annually. Nearly half of these payments are made via paper checks, which are mailed. There are certain vulnerabilities associated with checks, such as the possibility of forgery, theft and loss. We have several initiatives which will significantly improve the certainty of the payments reaching the intended recipients on a timely basis, and improves the ability of recipients to use those payments safely and conveniently.

FMS continues to support the development of a nationwide program to make Electronic Benefit Transfer (EBT) a viable payment mechanism. Geared toward those individuals without a bank account or who choose not to use Direct Deposit, EBT is an electronic benefit delivery mechanism that enables recipients to use plastic debt cards to access their benefits at automated teller machines or point-of-sale terminals. There are currently 8 operating projects delivering State benefits (e.g., Food Stamps, Aid to Families with Dependent Children, and General Assistance) and 1 project in Texas delivering direct Federal benefits (e.g., Social Security and Supplemental Security Income). Twenty-eight other States are currently planning an EBT project or investigating the possibility of using EBT.

The direct Federal pilot project, begun in April 1992, in the Houston, Texas, areas, was extended to Dallas/Fort Worth in November 1993, and is ready to be implemented on a statewide basis. The pilot is targeted to recipients who receive their monthly benefit by check. Currently, over 8,500 recipients of Social Security, Supplemental Social Security Income, Railroad Retirement, Civil Service Retirement, and Veteran's Pension and Compensation use an EBT card to receive their benefits.

FMS also provides direct support as one of the key agencies active in the Federal EBT Task Force, including the Office of Management and Budget and the Departments of Agriculture and Health and Human Services, to create a nationwide integrated Federal/State EBT program. FMS is currently working with the EBT Task Force and seven southern States to design and implement an integrated Federal/State EBT system. FMS is also preparing to acquire Federal and State EBT services nationwide. The objective is to have nationwide EBT for Federal and State benefits by 1999.

U.S. SAVINGS BONDS DIVISION

During Fiscal Year 1994 the U.S. Savings Bonds Division continued to provide information about Bonds to the public, including older Americans. The Division recognized the importance of maturing Series E Savings Bonds for older Americans by producing information bank leaflets, publicity, and public service advertising promoting the exchange privileges for Series HH Savings Bonds. Series HH Bonds allow the accrued interest of Series E and EE Savings Bonds to be tax-deferred for up to an additional 20 years while earning interest that is treated as current income for the owner.

Public service advertising incorporated closed captioning for the hearing impaired and promotional print materials will be designed to be enlarged for the visually impaired.

With respect to the education tax benefits of Savings Bonds used to pay for higher education tuition and fees at qualifying institutions, older Americans were informed of ways to purchase Bonds for the benefit of their adult child's or grandchildren's college education.

The Division continued to promote the sale and retention of Savings Bonds to the public, including older Americans, through news media, financial institutions, employers and major national organizations.

BUREAU OF THE PUBLIC DEBT

The Bureau of the Public Debt continued to make improvements in programs to better serve all investors. The Bureau's efforts to streamline and simplify access to Treasury securities are of particular benefit to elderly investors.

Savings Securities

Customer Service.—In compliance with Executive Order 12862, dated September 11, 1993, setting customer service standards, we are taking steps to formalize and enhance our existing commitment to customer satisfaction. The elderly compose a very important part of our customer base, making up an estimated 28 percent of the nearly 11 million Americans who purchase savings bonds each year. In addition, persons over the age of 55 represent 48 percent of adults owning savings bonds worth more than $10,000. Consequently, our efforts to improve service to our customers will undoubtedly have a positive effect on many older people. We have established standards to ensure the timely delivery of savings bonds, the accuracy of inscribed bonds, and courtesy extended to our customers. In addition, we continually modify internal processes to improve efficiency and simplify the purchasing procedure. Finally, we actively promote savings bonds as an investment for retirement through advertisement and informative brochures.

Matured Bonds.—We have two programs that provide better service to owners of current income bonds. The first involves contacting owners of current income bonds, many of them elderly, whose bonds have matured. We advise owners of bonds that are no longer earning interest to redeem or reinvest them. The second initiative consists of a new automated telephone system. It expedites business by allowing a caller to speak directly to a customer service representative rather than leaving a message and waiting for a return call.

Automated Clearing House.—Owners of all current income bonds may have their semi-annual interest payments deposited immediately to their bank accounts. The Automated Clearing House (AC) method eliminates any worry about lost, stolen, or delayed interest checks, provides assurance that the money is on deposit and available to use on the payment date, and eliminates the item and expense of special trips to deposit interest checks. We now make nearly half of all such interest payments through ACH.

Public Information.—Our Division of Transactions and Rulings has the most contact with the public and, therefore, the elderly. It tries to write its forms and letters to be easily read and understood by persons of all ages. It gives special attention to those having difficulty understanding by amending forms as much as possible and writing clearly.

Marketable Securities

Book-Entry Conversion.—Public Debt continues to encourage owners of registered and bearer securities to convert these paper certificates to book-entry form. Holding Treasury securities in book-entry form provides a much safer and more convenient method than holding them in definitive form. The maintenance of book-entry accounts is more cost effective for the Federal Government and therefore the taxpayer.

Public Debt's Smart Exchange program is an excellent way for investors to hear about, and convert to, book-entry holdings. The Smart Exchange begins with a mailer, included with interest payments made by check to holders of paper certificates. The mailer suggests the investor call the 1–800 number to talk with a Bureau representative about the advantages of converting to book-entry. Specific information regarding the streamlined procedures for converting are shared with the investor and needed materials are sent quickly.

Since April 10, 1992, more than 10,000 investors have called about Smart Exchange, with conversions exceeding 30 percent.

Consumer Information Center.—Public Debt makes two brochures available through the Consumer Information Center in Pueblo, Colorado.

Buying Treasury Securities provides basic information on purchasing marketable securities.

Make the Smart Exchange informs interested investors about converting their marketable Treasury securities held in definitive form to book-entry accounts in the Treasury Direct system.

OFFICE OF THE COMPTROLLER OF THE CURRENCY

During 1994, the Office of the Comptroller of the Currency (OCC) continued its active liaison with national organizations representing bank customers, including the American Association of Retired Persons, to share information about banking-related issues. Comptroller Eugene Ludwig met monthly with representatives from these national organizations at informal meetings held at the OCC. The Comptroller met with local consumer and community representatives from each of the OCC's six districts. The purpose of the meetings was to share information about affordable housing for low- and moderate-income and elderly persons and families, community development lending, and small business and economic development. These meetings were held in Dallas, Omaha, Salt Lake City, Chicago, San Francisco and Atlanta.

OCC district offices continued their outreach programs for purposes of contacting and meeting with local consumer and community groups to share information about banking-related issues. Organizations representing the elderly were among those contacted. The OCC also distributed 7 banking issuances to over 1,400 consumer and community groups throughout the United States including those representing the elderly.

Throughout the year, the OCC provided copies of its publications, including its quarterly newsletter *Community Developments* to national banks, bank trade associations and bank customer groups, including those representing the elderly. Affordable housing for all citizens, including the elderly, continues to be an issue voiced by consumer and community groups in meeting with the OCC. The publications provided by the OCC provide guidance to bankers on innovative programs banks can utilize in partnership with community organizations, as well as federal, state and local governments, to finance low- and moderate-income housing and other community economic development programs. The objective of these programs is to increase the affordable housing and economic opportunities for low- and moderate-income persons, including the elderly.

The OCC also is responsible for resolving complaints against national banks. Through the first 11 months of 1994, the OCC received 14,884 written complaints. Older Americans seek OCC's assistance in resolving problems with their bank.

SECRET SERVICE

The Secret Service continued to protect elderly recipients of Government payments. During Fiscal Year 1994, the Secret Service closed 16,108 Social Security check investigations. In addition, the Secret Service closed 1,976 check investigations involving Veterans' benefits, 408 involving Railroad Management checks and 931 involving Office of Personnel Management checks. The majority of these checks were issued to retirees.

The Secret Service also conducted 1,757 investigations involving attempts by individuals to illegally divert funds during the direct deposit/electronic funds transfer process. Elderly Americans have been encouraged to utilize the electronic transfer process as a matter of convenience and as a safeguard against the loss of funds.

BUREAU OF ENGRAVING AND PRINTING

The Bureau of Engraving and Printing (BEP) continued to recognize the special needs of aging citizens during 1994.

Bureau of Engraving and Printing Tour.—The BEP Tour is one of the Treasury Reinvention Laboratories. The implementation of this laboratory will include several

changes to make the Tour more customer friendly, which will help Seniors as well as the other tourists that visit the Bureau. Some of the changes include: (1) a sidewalk along the building so the seniors will no longer walk on the alleyway road; (2) better signage that will direct the visitors along the tour and how to return to the buses; (3) more and improved exhibits that explain the Bureau's mission; (4) a canopy over the pathway from 15th Street to 14th Street to protect visitors from the inclement weather and the heat of the summer; (5) better ventilation on the tour; (6) opening up narrow walkways so the areas will be less confining; (7) allowing fewer people through the tour each 15 minute period to make it more comfortable and less crowded for each group going through; and (8) providing guides for each group going through the tour and eliminating self-guided tours.

The operation of the BEP tour is managed by an "8a" firm, a minority-owned business under the SBA 8(a) program, which employs retired individuals as tour guides.

The Bureau provides CPR training on an ongoing basis to its tour, medical, and police units in the event that an emergency should occur.

The Bureau has wheelchairs available for senior citizens touring the facility, as well as tour guides trained to assist senior citizens with special needs.

The Bureau has ramps, wide entrances, and restrooms designed to accommodate persons using wheelchairs or walkers.

Programs for Bureau Employees.—The Bureau periodically conducts a Pre-retirement Program for employees 50 years of age and over. The program, also available to spouses, emphasizes the importance of planning for retirement in advance. It is offered to employees who are planning to retire within the next 5 years, and covers areas such as calculation of benefits, financial planning, discovering hidden talents, legal affairs, relationships and health.

Other Assistance.—The Office of Equal Employment Opportunity and Employee Counseling Services works with older employees who have experienced problems with housing, finance, health, or energy conservation requirements. The Office also provides assistance to employees who are part of the "sandwich" generation, who are responsible for providing care for both older and younger generations. In addition to providing for their children, they often are the primary caregivers for elderly parents or relatives who must have adult day care or require nursing home placement. The Office also maintains information on referral services available to older employees or to employees who are providing for older parents or relatives.

The Bureau's on-site medical staff provides life-style counseling for employees who are senior citizens. The emphasis is on wellness and prevention of disease, and include advice on nutrition and weight control, testing of blood pressure and cholesterol levels, and examination of possible vision and hearing deficiencies.

An assessment of our facilities, including the tour areas, has been completed in accordance with the Americans with Disabilities Act (ADA), and we will be incorporating recommended modifications.

The BEP is contracting with the National Academy of Sciences to conduct a study, with the cooperation of the American Counsel for the Blind, to determine ways to assist the blind and partially sighted with handling currency.

U.S. CUSTOMS SERVICE

The U.S. Customs Service does not specifically target any group of individuals, including the aged, for expedited Customs processing. However, the aged are included among those who are entitled to request special treatment when they arrive from abroad. This group not only includes the elderly, but also persons who are handicapped or ill and are unable to wait in line, persons returning home for emergency reasons such as a death in the family, and a parent arriving with several infants. Travelers meeting any of the aforementioned criteria may request to speak with a Customs supervisor as soon as he or she arrives in the Customs processing area of the airport or other Customs port of entry. The supervisor will provide all possible assistance within his or her means to facilitate the traveler's Customs clearance without compromising Customs enforcement responsibilities.

In addition, Customs works with government and private architects to ensure that federal inspection facilities, including restrooms, permit the unrestricted movement of those individuals who must rely on a wheelchair or walker.

The U.S. Customs Service places a high priority on professionalism and the courteous treatment of travelers. Our policy of professional pride, image, and attitude is not only limited to our treatment of the elderly, but to all travelers to this country.

U.S. MINT

The U.S. Mint continues to consider the special needs and concerns of senior citizens in it programs and services.

Special accommodations for elderly visitors are available at the Philadelphia Mint, Denver Mint, and San Francisco Old Mint Museum which offer public tour programs. Most significant of these services during Fiscal Year 1994 was the continuing improved accessibility project at the Denver Mint. The second phase of this project includes accessibility for physically challenged visitors via a motorized chair lift to the Sales & Exhibit Center from the sidewalk along one side of the building. We expect to have this phase of the project completed by February 1995.

BUREAU OF ALCOHOL, TOBACCO AND FIREARMS

The Bureau of Alcohol, Tobacco and Firearms (ATF) began a program called Project Outreach in May 1990. This is a public awareness program which informs citizens of the growing threat of street gang violence. The information is presented to civic groups as well as local community anti-drug educational organizations.

The American Association of Retired Persons (AARP) has been used by Compliance Operations of ATF to fill clerical positions in areas offices in the past. Currently, Compliance Operations is consulting with AARP to determine if they can supply us with people to perform clerical tasks in the Technical Services in Cincinnati. We continue to urge our various offices to explore these and other possibilities to fill needed positions.

Program for Employees.—ATF supports its Health Improvement Program and encourages persons of all ages, especially those over 50 years of age, to participate frequently.

ATF offers pre-retirement seminars to all of its employees who are eligible to retire within 5 years or less. These seminars cover financial planning, retirement benefits, and health and legal affairs.

ATF has an ongoing Employee Assistance Program and encourages elderly employees to seek help in any area where they feel there is a need.

Under the Quality of Worklife Program, ATF is developing an Eldercare program to provide information, counseling, and support to elder employees and employees with older relatives.

ITEM 14. COMMISSION ON CIVIL RIGHTS

During FY 1994, the Commission continued to process complaints received from individuals alleging denials of their civil rights. Specifically, 33 complaints alleging discrimination on the basis of age were received by the Commission and referred to the appropriate agency for resolution.

ITEM 15. CONSUMER PRODUCT SAFETY COMMISSION

REPORT ON ACTIVITIES TO IMPROVE SAFETY FOR OLDER CONSUMERS

Each year, according to estimates by the U.S. Consumer Product Safety Commission (CPSC), nearly 1 million people over age 65 are treated in hospital emergency rooms for injuries associated with products they live with and use everyday. The death rate for older people is approximately five times that of the younger population for unintentional injuries involving consumer products, including motor vehicles. Specifically, there are 60 deaths per 100,000 persons 65 and older, while there are about 12 deaths per 100,000 persons under 65.

Slips and falls are the main source of injury for older people in the home. Older consumers can slip in the bathroom, especially in the bathtub. Falls can happen on stairs, stepstools, and floors with loose carpets. When older people fall, their risk of serious injury or death is much higher than that of the general population. CPSC recommends the use of grabbars and non-slip mats by the bathtub; handrails on both sides of the stairs; and slip-resistant carpets and rugs.

Burns occur from hot tap water and from open flame fires in the home and are an important source of injury to older Americans. CPSC recommends the installation and maintenance of smoke detectors on every floor of the home. Older consumers should look for nightwear that would resist flames, such as a heavy weight fabric, tightly woven fabrics such as polyester, modacrylics, or wood. CPSC also recommends that consumers turn down the temperature of their water heater to 120 degrees Fahrenheit to help prevent scalds.

As part of the Home Electrical System Fires project, CPSC is conducting studies to investigate new technology to address electrical wiring fires in older homes, and

to identify less destructive and costly means of updating the wiring. This is particularly important to the elderly since they often live in the older homes.

CPSC is also looking to new technology to address range cooking fires. Studies are being conducted to develop technology to sense fire conditions and shut the burner or oven off. Older consumers are often involved in kitchen fires when they forget food is on the range.

CPSC is investigating fires involving both upholstered furniture, and mattresses and bedding to determine how the fires start and the age of consumers involved. Older consumers are a part of the focus because they have a slowed response time. If the flammability of furniture and bedding is reduced, the elderly have a chance to react and get out.

In 1994, CPSC distributed more than 60,000 copies of the "Home Safety Checklist for Older Consumers" (English and Spanish). The "Home Safety Checklist" is a room-by-room check of the home, identifying hazards and recommending ways to avoid injury. Consumers may order a free copy by sending a postcard to "Home Safety Checklist," CPSC, Washington, D.C. 20207.

Another publication to which CPSC contributed is "What Smart Shoppers Know About Nightwear Safety." This brochure was developed by a group of experts in apparel flammability and distributed by the American Association of Retired Persons (AARP). The brochure encourages older consumers to look for sleepwear that is flame resistant. Consumers may request a copy by sending a postcard to AARP, 601 E Street, N.W., Washington, D.C. 20049.

The Chairman has invited manufacturers and retailers of nightwear for older consumers to come to the CPSC to discuss the flammability hazard with nightwear. Elderly consumers have been involved in a number of incidents in which loose fitting, long hanging nightwear has caught fire while the consumer was cooking. The Chairman is holding this meeting in order to explore ways with industry to address the hazard.

Older consumers are involved in the childhood poisoning issue because many young children are poisoned when they swallow grandparents' medicine. In October 1990, the Commission proposed changing the test protocol for child-resistant packages under the Poison Prevention Packaging Act to make it easier for all adults to use child-resistant packages. CPSC has data estimating that the widespread use of child-resistant closures on aspirin and oral prescription medicines saved the lives of at least 700 children under age 5 since 1972. However, many adults (particularly older consumers) do not use child-resistant packaging because they find it physically difficult to use. To make it easier for all adults, especially older ones, to use child-resistant packaging, CPSC proposed to change the regulation by requiring that the adults on the test panel be 60 to 75 years of age rather than 18 to 45 years old. This is expected to increase the use of child-resistant packaging by all adults.

In 1995, CPSC plans to decide whether to finalize these changes in the test protocol for child-resistant packaging. If made final, these changes will encourage industry to develop innovative closures that appeal to older people's "cognitive skills" instead of their physical strength. In addition, CPSC reminds all adults to keep medicines out of the reach of children who can be poisoned if they swallow medicines or household chemicals.

Older consumers are the focus in the development of revised CPSC regulations for special packaging of prescription and nonprescription medicines and household chemical products. Older adults often find it difficult to open current child-resistant packaging and may not replace caps—thereby exposing young children to potential poisonings. The Commission is reviewing a final rule for Poison Prevention Packaging Act (PPPA) protocol revisions which specifically include older consumers in testing to determine if the elderly can open the packaging without young children opening it.

In a new innovation this year the Chairman, Ann Brown, has given commendations to two companies for safety innovations. They are Procter and Gamble for senior friendly and child-resistant caps on mouthwash and to Sunbeam Plastics for an entire line of senior friendly and child-resistant closures.

Finally, CPSC is currently working with the Food and Drug Administration (FDA), to issue a joint safety release on heating pads. CPSC receives reports of 6 to 10 deaths each year associated with heating pads; most of these deaths involve fires with victims over 65 years of age. In addition, CPSC estimates that there are about 1,500 injuries associated with heating pads treated each year in hospital emergency rooms; most of these injuries involve burns with an estimated 40 percent of the victims over 65 years of age.

ITEM 16. CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

NATIONAL SENIOR SERVICE CORPS

On September 21, 1993, the President signed into law the National and Community Service Trust Act, which created the Corporation for National and Community Service (Corporation). The Corporation's mission is to engage Americans of all ages and backgrounds in community-based service. This service addresses the Nation's unmet education, public safety, human and environmental needs to achieve direct and demonstrable results. This commitment to "get things done" is honored by the Corporation's three national service initiatives: National Senior Service Corps (NSSC), AmeriCorps, and Learn and Serve America.

NSSC, also known as the Senior Corps, is comprised of three seasoned programs previously supported by the Federal agency ACTION: The Retired and Senior Volunteer Program (RSVP), the Foster Grandparent Program (FGP), and the Senior Companion Program (SCP).

In 1994, the Senior Corps utilized the skills of half a million volunteers to fulfill the Corporation's mission. A sample of accomplishments follows.

HUMAN NEEDS FORUM

On April 20, 1994, the Senior Corps participated in an intergenerational event focused on independent living hosted by First Lady Hillary Clinton at the White House to honor outstanding service leaders and organizations.

This event reflected the First Lady's commitment to health care reform and her support of the role that community-based organizations play in improving the quality of life for Americans. While this event placed particular emphasis on the Senior Companion Program's dedication to serving the frail elderly and enabling them to remain independent in their own homes, all three Senior Corps programs were showcased because of their ability to mobilize the vast resources of senior volunteers in support of independent living.

Thirteen Senior Corps volunteers from around the country were selected to participate from over 30 nominees. Ranging in age from 65 to 100 and representing a variety of backgrounds, these seniors have collectively contributed over 70 years of service through the Senior Corps to individuals and communities nationwide.

Two of the thirteen volunteers gave brief presentations on the support they have provided to their peers over the years. For example, Senior Companion Alta Nuzman, 76, spoke of her 4-year commitment to the frail elderly and their independence. The remainder of volunteers were individually recognized for similar contributions.

SUMMER OF SAFETY (SOS)

In June 1994, the Senior Corps launched the Senior Summer Corps (SSC) as part of the Corporation's Summer of Safety demonstration initiative. Twenty grants were awarded to the sponsors of 20 Senior Corps projects to develop flexible program models appropriate to specific local public safety problems. Over an 8–12 week period, SSC drew upon the accumulated life experience of 2,400 seniors in implementing and testing program models to reduce violence, drug abuse, fraud, vandalism, and the fear associated with these pervasive problems.

For example, volunteers created neighborhood watch organizations, offered victim assistance, taught conflict resolution and established safe havens where children could play without fear. As of October, 2 out of every 5 volunteer positions funded by SSC were sustained beyond the summer, an indication that grantees were able to transition their projects from demonstration to long-term initiatives.

LEADERSHIP ROUNDTABLE: A VISION FOR SENIOR SERVICE IN AMERICA

On September 29 and 30, 1994, the Corporation participated with selected public and private organizations involved in the fields of aging and voluntarism to explore issues and areas for collaboration and partnership around senior service. Participating organizations included: the University of Maryland's Center of Aging, American Association of Retired Persons (AARP), Administration on Aging (AOA), Save Our Security, Public/Private Ventures, Johns Hopkins Health Institutes, the Retirement Research Foundation, Generations United and the National Directors Associations for FGP, SCP and RSVP, to name a few.

Over this 2-day period, attendees discussed possible strategies for developing a senior service movement of substantial proportions and impact, one that would help communities and community-based organizations dramatically enhance the service opportunities currently available to older Americans. The Corporation expects to

play a significant role in moving senior service to this next level of significance and is in the process of clarifying the roles of other key organizations and sectors. Future gatherings similar to the Roundtable have been tentatively arranged to continue the development of this service movement.

NATIONAL TRAINING INSTITUTES FOR LEADERSHIP IN SENIOR VOLUNTARISM

Four National Training Institutes for Leadership in Senior Voluntarism, co-sponsored with the University of Maryland, were held in Washington, DC; Atlanta, Georgia; Denver, Colorado; and Minneapolis, Minnesota. The Corporation sponsored 80 participants, including select project directors from FGP, SCP and RSVP, Corporation staff, State Commissions and Executive Directors of sponsoring organizations. The training was designed to develop a core set of leadership skills for current or potential leaders in community-based organizations having a mission in voluntarism and aging.

RETIRED AND SENIOR VOLUNTEER PROGRAM

In fiscal year 1994, with a budget of $34.4 million, the Retired and Senior Volunteer Program (RSVP) completed its 23rd successful year. There were 746 Corporation funded projects and 445,500 volunteers assigned to 60,000 community agencies nationwide, providing over 80 million hours of service. RSVP volunteers served in courts, schools, museums, libraries, hospices, hospitals, nursing homes and a wide range of other public and private nonprofit organizations. Volunteers serve without compensation, but may be reimbursed for, or provided with, transportation and other out-of-pocket expenses. All volunteers are covered by appropriate accident and liability insurance coverage.

The RSVP continues to match its resources to the diverse needs of hundreds of American communities by providing increased and diversified opportunities for persons 55 years of age and older to serve on a regular basis in a variety of settings.

RSVP, in partnership with the National Association of RSVP Directors, conducted a National Training Conference entitled "Experienced Partners in National Service." Almost 1,000 RSVP Project Directors and staff, Project Sponsor staff and Corporation staff attended the Conference at three decentralized locations. The core curriculum included sessions on the Corporation mission and priorities in relation to senior service, the new AmeriCorps programs, national societal trends resulting from the graying of America, thinking strategically and bringing the national senior service agenda home to local communities.

A total of 19 projects received "Programs of National Significance Awards" totalling $103,000. These awards support on additional 545 volunteers in 15 specific program areas. New areas include public safety, environment, apprenticeship programs and assistance to State and local governments.

PUBLIC/PRIVATE PARTNERSHIPS

A continuing effort to maximize partnerships with other public and private entities resulted in the following:

The Environmental Alliance for Senior Involvement (EASI) was formed by 15 Federal agencies and national organizations to increase involvement of senior volunteers with local environmental improvement efforts. RSVP, as the Nation's largest senior volunteer network, was one of the lead programs in the formulations of EASI, joining with the American Association of Retired Persons, the Environmental Protection Agency (EPA), and components of the Departments of Agriculture and Interior. EASI sponsored its second national conference in September 1994. As a result of funding provided by EPA, a number of RSVP projects received small grants to initiate or expand ground water protection efforts.

Through the Intergenerational Alliance, RSVP extended 13 RSVP projects participating in inter-generational activities with local youth service agencies. A grant to Generations United was awarded to provide training and technical assistance to those projects to facilitate linkages and encourage participation among all networks involved in intergenerational programming.

Volunteers from RSVP are serving effectively in partnerships with a growing number of State Health Insurance Counseling Programs, administered by State Office on Aging and State Insurance Departments. These State programs have been fostered by the Office of Beneficiary Services (OBS) of the Health Care Financing Administration. For more than 5 years, the OBS has provided training materials to all RSVP projects to assist volunteers who counsel Medicare/Medicaid beneficiaries regarding Health Insurance and related topics such as select-

ing the most appropriate HMO and choosing a nursing home. In some States, State Insurance Departments are contracting directly the RSVP projects through the Senior Health Insurance Benefits Advisors Program. In other cases, RSVP is contracted through local Administration on Aging (AoA) offices, and training and funding support is subcontracted by local agreements. In Maryland, for example, seven of the nine RSVP projects receive support funds for transportation and travel expenses, and training ranging from $2,000 to $12,000 per project. Other States which are just starting counseling programs are eager to use RSVP volunteers when possible.

NON-FEDERAL SUPPORT

Projects have successfully generated non-Federal resources to help expand and improve volunteer services. RSVP sponsors, their advisory councils and staff, have used imaginative and varied approaches to attract cash and in-kind contributions. RSVP's total non-Federal support totaled over $36.7 million in FY 1994. Non-Federal support was 52 percent of the total funding for RSVP.

PROJECT EXAMPLES

GREEN BAY, WISCONSIN

Many volunteer opportunities are available for active older people, but what about the frail or homebound seniors? RSVP of Brown County has identified "stay at home" volunteer opportunities for seniors who are unable to get around so that they can continue to offer something to their communities and feel needed. These volunteers not only do more traditional "stay at home" work like knitting warm hats and mittens for the homeless, telephone reassurance calls to other elderly people, and making dolls and teddy bears for hospitalized children, but are also engaged in more creative projects. For example, a growing number of RSVP volunteers are working with the Einstein Project to improve science education in the schools. Volunteers develop special kits for students to do hands-on science projects that the students will particularly enjoy, making science infinitely more interesting. Since the Einstein Project works with all grade levels in all the school districts in Brown County, the volunteers are making a major impact in the lives of many students, while contributing to their communities, despite being limited in their ability to get around.

DENISON, TEXAS

When the County Health Department reported that only 35 percent of the children in the Denison area had received the vaccinations recommended by the American Academy of Pediatrics, the Denison RSVP and its volunteers decided to do something to alleviate this problem. Many parents are unaware of recommended vaccination schedules or that free or low-cost immunizations are available. So in the phase one, RSVP volunteers visit new mothers in local hospitals, providing information on the importance of vaccinating children on a regular schedule. Then, the volunteers work with the health department to contact parents in writing and by telephone to both remind them of the vaccination schedule and help set up appointments to complete vaccinations.

The goal is for children by age 2 to have all the recommended vaccinations rather than waiting until the mandated school age. By eliminating these vulnerable, unvaccinated years, many disabling and crippling diseases can be avoided and much suffering relieved.

SEATTLE, WASHINGTON

Since 1986, the King County RSVP in Seattle as been providing consultation services to a broad spectrum of nonprofit agencies through its Retired Executive Volunteers (REV) program. This group of retired professionals and business managers have applied their various skills, to assist a nonprofit adult day center do long-range planning; a nonprofit child care agency to strengthen their board structure and participation; a program serving at-risk youth to develop personnel policies; and a County probation office to restructure.

CHARACTERISTICS OF RSVP VOLUNTEERS

	Percent
Distribution by Gender:	
Female	76
Male	24

	Percent
Distribution by Age:	
55–59	3
60–69	28
70–79	46
80–84	15
85+	8
Distribution by Ethnic Group:	
White	84
Black	10
Hispanic	4
Asian/Pacific Islanders	1
American Indian or Alaskan Native	1

FOSTER GRANDPARENT PROGRAM

The Foster Grandparent Program (FGP) is one of the most successful and respected volunteer efforts in the United States. Through FGP, income eligible persons, aged 60 and older, provide person-to-person service to children with special or exceptional needs.

In FY 1994 there were 262 Corporation-funded FGP projects in all 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands. In addition, there were 14 projects totally supported by non-Federal funds, bringing the total number of FGP projects to 276.

Nearly 23,800 volunteers contributed about 21.7 million hours assisting children with special or exceptional needs, such as mental retardation, autism, and physical disabilities. Children with special needs also include those who have been abused and neglected, children of single teenage mothers, runaway youth, juvenile delinquents, as well as those in need of protective intervention.

Foster Grandparents assist over 80,000 children everyday. They usually serve 4 hours a day, 5 days a week. The Program provides certain direct benefits to these income eligible volunteers, including a modest stipend, transportation and meal assistance when needed, insurance protection and an annual physical examination. Foster Grandparent services are provided through designated volunteer stations in private nonprofit organizations and public agencies. They include schools, hospitals, juvenile detention centers, Head Start programs, shelters for abused or neglected children, State schools for the mentally retarded, and drug abuse rehabilitation centers.

During FY 1994, the Corporation for National and Community Service, under Subtitle H, continued an agreement initially funded by the Commission on National and Community Service intended to stimulate greater FGP involvement with Head Start Parent Child Centers.

PROJECT EXAMPLES

NEW YORK, NEW YORK

The FGP Family Mentor Program is funded by the New York City Department of Aging in collaboration with the Child Welfare Administration and serves all five boroughs. There are 77 Foster Grandparent volunteers assigned as mentors to work in the homes of "high-risk" families who have been reported for abuse and/or neglect, as an alternative to removing the children from their families and placing them into foster care.

The Foster Grandparents are assigned to two or three families having no more than two children under 18 years of age. The Foster Grandparents provide love and attention to the children; act as role models for good parenting skills; reinforce guidance to parents on child management; introduce families to available community sources of support; and expose children and their families to cultural activities in order to alleviate the stresses that lead to abuse and/or neglect.

The Family Mentors Field Workers work closely with the Family Mentor Coordinator on the monitoring and supervision of the Foster Grandparents. Foster Grandparents regularly meet with the Field Worker at the host site to discuss issues and concerns pertaining to each family in order to enhance their effectiveness. In this fashion, the volunteers take an active role in family care management and enable them to make valuable contributions to the families' successful development.

PORTLAND, MAINE

Youth Alternatives Emergency Boy's Shelter is a safe haven for boys ages 7 to 17 years of age. The boys are allowed to stay at the shelter for a maximum of 28

days. Some of these boys are homeless, some are runaways and some are in between placements having just been released from the Maine Youth Center, a correctional facility, or waiting for a foster home. This transition time can be very stressful for the boys and their Foster Grandmother is there to nurture and lend an ear. For many of them, she is the only adult who makes an "extra effort." She provides support by helping them with their homework or writing letters, plays games, models good manners and helps them prepare meals and eats with them. She encourages them to complete their chores and always goes that "extra mile" by being willing to volunteer evenings and weekends when they need her most. One boy who happened to forget the Foster Grandparent's name asked her "can I just call you nice lady?"

In April 1994 Foster Grandparents were assigned to a program called Sentencing Options, a nonprofit agency that works with the courts in developing alternative sentences for youth who have committed nonviolent crimes. A Foster Grandfather has been successfully matched as a mentor with young men helping them to develop goals and the steps needed to accomplish them. He encourages them to attend substance abuse support groups, often accompanying them to make meetings easier to attend. If his assigned children are incarcerated, the mentor will visit them to assure support so that upon leaving the correctional facility they have someone to talk to that will assist them in making good choices about employment, housing, financial needs, and social interactions. Making this contact with a mentor upon release can lead to the youth making good choices and reducing their chances of returning to prison for lack of community connections.

NON-FEDERAL FUNDING

Non-Federal funding for the Foster Grandparent Program increased by approximately $900,000 in FY 1994. Approximately, $30.7 million in non-Federal funding was contributed to support FGP projects nationwide. A major portion of these funds came from State governments, either through direct appropriations or contributions from State-funded agencies. The balance came from local governments and private sources. Non-Federal funds matched approximately 46 percent of the Federal appropriation for FGP in 1994.

Fourteen non-federally-funded FGP projects are operating in the country today—seven in Michigan, one in New York, one in Wisconsin, three in New Mexico, and two in Georgia.

CHARACTERISTICS OF FGP VOLUNTEERS

	Percent
Distribution by Gender:	
Female	90
Male	10
Distribution by Age:	
60–69	34
70–79	50
80–84	12
85 +	4
Distribution by Ethnic Group:	
White	49
Black	37
Hispanic	10
Asian/Pacific Islanders	2
American Indian or Alaskan Native	2
Ages of Children Served:	
0–5	38
6–14	42
15–20	16
21 +	4

SENIOR COMPANION PROGRAM

The Senior Companion Program (SCP) offers volunteer service opportunities to income eligible Americans 60 years of age and older. Senior Companions provide person-to-person non-medical assistance and peer support to adults, primarily the frail elderly who experience difficulties with activities of daily living. The clients served by the Senior Companion are chronically homebound with physical, emotional, and mental health limitations that place them at risk of being placed in very costly institutionalized care facilities. Companions help strengthen their clients' capacity to live independently in the community.

In FY 1994, with a budget for the Senior Companion Program of $29.8 million, 147 Corporation-funded Senior Companion projects were funded. In addition, 40 projects were non-federally funded, bringing the total to 187 projects. These projects supported approximately 13,200 volunteers, contributing over 11 millon hours of service. Through the projects, community agencies such as home health care agencies, day care centers, residential institutions, hospitals and hospices match volunteers to about 33,000 clients, primarily the frail elderly. The majority of the Senior Companions provide in-home care to their clients.

A national conference was held to celebrate the 20th anniversary of the Senior Companion Program and explore new avenues for expanding SCP's role in addressing the emerging health and social service needs of the growing older American population. Examples of two new avenues for program development explored were the Health Care Financing Administration's (HCFA) Medicaid waiver program and public/private partnerships through the insurance industry. Approximatley seven projects are supporting volunteers under the Medicaid home and community-based waiver program. A second publc/private partnership grant with the Visiting Nurse Associatiosn of America (VNAA) extended "best practices learned" into a new initiative involving four projects and a future search technology conference with selected public and private organizations. Funds supported public relations marketing activities to give SCP greater visibility.

A sum of $225,000 was awarded to support Programs of National Significance grants to 18 projects with a total of 59 additional service years funded to both Corporation and non-federally funded SCP projects.

PROJECT EXAMPLES

HOT SPRINGS, ARKANSAS

Loneliness had cause a 69 year old man who had once been the "life of the party" to become a hermit and his "social drinking" had lead him to become an alcoholic. When the hospital could do no more for his damaged stomach, he was sent home to die unless he drastically changed his ways. He made up his mind to quit drinking but was too weak and depressed to take care of himself. He was assigned a Senior Companion volunteer to help him. She is a very cheerful and kind person and her good cooking soon enticed him to eat. She has helped him with his house work and assists in helping him keep his clothes and bedding clean and has helped encouraged him with his personal cleanliness. Her patience and positive attitude has given him hope. He is now strong enough to get out of his apartment on short trips. He continues to get stronger and is enjoying life like he never thought possible 1 year ago. He is the first to admit he wouldn't even be alive this year without his Senior Companion.

TAZEWELL, VIRGINIA

Working with the terminally ill is not usually a happy assignment. however, when Helen was assigned to work with a terminal cancer patient as her first client, she found that it was necessary that she faced the assignment with a "can do" philosophy. Because of this attitude, she feels that she was able to make a difference in the comfort of her client. She not only did housekeeping duties her client was unable to do for herself any longer; but she helped to arrange for Meals On Wheels to provide meals to help out when she could not be with her client. She contacted the health department and local home health group to arrange professional bathing and other needed services and looked for any any other possible assistance. When her client went into the last stages of her illness, she continued to assist her by relieving the family at her bedside in the hospital and was with her client when she died. She took care of her client's physical needs and became her friend. If you ask her why she did so much, she will answer that, "Its just part of my job. You can't be around someone in need and not help them."

BIRMINGHAM, ALABAMA

Ms. Dorothy Cates, age 70, has been a Senior Companion since March 1990 and has helped take care of her 92 year old neighbor. She assists her with taking a bath, preparing meals, reads her mail and helps balance her checkbook. All these activities are normally performed by most Senior Companions but Ms. Cates has consistently gone beyond the call of duty. When her client fell and fractured her ankle, Ms. Cates called the paramedics, stayed at the hospital and spent the first night with her. On another occasion when Ms. Cates came to care for her client, she found that she had fallen again but she could not get in to the house to help her. She had to call the fire department for assistance in getting the door opened. Again she

stayed with her client in the emergency room so that she could be available if her client needed any assistance. Ms. Cates loves to do for people, to make them happy. Her volunteer work far exceeds her volunteer hours. But Ms. Cates is only one example of a typical Senior Companion.

The project was recently chosen to be one of four agencies featured in the United Way of Central Alabama Campaign. United Way knows Senior Companions, too many of our frail elderly would be institutionalized earlier than necessary.

NON-FEDERAL FUNDING

In 1994, $17.8 million in non-Federal funding was contributed to support SCP projects, including 40 projects that were totally non-federally funded. The source of most of these funds is State governments, either through direct appropriations or contributions from State-funded agencies. County/city governmental and private community sources make up the balance. These projects are operating nationwide with New Mexico, California, Michigan, and Illinois having the greatest number of non-Federal projects.

CHARACTERISTICS OF SCP VOLUNTEERS

	Percent
Distribution by Gender:	
Female	85
Male	15
Distribution by Age:	
60–69	40
70–79	49
80–84	9
85+	2
Distribution by Ethnic Group:	
White	51
Black	33
Hispanic	10
Asian/Pacific Islanders	3
American Indian or Alaskan Native	3
Ages of Clients Served:	
22–45	5
46–59	5
60–74	27
75–84	37
85+	26

ITEM 17. ENVIRONMENTAL PROTECTION AGENCY

ENVIRONMENTAL PROTECTION AGENCY 1994 ACCOMPLISHMENTS ON AGING

The U.S. Environmental Protection Agency conducts a research program to improve our understanding of the effects of environmental exposures on human health to reduce the uncertainty in Agency health risk assessments. Our research programs addressing issues associated with aging focus on the following questions: (1) Do physiological changes in the body normally associated with aging increase the susceptibility of aged individuals to the effects from environmental pollution? and (2) What role do environmental factors play in the aging process?

The 1993 WHO report on Principles for Evaluating Chemical Effects on the Aged Population (Environmental Health Criteria 144) concluded that the aged population is likely to be more susceptible to the harmful effects of environmental chemicals. Results from two recent EPA research projects support this conclusion. In the first study, aged male rats appear to be more susceptible to the toxic effects of carbon tetrachloride, a model liver toxicant whose toxicity is mediated by reactive metabolites rather than by the parent compound. Research is underway to examine the underlying mechanisms responsible for the enhanced hepatotoxicity in the aged rat. The second study conducted in collaboration with Health and Welfare Canada, determined that aged rats were found to be more sensitive and to show more individual variability of response to inhaled ozone than young rats; current work is investigating possible mechanisms of the increased sensitivity. These animal models provide data which suggest that aging may be a significant factor in susceptibility to environmental contaminants.

Another research study involving human subjects ranging from 19 to 70 years of age was initiated to determine the variability in lung deposition of air pollutants

as a function of age and lung disease. Results from this study will be available in 1996.

Collaborative research with Duke University has shown that less oxygen is taken up into tissues of old rats and that there are large differences in tissue antioxidants (vitamins C and E, glutathione, antioxidant enzymes) in old versus young rats. Similar results in another species have been obtained in collaborative research with NCTR (National Center for Toxicological Research), i.e., oxygen uptake is less in old mice than in young mice. The role of oxidation in aging is being studied in a laboratory animal model (fruit fly mutants) deficient in antioxidant enzymes (catalase, superoxide dismutase, etc.), the goal of this collaborative research with NIEHS is to determine the correlation between longevity and oxygen uptake into tissue.

Neurotoxicological results emphasize the need to conduct longitudinal research to detect effects of early exposure of chemicals on the aging process. It has been postulated that sublethal exposure of brain cells to toxicants could cause changes which render the cells susceptible to premature aging and death. While models of accelerated aging have been postulated, there are few experimental data demonstrating that such a phenomenon actually exists. Recent research in an animal model has shown that exposure to a neurotoxicant, triethyl tin, during development accelerated cognitive dysfunction and changes in neuroanatomical markers normally associated with senescence.

ITEM 18. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

OFFICE OF PROGRAM OPERATIONS

INTRODUCTION

The Office of Program Operations (OPO), established in 1982, provides direction to EEOC's administrative enforcement program and activities. Through management of the Commission's headquarters program components and the field establishment, OPO ensures that EEOC's charge resolution responsibility is accomplished in accordance with its legislative mandate and mission statement. Utilizing definitive principles of leadership, consistent program objectives, a single charge resolution management system, and a dedicated national staff, OPO has consistently contributed to the accomplishment of agencywide program and administrative goals at the optimal level.

The Director of the Office of Program Operations serves as a principal advisor to the Chairman in matters of equal employment opportunity and administrative enforcement. The Director exercises overall supervisory, managerial, and fiscal responsibility for all OPO activities. At headquarters, the Director carries out the mission of OPO with an organization consisting of four staffed program areas and an administrative unit. OPO field staff conduct EEOC law enforcement activities in 50 offices which are organized into 1 field office and 23 district office jurisdictions to which the remaining 26 area and local offices are assigned. OPO staff at headquarters and in the field are charged with the efficient and effective implementation of EEOC's program responsibilities.

In FY 1993, OPO continued its efforts to enforce Federal legislation prohibiting employment discrimination in an environment of reduced resources and increased demand on agency services. Dramatic increases in the workload resulted from implementation of the Americans with Disabilities Act and economic conditions. Field office productivity increased in private sector charge resolutions as well as in Federal sector hearings findings, continuing the upward trend of the last five years. OPO launched new programmatic and management initiatives aimed at improving customer service in charge resolution activities. Seeking alternative methods for resolving charges in less time, OPO piloted a new approach to charge resolution through mediation. This method was intended to take less time and fewer resources, while continuing to provide quality charge resolution services to the public. Efforts were undertaken to improve and better coordinate technical assistance and communications services to the public.

OVERVIEW

OFFICE OF THE DIRECTOR (OD)

Provides overall direction, coordination, leadership, and administrative support to OPO program areas. Retains supervisory and fiscal responsibility for the Office of Program Operations.

FIELD MANAGEMENT PROGRAMS (EAST AND WEST) (FMP)

Ensures effective and efficient operation of field offices through operational oversight and monitoring of program implementation, evaluation of performance, and provision of technical assistance and administrative services.

Field Management Programs, East and West, provide headquarters oversight and management of EEOC's fifty field offices. Each field office is assigned a jurisdiction based on specific geographic boundaries. Within its jurisdiction, each field office is charged with accomplishing the statutory enforcement responsibilities of the Commission through investigation, conciliation, and litigation of charges filed. The operational mandate given to each field office is to achieve timely and appropriate resolution of discrimination charges through efficient administration and effective implementation of systematic case development and case management practices.

SYSTEMIC INVESTIGATIONS AND REVIEW PROGRAMS (SIRP)

Develops and recommends charge resolution procedures; provides technical and administrative support systems for systemic and individual charge investigations; and develops intermittent instructions which assist field staff in the timely investigation of Title VII, EPA, ADA and ADEA charges. SIRP investigates class and pattern and practice systemic charges in headquarters units and provides technical assistance to district offices as they accomplish pattern and practice charge investigative responsibilities.

OPERATIONS RESEARCH AND PLANNING PROGRAMS (ORPP)

Produces summary statistical reports of data required by OPO in planning and carrying out its functions; designs and conducts national surveys of employment sectors; analyzes data from employment sectors and from OPO field and headquarters offices; produces research and analytical reports based on employment sector data; conducts reviews and issues reports on effective field office investigative strategies; and provides long- and short-range planning systems from which OPO decisions regarding operational plans and goals, resource and staffing determinations, and workload distribution may be made on a national and office-specific basis.

Develops the procedural guidance for enforcement through Volume I of the Compliance Manual and other guidance materials. Refines and develops charge resolution policies and procedures. Provides program development and support for the field technical assistance function.

CHARGE RESOLUTION AND REVIEW PROGRAM (CRRP)

Reviews both EEOC and FEPA charge files as a quality control function in coordination with Field Management Programs' oversight of field operations. In addition to reviewing FEPA charge files, CRRP's state and local responsibilities include oversight of worksharing agreements with FEPAs as well as conducting on-site audits for the purpose of enhancing FEPA charge-handling capabilities and improving the quality of their product.

ADMINISTRATIVE SUPPORT SERVICES STAFF (ADM)

Provides administrative and technical support services to all OPO components. In addition, conducts comparative analyses of financial transactions and monitors their impact on budget allocations, administers the OPO management reporting system, and conducts special studies and evaluations on specific program office units.

ACCOMPLISHMENTS

FIELD MANAGEMENT PROGRAMS

In FY 1993, Field Management Programs (FMP) and field office managers addressed problems related to the workload, implementation of a new statute, the Americans with Disabilities Act (ADA), and a new 180-day time limit for the Federal sector hearings process. Initiatives to enhance the agency's technical assistance and communications programs were also implemented.

This section discusses the workload and staffing challenges confronting OPO managers; the response in terms of productivity; caseload management and quality indicators; individual district achievements and significant resolutions; and litigation and Federal sector activities.

WORKLOAD AND STAFFING

EEOC's incoming workload has grown significantly in the last four years, up by 46.1 percent from 63,085 to 92,136 in FY 1993. Incoming workload includes charges filed with EEOC offices and net charge transfers from State and local agencies. FY 1993's 87,942 charge receipts were 48 percent (28,516) charges) higher than FY 1990's. During the same period, net transfers into EEOC's workload from State and local agencies grew by 14.6 percent. The greatest 1-year increase in receipts was 24.9 percent (17,543 charges) from FY 1992 to FY 1993, reflecting ADA implementation.

However, since EEOC did not receive additional resources, the number of investigators available to resolve charges did not keep pace, declining by 3.1 percent from 762.2 investigators in FY 1990 to 738.3 in FY 1993. Consequently, there was a sharp increase in the number of open charges awaiting resolution, up by 74.2 percent from 41,987 at the end of FY 1990 to 73,124 at the end of FY 1993. This unprecedented jump in pending inventory, which occurred despite historically high productivity in FY 1993 (97.1 charges per investigator), represented a major turnabout. Prior to FY 1991, pending inventory had steadily declined and was approaching a long-sought goal, measured in the time required to complete all pending cases, of 6 months. Instead, months of pending inventory, which had dropped to 7.9 months in FY 1990, reached 12.2 months in FY 1993.

As a result, the average caseload carried per investigator grew by 41.5 cases or 80.9 percent from 51.3 in FY 1990 to 92.8 in FY 1993. Caseloads ranged from 61.3 in the district office with the lowest, to 131.7 cases per investigator in the district office with the highest caseload. Attempting to meet this challenge, FMP managers continually monitored the workload for each office, redistributing charges to minimize caseload imbalances nationwide. In FY 1993, FMP also continued efforts to consolidate and coordinate investigations between districts to make the most efficient use of resources; as well as to ensure consistent application of remedies when investigations against an employer were ongoing in different offices at the same time. These efforts reduced duplication of effort, saving time and resources.

With only two more investigators available nationwide in FY 1993 than in FY 1992, FMP managers also responded to ADA-generated workload increases by initiating computerized oversight of field staffing vacancies, identifying critical needs and shifting limited resources where possible. Both FMP and field office managers implemented case resolution efficiencies that led to improved productivity. EEOC resolved 71,716 charges in FY 1993, 4.9 percent (3,350 charges) more than in FY 1992. Productivity, at 88.4 resolutions per investigator in FY 1990, rose from 92.8 in FY 1992 to an historical agency high of 97.1 in FY 1993. Productivity by district ranged from an average of 83.2 to 118.7 resolutions per investigator in FY 1993.

WORKLOAD, RESOLUTIONS, INVENTORY FY 1990–1993

	Fiscal year			
	1990	1991	1992	1993
Receipts to process	59,426	62,806	70,399	87,942
Net trans (f/FEPAs)	3,659	4,703	4,798	4,194
Total inc work	63,085	67,509	75,197	92,136
Inventory available	762.2	727.1	736.3	738.3
Productivity	88.4	88.5	92.8	97.1
Resolutions	67,145	64,342	68,366	71,716
Pending inventory	41,987	45,717	52,856	73,124
Caseload/Investigator	51.3	58.7	67.6	92.8
Months pending inventory	7.9	9.0	10.4	12.2

CHARGE RESOLUTION QUALITY

Equally important to FMP as managing the size of the national caseload, was its responsibility to monitor and assure high quality standards for the charge resolution process. FMP conducted on-site quality reviews to assess field office effectiveness in investigative quality, procedural consistency, and case management/case tracking. FMP completed on-site quality reviews of 37 field offices in FY 1993. With input from the Charge Resolution Review Program's review of enforcement files and charge data information, FMP issued special reports to district offices on their case management and development efforts. FMP also conducted joint reviews with the Office of General Counsel to assess the quality of legal/enforcement interaction in field offices. Indicators of quality in the charge process include:

Timely Charge Processing.—FMP managers and field office were successful in maintaining timely processing of the workload at close to FY 1992 levels, despite the rapid growth in charge receipts. FY 1993 average charge processing time was 294 days, only 2 days higher than in FY 1992. Likewise, the average age of open charges in EEOC's inventory increased by 3 days to 201 days in FY 1993. The percentage of charges in the workload over 270 days old increased from 16.3 percent in FY 1992 to 20.4 percent in FY 1993. This increase was lower than the 24.9 percent increase in receipts, indicating that field offices were continuing to resolve charges on a first come, first serve basis.

Merit Resolutions.—Merit resolutions are charges with outcomes favorable to charging parties. They include negotiated settlements, withdrawals with benefits, successful conciliations, and unsuccessful conciliations. FY 1993 merit resolutions were 15.7 percent of total resolutions, 0.2 percentage points higher than in FY 1992.

Determinations on the Merits.—Determinations on the merits are charges resolved after full investigation with findings that discrimination did or did not occur. FY 1993 determinations on the merits (42, 148) included 40,183 no reasonable cause (95.3 percent) and 1,965 reasonable cause (4.7 percent) findings. Reasonable cause determinations resulted in 589 successful conciliations and 1,376 unsuccessful conciliations. Determinations on the merits were 58.7 percent of total resolutions in FY 1993, down 4.7 percentage points from FY 1992. This decline was due primarily to an increase in administrative resolutions from FY 1992 to FY 1993. Charges resolved administratively are resolved prior to full investigation. In FY 1993, administrative resolutions comprised 28.3 percent of all resolutions. Implementation of the Civil Rights Act of 1991, which offers potential punitive and compensatory damages, contributed to the growth in administrative resolutions by triggering charging parties' requests for issuance of notices of right-to-sue (RTS), enabling them to file suit without waiting for the completion of the charge resolution process. RTS's accounted for 75 percent of the increase in administrative resolutions in FY 1993. Also, administrative resolutions occurring after EEOC attempts to conciliate charges under Section 7(d) of the ADEA increased in FY 1993.

Benefits to Charging Parties.—In FY 1993 monetary benefits resulting from enforcement and systemic unit efforts were $126.8 million dollars, up 7.7 percent from FY 1992's $117.7 million, and 54.6 percent higher than FY 1990. Average monetary benefits ($14,823 for all charges) were highest for ADEA resolutions at $22,409, while ADA resolutions were a close second at $20,471. Also, 19,528 individuals received non-monetary benefits. FMP implemented a management initiative to ensure the consistency of nationwide punitive and compensatory damages awarded under the Civil Rights Act of 1991. (See individual field office case resolution activity below for a sampling of benefits obtained in specific cases.)

LITIGATION ACTIVITIES

In each district office, litigation units carry out necessary legal actions within their jurisdictions. These units submit litigation to the Office of General Counsel recommending that the Commission approve or disapprove litigation on reasonable cause cases. A total of 825 presentation memoranda (702 positive and 123 negative) were submitted to the Commission in FY 1993, up from 665 in FY 1992. Litigation units also took other legal actions related to the administrative charge process, such as enforcing subpoenas. The increase in presentation memoranda reflects improved coordination between district office enforcement and legal units in the development of cases for litigation.

FEDERAL SECTOR ACTIVITIES

District offices are responsible for administration and enforcement of antidiscrimination laws in the Federal government. This includes the hearings function, which examines complaints filed by employees against Federal agencies; and the Federal Affirmative Action (FAA) program, which approves and monitors Federal affirmative employment plans, and provides technical assistance to agencies.

HEARINGS

During FY 1993, hearings units received 8,882 new complaints, an increase of 28.6 percent over FY 1992's 6,907 receipts. This was largely the result of revisions to Section 1614 of the CFR which went into effect on October 1, 1992, imposing a mandatory 180-day processing limit both for agencies investigating EEO charges and EEOC's hearings on the resolution of those charges. In response, and to substantially reduce the number of 180-day-old complaints in the inventory, FMP redistributed hearings workload among field offices and temporarily detailed field office staff from other functions to hearings units.

Administrative judges (AJs) increased their annual productivity rate by 11.1 percent from 113.5 to 126.1 resolutions. Consequently, complaints were resolved on a one-to-one basis with receipts in FY 1993, up from 0.88 in FY 1992.

AJs available increased by 16.8, up 31.2 percent from FY 1992. Due to increases in both available AJs and the annual productivity rate, resolutions in FY 1993 (8,906) increased 46 percent from FY 1992 (6,100).

In spite of the increase in resolutions, pending inventory remained virtually unchanged (3,991 on 9/30/93 compared to 3,977 on 9/30/92). Open complaints more than 180 days old constituted 13.3 percent of pending inventory. Average processing time declined 10 days to 183 days.

HEARINGS OVERVIEW

	Fiscal year		Change	Percent Diff
	1992	1993		
Receipts	6,907	8,882	1,975	28.6
Resolutions	6,100	8,906	2,806	46.0
Pending inventory	3,977	3,991	14	0.4
AJs available	53.8	70.6	16.8	31.2
Adjusted prod/AJ	113.5	126.1	12.6	11.1
Average days	193	183	(10)	(5.2)
180-day inventory [1]	N/A	530	N/A	N/A
Percent 180-day inventory [1]	N/A	13.3	N/A	N/A

[1] 180-Day inventory not tracked in fiscal year 1992.

Significant Hearings Resolutions.—Examples of significant hearings resolutions follow:

The *Birmingham District Office* resolved by negotiated settlement an ADEA charge filed by a 50-year-old branch manager against a financial lending institution. The charging party alleged that he had been demoted and subsequently forced to resign due to his age. Under the terms of the settlement, the charging party elected to take early retirement in lieu of reinstatement. He received monetary benefits totalling $92,121 which included retirement annuities, a lump sum payment, and other benefits, a significant benefit for an individual charging party.

The *Charlotte District Office* found reasonable cause to believe that a manufacturer violated the ADEA by failing to consider for employment two job applicants over 40 years of age. The case was expanded to include the ADEA violations which were discovered during the course of a Title VII race discrimination investigation. In the Title VII case, a 25-year-old secretary who alleged race discrimination when she was fired after she put a picture of her biracial child on her desk. Her charge was resolved via withdrawal with benefits ($1,000). In gathering evidence related to the charging party's allegation, the investigator contacted the employment agency that had referred her to the company. An official of the agency testified that prior to hiring the 25-year-old secretary, the company had turned down two of the agency's referrals, ages 41 and 44, because the company wanted "someone young who wore heels and a short skirt." The Charlotte District Office entered into a conciliation agreement with the company under the terms of which the two older job applicants received a total of $1,750 in backpay. Both of the applicants had found other jobs and were no longer interested in employment with the company.

The *Cleveland District Office* resolved by negotiated settlement a charge filed by a conversion manager against a computer service. The charging party alleged that he had been discharged due to his age. Under the terms of the settlement, the charging party was reinstated in his conversion manager job at his annual salary of $31,000 along with full seniority and fringe benefits.

The *Milwaukee District Office* found reasonable cause to believe that an employer had engaged in a pattern and practice of discharging older employees due to their age. The parties entered into a conciliation agreement resulting in significant benefits for each class member. It provided $2,649,595 in monetary benefits paid to seventeen class members who had been employed in various salaries jobs including engineer, buyer, expeditor, cost estimator, dispatcher, and a scheduler.

The *New York District Office* found reasonable cause to believe that a securities brokerage firm had violated the ADEA by discharging an employee due to his age. The parties agreed to enter into a conciliation agreement which provided $500,000 in monetary benefits to the charging party. The $500,000 included $300,000 in backpay, $150,000 in compensatory damages, and $50,000 in attorney's fees. This resolution provided a significant monetary benefit for a single individual.

The Newark Area Office in the *Philadelphia District* resolved by negotiated settlement a charge filed by a vice president of a reinsurance company who alleged that her employer had discriminated against her on the basis of sex and age. Specifically, the respondent allegedly discriminated against the charging party by changing her job assignments and then denying her salary increases. In addition, after she filed her initial charge, the respondent denied her a promotion as well as additional salary increases. Under the terms of the settlement agreement, the charging party received a significant lump sum settlement of $344,822 plus $18,578 in backpay, for a total of $363,400 in monetary benefits.

The *Phoenix District Office* found reasonable cause to believe that a public employer demoted a fleet manager over 40 years of age due to his age. The parties entered into a conciliation agreement which provided $35,000 in backpay. The agreement also mandated the training of all managers on the ADEA and the posting of a notice informing all employees of the prohibitions against age discrimination.

The *Seattle District Office* found reasonable cause to believe that a beverage distributor discharged an employee because of his age and replaced him with a younger employee. The parties entered into a conciliation agreement which provided $73,000 in backpay to the charging party. The agreement also mandated the training of all of the company's employees with respect to the provisions of the ADEA.

The *St. Louis District Office* issued a reasonable cause finding against an aerospace firm which had engaged in a pattern and practice of laying off workers 55 years of age and older due to their age. After conciliation efforts failed, EEOC filed suit. This case was resolved by a consent decree which provided for the reemployment of 216 class members and the payment of monetary benefits totaling $20.1 million to 950 class members. This is one of the single largest dollar amounts obtained by the Commission through its own litigation efforts.

The resolutions above are examples of the 11,248 merit factor resolutions which constituted 15.7 percent of all resolutions in FY 1993. Merit factor resolutions are those with outcomes favorable to the charging party and include negotiated settlements, withdrawals with benefits, successful conciliations, and unsuccessful conciliations.

SYSTEMIC INVESTIGATIONS AND REVIEW PROGRAMS

SYSTEMIC ACTIVITIES

In FY 1993, Systemic Investigations and Review Programs (SIRP) continued the level of program activity sustained over the last 4 years. The Commission approved 69 case actions for headquarters and field office systemic activities. This total included 28 new Commissioner charges, and 41 resolutions, of which 32 were decisions on the merits. Of the 28 new charges, one was filed under Title VII/ADEA and four were filed under the ADA. The remaining 23 were filed under Title VII. There were two ADEA directed resolutions and two Title VII/ADEA resolutions. Thirty-seven other resolutions were filed under Title VII. Of the 41 resolutions, in 36 there was reasonable cause to believe that discrimination had occurred. Of these, 17 settlement and conciliation agreements generated $1,326,639 in monetary benefits for 290 persons. In 19 other resolutions, although the Commission found reasonable cause to believe that discrimination occurred, subsequent efforts to conciliate the cases failed and they were referred to the Office of General Counsel and field office legal units for litigation.

PENDING CHARGES

The systemic case docket included 80 active cases in various processing stages at yearend. Three of the pending charges were filed under Title VII/ADEA and four were filed under the ADA. The remaining 73 charges were filed under Title VII. Of the 80 pending charges, 95 percent were less than 3 years old, compared to only 74.9 percent that were less than 3 years old in FY 1990. In FY 1993, SIRP continued to reduce the age of its workload by resolving the four remaining charges in its inventory initiated prior to FY 1988.

The 80 systemic charges pending at the end of FY 1993 included charges filed against employers in varied industries, including service providers (30), manufacturing (17), retail establishments (14), wholesale establishments (7), and 12 companies in other categories, including four financial institutions. Of the charges filed against employers in the service industry, 14 were against companies providing business services. Seven of the 14 retail establishments were restaurants, one of them a national chain.

During FY 1993, SIRP implemented a system for streamlined processing of proposed Commissioner charges involving *per se* violations of the ADA. SIRP also devel-

oped guidance encouraging joint investigations across district boundaries. The prototype for this effort was coordination between the Birmingham and Memphis offices in the investigation and conciliation of charges filed against a company with locations in both jurisdictions. As a result, staff and funds required to investigate the charges were reduced and consistent company-wide remedies were obtained. SIRP also improved the coordination of headquarters and field office systemic investigations by linking headquarters investigations, regionally or nationally, with field efforts in order to ensure more effective use of resources. During FY 1993, SIRP developed new methods for accelerating investigations, including deposition taking during investigations. Two new nationwide or multi-district charges were approved by the Commission and two were resolved.

CHARGE RESOLUTION REVIEW PROGRAM (CRRP)

STATE AND LOCAL PROGRAMS DIVISION

Fair Employment Practices Agency (FEPA) Workload Increases. In FY 1993, FEPA charge receipts (61,289) increased by 13.3 percent over FY 1992, primarily due to receipt of 9,552 new ADA charges. This increase occurred at a time when most FEPAs were affected by continuing revenue and budget reductions for State and local governments. The increase in receipts was accompanied by a 3.3 percent decrease in resolutions. Consequently, FEPA pending inventory increased by 13.1 percent in FY 1993.

FEPA CHARGE PROCESSING

	Fiscal year		Fiscal year 1992–93 difference (percent)
	1992	1993	
Receipts to process	54,080	61,289	13.3
Net Transfers to EEOC	4,798	4,194	−12.6
Resolutions	49,791	48,166	−3.3
Pending Inventory	66,590	75,289	13.1

AAAFiscal year 1992 FEPA resolutions include 33 more charges added to the database since publication of the fiscal year 1992 OPO Annual Report. Fiscal year 1993 FEPA resolutions include 1,840 bankruptcy and NRTS administrative resolutions not previously reported.

Initiatives to Assist FEPAs.—To respond to declining FEPA budget resources, the State and Local Programs Division (SLPD) explored methods for increasing the agencies' capacity to resolve more charges with fewer resources, enhancing charge-handling capabilities, and improving the quality of their charge resolutions. EEOC initiatives implemented in FY 1993 included:

Facilitating the delivery of the EEOC-developed Automated Intake System to FEPAs to speed the FEPA charge intake process by streamlining the entry of charge receipt data in the Charge Data System (CDS).

Ensuring that FEPAs were provided access to the EEOC Compliance Manual via a computerized bulletin board system. The manual specifies policy and procedures for conducting investigations.

Developing surveys for use by EEOC district offices and Tribal Employment Rights Organizations (TEROs) to obtain recommendations that would enhance the TERO program.

Annual EEOC–FEPA Training Conference.—The SLPD held the annual EEOC–FEPA conference, focusing on management strategies for effective and timely charge resolution. Workshops were conducted on implementing effective worksharing arrangements under contracts; on EEOC's ADA charge processing policies and procedures in preparation for contracting with FEP agencies to resolve ADA charges in FY 1994; on procedures for ensuring automated data integrity; and on current charge resolution issues impacting the capacity of FEPA's to reduce pending inventories.

DETERMINATIONS REVIEW DIVISION

Charge Resolution Quality Control Reviews.—The Determinations Review Division (DRD) reviewed the files for more than 2,600 field office charge resolutions in FY 1993 and conducted on-site reviews with FMP analysts to assess the quality of investigations and compliance with agency policies and procedures.

Charge Investigation Project.—During fourth quarter FY 1993, as part of an OPO-wide initiative to explore new alternatives for balancing the national field office workload, DRD received 399 charges from a district office for investigation and reso-

lution. This redistribution of workload reduced the caseload of each investigator in the district office to a more manageable level. By the end of FY 1993, DRD had completed several on-site investigations and had resolved a number of the charges. The project was continued into FY 1994.

Charges Against Elected Officials.—In FY 1993, DRD attempted to resolve 20 charges filed against elected State and local government officials under Section 321 of the Civil Rights Act of 1991. Section 321 requires a new process for which the Commission is developing procedures. Attempts were made to settle these charges through mediation. One charge was resolved with benefits totalling $66,887.

OPERATIONS RESEARCH AND PLANNING PROGRAMS (ORPP)

PROGRAM RESEARCH AND SURVEYS DIVISION

Survey Processing.—The 1992 Employer Information Report (EEO–1) survey data file, for 38,372 employers, included the highest employment number (42,113,681) and EEO–1 establishments (158,230) in the history of the survey. Also, in FY 1993, several large employers that had not been filing reports were brought into the EEO–1 filing system. The Surveys Division developed on-line access to the Apprenticeship Information Report (EEO–2) survey database enabling retrieval of the latest available employer data. Major revisions to computer programs used to aggregate the Higher Education Staff Report (EEO–6) survey data were completed. Over 1,150 requests for survey data from members of the public were processed, resulting in distribution of approximately 21,000 reports. Data aggregated by industry and various geographical areas are used by private employers to design individual affirmative employment programs. The number of unions not responding to EEOC requirements for survey data was reduced significantly, from 343 to 49.

Research.—Three research efforts were initiated. One report, "The Glass Ceiling for Women and Minorities: An Employment Issue of the 1990s," included data by industry for women, Blacks, Hispanics, Asians, and American Indians. A second report, "Sexual Harassment in Charge Receipts and Resolutions," examined the agency's resolution of sexual harassment charges. The third report, "Congressional Oversight Hearings on the Equal Employment Opportunity Commission by the U.S. Senate and U.S. House of Representatives, 1982 to 1992," addressed Congressional consideration of the agency's general administration and specific program areas.

In addition, two updated reports were prepared and released in FY 1993. The first, "Equal Employment Opportunity (EEO) Profile of the Private and Public Employers Surveyed by the Commission," compared the employment participation rates of minorities and women in the various sectors of the economy. The second, "Indicators of Equal Employment Opportunity—Status and Trends," provided employment and salary status trends of minorities and women in the labor force.

Technical Assistance.—The Surveys Division provided labor force availability statistics, census data, employment trends for particular companies/industries, and occupational analyses of targeted companies for headquarters systemic investigations and field office systemic and individual investigations. In addition, the 1992 JURIS System was distributed to all district offices to provide linkage between the EEO–1 employment database and charges filed against private employers. The system also provided support in identifying and contacting employers to notify them of Technical Assistance Program Seminars.

PROGRAM PLANNING AND ANALYSIS DIVISION

Planning.—The Program Planning and Analysis Division automated the development of quarterly field office performance expectations used for annual national workload planning. Performance rating guides for field managers were revised to reflect requirements of the Civil Rights Act of 1991 and CFR Section 1614 regulations which mandate a 180-day maximum time frame for hearings processing. Workload and staffing projections were developed for EEOC's FY 1993 and FY 1994 budget justifications. Analyses identifying emerging workload trends and their impact on agency charge processing capabilities were prepared. Reports and analyses were developed in response to issues raised by government agencies and the public.

Data Analysis and Dissemination.—Graphics were developed depicting trends in selected issues, including sexual harassment and pregnancy, and for each statute enforced by EEOC. Graphics presentations were developed for EEOC planning meetings and EEOC/FEPA management conferences as well as for public briefings and speeches. Implementation of the ADA in its first full year was closely tracked with issuance of numerous statistical summaries providing an up-to-date account of the new statute's enforcement. Analyses of litigation recommendations by district and the relationship between productivity and performance ratings were also devel-

oped during FY 1993. Each quarter "fact sheets" on key charge processing statistics and detailed summary data reports were produced as were analyses of significant enforcement trends for the Commissioners and program directors. This information was used to identify workload imbalances, to support agency resource requests, and to provide field directors and others speaking to the public with accurate and timely information regarding charge trends. The FY 1992 annual report of OPO accomplishments was prepared for dissemination to the public. The Planning Division also prepared this report on FY 1993 OPO accomplishments.

Data Integrity.—The capability to produce computerized summaries of various indicators of data integrity was developed, makimg possible timely identification and correction of data discrepancies in the national database. Quarterly guidance was prepared to assist field offices in more accurately reporting charge processing actions. A concerted effort was made to assure that national charge data information issued from OPO and other sources within the agency was consistent and accurate.

PROGRAM DEVELOPMENT AND TECHNICAL ASSISTANCE DIVISION

In FY 1993, the Program Development and Technical Assistance Division (PDTAD) provided training, technical assistance, and procedural guidance for the administrative charge resolution process, with emphasis placed on clarifying the complex, unprecedented issues presented by the ADA.

ADA Training.—In FY 1993, the Disability Rights Education and Defense Fund (DREDF), under contract, provided refresher training, support, and technical assistance to a cadre of people with disability to serve as community-based resources with expertise on the ADA. DREDF also conducted advanced mediation training on ADA employment issues. In addition, DREDF developed a directory of ADA Training and Implementation Network participants for publication by EEOC as a resource for the public.

ADA Technical Assistance.—To respond to questions raised by the novel issues presented by ADA, technical assistance was provided to EEOC headquarters and field offices, Congressional offices, the media, disability groups, employers, regional Disability and Business Technical Assistance Centers, and others.

Other ADA Implementation Actions.—Staff reviewed ADA charges resolved during the first six months after the July 26, 1992 effective date of Title I of the Act. Results of the review served as the basis for additional training of EEOC investigators on making an initial determination as to whether charging parties are "individuals with disabilities" and for revising CDS disability basis codes.

Extensive revisions to Volume I of EEOC's Compliance Manual were made to incorporate requirements of the ADA and the Civil Rights Act of 1991. Other sections were consolidated and revised to reflect new statutes enacted and changes in Federal government or agency policy. These changes included revising investigative procedures to incorporate ADA provisions, the Family and Medical Leave Act, procedures for calculating benefits pursuant to the requirements of the Civil Rights Act of 1991, and recent court decisions.

OFFICE OF DIRECTOR

AMERICANS WITH DISABILITIES ACT IMPLEMENTATION

In FY 1993, the first full year of ADA implementation, the Office of the Director coordinated a variety of activities executed by OPO program areas to ensure the effective administration of the ADA including.

Supplemental training to the public and EEOC staff in ADA policy and operational issues.

Review of ADA charges and affidavits to identify issues and trends regarding EEOC's initial experience with the statute.

Adjustment of systemic processing methods to ensure that charging parties' rights under the ADA were protected.

Issuance to the public of an ADA Training and Implementation Network participants directory.

Sexual Harassment Training.—Approximately 30 sexual harassment seminars were conducted nationwide on a cost reimbursable basis for approximately 900 managers of the Resolution Trust Corporation—one of EEOC's first efforts under the newly established reimbursable Revolving Fund.

GAO Audit.—During FY 1993, GAO audited EEOC's management of the ADEA and the overall charge resolution process. The Office of the Director provided in-depth analyses of charge data that facilitated GAO's completion of the audit and provided additional analyses for GAO's testimony before the House Select Commit-

tee on Education and Civil Rights. This input provided GAO with a clear picture of the constraints on agency management caused by the lack of sufficient resources.

Alternative Dispute Resolution Program.—The Office of the Director developed this initiative to explore alternative approaches to the current charge resolution process. When the program pilot was implemented, the Office of the Director participated in the selection of the contractor to provide mediation services, and monitored the progress of the program with the contractor and field office managers throughout the year. The program was piloted in four field offices and was extended through mid-FY 1994. Of the charges entering the pilot program, nearly 50 percent were settled with charging parties receiving over $194,000 in monetary benefits.

Technical Assistance Program.—Staff developed and participated in the implementation of a program to achieve a coordinated approach for delivering educational services, technical assistance and training services to the public by creating a new position dedicated to technical assistance activities focused on identifying and providing enhanced services to the public with an emphasis on under-served groups.

The Administrative Support Services Staff in the Office of the Director administered OPO's management reporting systems as indicated below.

Administration. The administrative staff monitored the OPO budget of over $26 million for six accounts, ensuring that no activity exceeded its allocation. The staff has responded to numerous requests for management reviews.

Document Tracking. In FY 1993, over 6,000 items were monitored for timeliness and accuracy through the OPO-ADM tracking system. Among these items, the most significant were 730 Congressional inquires, primarily regarding charges filed. The unit also monitored 616 requests for information from the Chairman. More than 2,400 headquarters and field personnel actions were tracked, as well as 1,400 financial documents and management reports.

COMMUNICATION, EDUCATION, AND TECHNICAL ASSISTANCE

In FY 1993 the Commission strengthened its efforts to enhance public awareness about EEOC and laws prohibiting employment discrimination. The Commission's outreach efforts included Technical Assistance Program Seminars (TAPS) implemented through the agency's Technical Assistance and Training Institute Revolving Fund, and other appearances in which EEOC representatives addressed members of the public. Every district office held at least one TAPS seminar and all but two held two seminars in FY 1993.

Technical Assistance Program Seminars.—EEOC district offices conducted 46 TAPS in FY 1993. Over four thousand managers, human resources specialists, union representatives, and others attended the seminars which provided information regarding the rights and obligations of employers and unions under Federal laws prohibiting discrimination in employment. Seminar fees, paid into the Revolving Fund, were used to finance the cost of the seminars.

Most seminar attendees were from medium- to large-sized employers, and most were managers, supervisors, or human resource management personnel. The seminars were generally well attended.

Sexual Harassment Training.—During FY 1993, the Revolving Fund also sponsored several projects responsive to the needs of both the private and public sectors. As noted above, in one project, staff from the Office of the Director developed and conducted training sessions on sexual harassment issues for managers and supervisors of a Federal agency.

Technical Assistance and Education Program.—In FY 1993, six field offices tested a program designed to increase the effectiveness of the Commission's outreach and education programs by ensuring a more coordinated and standardized approach. A new staff position dedicated to this function was created. Combining responsibility for training, outreach, education, public relations, and other agency special programs activities in a single staff position reporting directly to the office director produced better results in reaching all affected groups, especially those historically under-served.

Outreach Activities.—Field offices reached the largest audiences with information about EEOC's policy and program through their outreach activities—public presentations made at the request of outside organizations. In FY 1993, agency staff provided information to over 94,000 people who attended 1,694 presentations made in a variety of settings—including workshops, conferences, and on radio and television. Field office representatives communicated with a variety of audiences, including associations and advocacy groups (38.1 percent), respondent and educational organizations (37.4 percent), and representatives of other Federal and State governments (24.5 percent).

The topic most often addressed was general EEOC information (816). Presentations on these EEOC topics (48.2 percent of the total) included those covering more than one statute, the Civil Rights Act of 1991, and other issues of concern. The ADA was the topic addressed next most frequently (31.6 percent) while sexual harassment was the topic of discussion in 18.6 percent of the presentations. The percentage of presentations made concerning the ADA decreased from 49.2 percent last year when the employment prohibitions of the ADA first went into effect. The remainder of the presentations (1.6 percent concerned Title VII and ADEA issues.

EEOC field office staff at all levels participated in these presentations. Of the 1,694 public appearances made, office directors represented EEOC on 373 occasions (22.1 percent); managers and supervisors represented EEOC on 707 occasions (41.7 percent); and other staff addressed public gatherings on 614 occasions (36.2 percent). Nonsupervisory staff accounted for 67 more public appearances than last year.

Examples of outreach presentations included:

Managers from the *Baltimore District Office* addressed 500 employees of the Social Security Administration on Federal EEO matters.

The *Charlotte District Office* Regional Attorney addressed 200 managers on EEOC laws in a seminar held by a employers' association.

Management officials from the *Nashville Area Office* addressed 700 employees of a public utility on sexual harassment.

The *Atlanta District Office* Deputy Director made a presentation to 250 members of a city police department on sexual harassment.

Staff of the *Milwaukee District Office* addressed 550 members of an employers' association on the topic of sexual harassment.

Management officials from the *Denver District Office* addressed 100 members of a statewide disability advocacy group, providing information on the ADA.

The Director and staff of the *Houston District Office* addressed 370 people while participating in panel discussions on the ADA sponsored by an advocacy group.

Management staff from the *Albuquerque Area Office* made a presentation on the ADA to 230 staff members of an employer.

Headquarters OPO Activities.—The Director and his staff also took part in more than 25 speaking engagements in FY 1993. In addition, headquarters OPO program managers made numerous presentations to a variety of audiences nationwide.

OFFICE OF GENERAL COUNSEL

This report highlights the accomplishments of the Equal Employment Opportunity Commission's Office of General Counsel from October 1992 through September 1993.

I. Current Structure and Function of the Office of General Counsel

A. THE MISSION OF THE GENERAL COUNSEL

The Office of General Counsel was established by the Equal Employment Opportunity Act of 1972, which amended Title VII of the Civil Rights Act of 1964 to provide for a General Counsel, appointed by the President and confirmed by the Senate, with responsibility for conducting the Commission's litigation. Following transfer of enforcement functions from the U.S. Department of Labor to the Commission in 1979, the General Counsel was also vested with responsibility to conduct Commission litigation under the Equal Pay Act and the Age Discrimination in Employment Act. With the enactment of the Americans with Disabilities Act, the General Counsel was granted responsibility for Commission litigation under that statute as well.

Title VII Provides for a General Counsel, Appointed by the President, to Conduct the Commission's Litigation

B. ORGANIZATION STRUCTURE

The Office of General Counsel is divided into nine organizational units: (1) the District Office Legal Units; (2) Litigation Management Services; (3) Research and Analytic Services Staff; (4) Litigation Advisory Services; (5) Systemic Litigation Services (6) Appellate Services; (7) Administrative and Technical Services Staff; (8) the General Counsel's immediate staff; and (9) the Deputy General Counsel's immediate staff.

The District Office Legal Units are located in the Commission's 23 District Offices. Each legal unit is responsible for prosecuting enforcement litigation which has been approved by the Commission. In addition to their prosecutorial function, legal unit attorneys provide legal advice to enforcement units, which are responsible for investigating charges of discrimination. The legal advice function includes, among other things, completing written reviews of all proposed "reasonable cause" findings to ensure uniformity with legal standards, drafting determinations for the District Director on objections to administrative subpoenas, and making determinations on Freedom of Information Act requests.

The 23 District Legal Units Prosecute the EEOC's Field Enforcement Litigation

Each District Office legal unit is under the direction of a Regional Attorney who is appointed by the General Counsel and the Chairman of the Commission. The Regional Attorney manages the legal staff of the District Office under the legal direction of the General Counsel. In addition, many Regional Attorneys supervise a Hearings Unit, which is composed of administrative judges who conduct hearings and render decisions on claims of discrimination in federal employment.

Litigation Management Services is one of the three headquarters prosecutorial divisions of the Office of General Counsel. Formed in November 1991, as part of a reorganization of the former Trial Services Division, Litigation Management Services is managed by an Associate General Counsel under the supervision of the Deputy General Counsel. Litigation Management Services performs the following functions, pursuant to a delegation of authority from the General Counsel: (1) manages and oversees the Commission's litigation enforcement program in the 23 District Offices of the Commission; and (2) in conjunction with the Office of Program Operations, oversees the integration and interaction of District Office legal units into the administrative enforcement structure of the District Office.

Litigation Management Services Oversees All EEOC Field Enforcement Litigation

To accomplish its mission, Litigation Management Services is divided into two units staffed by three Assistant General Counsels. The Litigation Oversight Unit within Litigation Management Services oversees all litigation conducted by the District office legal units, and monitors the effectiveness of the legal units' interaction with administrative enforcement units. The Expert Services Unit is responsible for identifying and monitoring complex District Office litigation. This unit evaluates District Office suit recommendations in complex cases, drafts OGC litigation recommendations, monitors expert procurements, and evaluates case prosecutions and settlements.

Appellate Services of the Office of General Counsel is managed by an Associate General Counsel who reports through the Deputy General Counsel to the General Counsel. Organized into three divisions of staff attorneys who are supervised by three Assistant General Counsels, Appellate Services is responsible for conducting all appellate litigation where the Commission is a party or where the Commission participates as *amicus curiae*, usually in cases involving novel issues. Appellate Services also represents the Commission in the United States Supreme Court through the Solicitor General of the United States.

Appellate Services Conducts the EEOC's Appellate Litigation and Files Amicus Briefs

Appellate Services is responsible for reviewing every case in which the Commission receives an adverse judgment. The attorneys of Appellate Services then prepare written recommendations analyzing the facts and legal issues in the case for review by the General Counsel, who makes the final decision on whether to appeal. In *amicus* cases, Appellate Services drafts memoranda recommending Commission participation which, if approved by the General Counsel, is submitted to the Commission for authorization.

Appellate Services is also responsible for reviewing and, with General Counsel approval, making appeal recommendations to the Department of Justice in cases which are referred to the Commission and which involve certain employment discrimination issues arising in litigation against other federal agencies. In addition, Appellate Services reviews EEOC policy matters, such as proposed policy statements and regulations, from the Office of Legal Counsel, to determine the effect of such proposals on litigation.

Systemic Litigation Services Conducts Complex Class and Systemic Litigation

Systemic Litigation Services, located in the EEOC's Washington, DC headquarters office, operates under the supervision of an Associate General Counsel who reports through the Deputy General Counsel to the General Counsel. Staffed by two Assistant General Counsels who oversee two units of line attorneys, Systemic Litigation Services conducts litigation on behalf of the Commission in certain complex cases alleging patterns or practices of employment discrimination or involving complex legal or factual issues. The responsibilities of Systemic Litigation Services include evaluating and preparing litigation recommendations in certain complex cases for Commission consideration and, upon Commission approval, prosecuting those cases. Further, Systemic Litigation Services provides legal advice to systemic Investigations and Individual Compliance Programs within the Office of Program Operations during the investigation and conciliation of systemic charges. In addition, the General Counsel has delegated to Systemic Litigation Services the responsibility for coordinating the representation of the Commission in bankruptcy proceedings nationwide.

Litigation Advisory Services was established in the January 1993 realignment and is composed of two Assistant General Counsels who report directly to the Deputy General Counsel and who are responsible for the daily operations of litigation Advisory Services Division I and II. The Divisions of Litigation Advisory Services review and prepare recommendations to the Commission from the General Counsel on certain litigation recommendations submitted from the 23 District Office by the Regional Attorneys.

The Commission authorizes litigation by a majority vote of the Commissioners. Under EEOC's Enforcement Policy, the Commissioners consider for litigation all cases where reasonable cause determinations were issued and conciliation efforts failed. The District Office legal units, as well as Systemic Litigation Services, submit all such cases for consideration by the Commissioners in a standardized "Presentation memorandum" format. The Office of General Counsel reviews certain presentation memoranda, and advises the Commissioners whether litigation should be authorized.

Litigation Advisory Services has the responsibility of performing these review and advice services for the Office of General Counsel. Its primary function is to prepare a "Transmittal Memorandum," reviewing and recommending approval or disapproval of litigation in every "non-certified" case submitted by the field. Non-certified cases requiring independent headquarters review include, for example, cases that involve complex or novel legal issues, rely on a disparate impact theory of discrimination, involve a pattern or practice of employment discrimination, or propose intervention in a pending private suit. "Certified cases," which are initially submitted to the Commission without a recommendation from the Office of General Counsel, generally raise only individual claims of disparate treatment or involve Department of Justice referrals for litigation under Title VII.

Litigation Advisory Services Prepares Litigation Recommendations for Commission Consideration

The other major function of Litigation Advisory Services is to respond to Commissioner inquiries in cases under consideration for litigation. In responding to these inquiries, Litigation Advisory Services also acts as the Office of General Counsel's liaison and contact point between the Commissioners and the field legal units or Systemic Litigation Services. In addition, Litigation Advisory Services represents the General Counsel in Commission meetings where litigation recommendations are considered. Litigation Advisory Services also conducts audits, training, investigations, projects, and other special assignments for the Office of General Counsel.

The Research and Analytic Services Staff was established in December 1986, and reports directly to the Deputy General Counsel. The Research and Analytic Services Staff is the principal source within the EEOC of expert and analytical services for cases under investigation as well as cases in litigation. The Research and Analytic Services Staff has a professional staff of experts in the fields of the social sciences, economics, statistics, and psychology as well as a technical staff of research and statistical assistants. The Office of General counsel has estimated that the Research and Analytic Services Staff saves the Commission nearly two million dollars per year in expert service costs and other types of contract costs.

The essential function of the Research and Analytic Services Staff is to provide expert services for class action cases in litigation. These expert services include providing support during discovery, obtaining information, computerizing data, conducting analyses, producing reports (declarations or affidavits), generating exhibits, being deposed, and testifying at trial. The Research and Analytic Services Staff sec-

ondarily provides expert and analytic support to charges under investigation in the administrative process and to special research projects within the Agency.

The Research and Analytic Services Staff Provide Expert Services in Complex Cases

Other primary functions of the Research and Analytic Services Staff include providing expert and technical advice in implementing UGESP; creating and making EEO–1 data bases available to headquarters and field staff; developing and maintaining special Census files by geography, race, ethnicity, and sex, and detailed occupations; developing labor market availability estimates; constructing large employer personnel data files and work history records by coding and converting paper records into computer files; conducting statistical analyses of complex employment practices; and assisting in the retention of outside experts, when necessary.

Finally, the Research and Analytic Services Staff conduct training sessions for both attorneys and investigators, on such topics as the use of various statistical analysis software packages, and basic concepts in statistics, economics and psychology as they relate to Title VII, ADEA and EPA cases and charges.

The Administrative and Technical Services Staff is the central control unit for the Office of General Counsel and is responsible for providing administrative and technical services to all components of the Office, including the 23 field legal units.

The Administrative and Technical Services Staff Handles Procurement, Budget, Finance and Litigation Tracking Systems for the Office of General Counsel

The Administrative unit acts as the liaison between the Office of General Counsel and the Office of Management on financial concerns and staffing matters. It provides information to managers within the Office of General Counsel on procurement, budgetary, and financial matters based on policies, procedures, and guidelines contained in EEOC Directives, Federal Acquisition Regulations, and other sources. This unit also assists managers within the Office of General Counsel on personnel matters. In addition, the unit is responsible for preparing budget projections and monthly reconciliation reports for the allowance holders within the Office of General Counsel. The Administrative unit also reviews and processes expert witness procurement requests from Systemic Litigation Services and the 23 field legal units to insure that they are in compliance with applicable rules, regulations, and guidelines pertaining to procurement.

The Technical unit of the Administrative and Technical Services Staff maintains computerized systems for tracking Presentation Memoranda, and litigation filed by the Commission. These systems maintain the most current and accurate source of data available for describing the Commission's litigation activity. The Technical unit ensures the accuracy of the data by working closely with Litigation Management Services, Litigation Advisory Services, and the 23 District Office legal units.

To facilitate assessments of nationwide litigation activity, the Technical unit periodically prepares reports analyzing the Commission's litigation. Additionally, the Technical unit provides information to respond to inquiries from members of Congress, managers within the Office of General Counsel, other offices within EEOC, other governmental agencies, and the media.

C. LITIGATION HIGHLIGHTS

1. Generally

In fiscal year 1993, the Office of General Counsel prosecuted 1,029 cases on behalf of the Commission. Also in this fiscal year, the Commission filed a total of 481 lawsuits, including 398 direct suits and interventions, 64 subpoena enforcement actions, and 19 cases alleging recordkeeping or reporting violations. Among the direct suits and interventions, 260 were filed under Title VII, 115 under the ADEA, two under the EPA, three under the Americans with Disabilities Act, and 18 were filed concurrently either under Title VII and the ADEA or under Title VII and the EPA.

The Office of General Counsel resolved 427 cases in this fiscal year, including 362 substantive cases, 56 subpoena enforcement actions, six lawsuits alleging reporting and recordkeeping violations, and three actions for temporary restraining orders.

The Commission won its first case even filed under the Americans with Disabilities Act and in other areas focused on cases involving stereotypes that limit opportunities for women, discriminatory pilot age rules and class wide discrimination against Blacks and Hispanics in hiring. Other significant cases in this fiscal year involved discrimination based on English-Only rules, sexual harassment, a discriminatory seniority system, disparate wages paid to women, and the exclusion of older workers from jobs and benefits because of their age.

Appellate Litigation

In fiscal year 1993, Appellate Services filed the largest number of appellate briefs in at least a decade—101 total briefs, 50 as a party and 51 as *amicus curiae.* Of the briefs filed, 55 were under Title VII, 38 under the ADEA, four under both Title VII and the ADEA, one under the EPA, two under the ADA, and one under the Freedom of Information Act. Additionally, many cases briefed by Appellate Services were decided during the fiscal year. (*See* § IV for a brief description of the cases.)

Supreme Court Litigation

The Supreme Court issued critical decisions in two employment discrimination cases during fiscal year 1993. In *St. Mary's Honor Center* v. *Hicks,* No. 92–602 (June 25, 1993), the Commission had filed a brief as *amicus curiae* along with the Solicitor General's Office, arguing that the plaintiff was entitled to judgment as a matter of law once he had established a *prima facie* case and had shown that all the defendant's nondiscriminatory reasons for the adverse action in issue where unworthy of credence. The Supreme Court held, however, that although a finding of pretext may support an inference of discrimination, such a conclusion is not mandatory.

Supreme Court Adopts EEOC Position on Willfulness in Hazen Paper Co. v. Biggins

In the second case, *Hazen Paper Co.* v. *Biggins*, No. 91–1600 (April 20, 1993), the Commission had filed an *amicus* brief jointly with the Office of the Solicitor General during fiscal year 1992. Adopting the position urged by the Commission on the standard of willfulness, the Court issued its opinion in fiscal year 1993, holding that the *Thurston* standard of "knowing or reckless disregard" should be applied to cases of individual disparate treatment under the ADEA. The Court, however, found that the court of appeals had relied improperly on evidence that the defendant discharged the plaintiff because his pension was about to vest, ruling that an adverse action based on an age-linked characteristic does not in itself constitute a violation of the Act.

In several other cases pending before the Supreme Court, the Commission participated as *amicus curiae* during fiscal year 1993. In two companion cases, *Rivers* v. *Roadway Express,* No. 92–757, and *Landgraf* v. *USI Film Products,* No. 92–938 the Commission and the Solicitor General argued that the Civil Rights Act of 1991 should be applied retroactively. The Commission contended that because two sections of the Act explicitly limit the retroactive effect of particular provisions, and a general provision expressly states that "except as otherwise specifically provided, this Act . . . shall take effect upon enactment," Congress intended the other provisions of the Act to apply retroactively.

EEOC Filed Amicus Briefs in Three Cases Before the Supreme Court in Fiscal Year 1993

In a significant case in the area of sexual harassment, *Harris* v. *Forklift Systems, Inc.,* No. 92–1168, the Commission and the Solicitor General argued that an employee establishes hostile environment sexual harassment by showing that the objectionable work place conduct is sufficiently severe or pervasive to interfere with the job performance of a reasonable person. The Commission contended that the Court should therefore reverse the lower courts' decisions that an employee subjected to the offensive conduct must show that he or she suffered psychological injury.

Commission Wins Its First Case Under the Americans with Disabilities Act

In the first case ever brought by the Commission to endorse the Americans with Disabilities Act, *EEOC* v. *AIC Security Investigations, Ltd., et al.,* No. 92–C–7330 (N.D. Ill.), the Chicago legal unit won a major jury verdict on the issue of liability, and a magistrate awarded the charging party $222,000 in back pay, and in punitive and compensatory damages. The Commission successfully contended that the defendants had discharged the charging party because he had brain cancer, even though he had continued to perform the essential functions of his position as Executive Director of the company.

EEOC Obtains $20 Million Consent Decree in Major Reduction-in-Force Case

The St. Louis legal unit successfully resolved a major class case under the ADEA, alleging that the defendant had forced employees age 50 or older to retire during two reductions-in-force. *See EEOC* v. *McDonnell Douglas Corporation* No. 4:93CV00526 (E.D. Mo.). Under the consent decree resolving this case, the defendant is required to reimburse approximately 940 class members $20,100,000 in back pay and enhanced pension benefits.

Other Significant Class Cases

In this class case on behalf of more than 3000 class members, the EEOC alleged that the defendant referral agency had discriminated against the class on the basis of race, sex, national origin and age in failing to refer for employment and in failing to hire. *See EEOC* v. *Transworld Placement, Inc. d/b/a Interplace,* No. C–91–0694–SAW (N.D. Cal.). The San Francisco legal unit successfully resolved this case through a consent decree providing for a $2,000,000 settlement fund, which includes an estimated $1,420,000 in back pay to 3271 class members, $35,000 in back pay and liquidated damages for two individuals, and $100,000 in compensatory damages for a class of African Americans represented by a private intervenor.

In *EEOC* v. *United Airlines, Inc.,* No. 73–C–972 (N.D. Ill.), the Commission alleged that the defendant discriminated against the class based on race (Black), sex (female), and national origin (Hispanic, Asian, and Native American) in its failure to hire for pilot positions. Systemic Litigation Services reached a partial settlement with the defendant airline, which will pay $404,000 in back pay to 20 individuals. This settlement is a follow-up to a consent decree entered in 1976, which obligated the defendant to hire qualified minorities and women at two times their application rate until 1,200 pilots had been hired.

6. AGE DISCRIMINATION

EEOC Obtains $1.66 Million in Pilot Hiring Case

In another major class case, the Commission alleged that the defendant airline company refused to hire pilot applicants who were age 50 or older. *See EEOC* v. *Southwest Airlines Company*, No. 3:89–CV–2238–P (N. D. Tex.). The Dallas legal unit resolved this case through a consent decree providing for $1.25 million in back pay for 29 class members and $415,000 in back pay and attorney's fees for the charging party. The defendant also agreed that all its future hiring practices will be conducted in accordance with the ADEA.

Consent Decree Removes Threat of Lost Health Benefits for Older Workers

In *EEOC* v. *Quail Creek Country Club*, No. 90–119–FTM–99 (M.D. Fla.), the Miami legal unit obtained a consent decree which resolved the charging party's claim that he was discharged after resisting his employer's attempt to remove him from its health insurance policy and require him to accept Medicare at age 65. The decree provides for $42,500 in back pay and liquidated damages as well as reinstatement. In addition, the employer has agreed that all employees 65 or older have the right to elect voluntarily to accept Medicare coverage or to remain on the employer's health plan.

EEOC Wins Trial on Insurance Coverage for Seventy-Year-Old Driver

In *EEOC* v. *Pro Transport and Leasing, Inc.*, No. A2–91–186 (D.N.D.), the Commission alleged that the defendant had discharged the 70-year-old charging party from a temporary over-the-road truck driving position because of his age. After being told by its insurance carrier that the carrier did not insure individuals over age 65, the defendant had discharged the charging party the same day he was hired. During a 2-day trial litigated by the Denver legal unit, the Commission demonstrated that there were risk pool policies available that would have covered the charging party and that the defendant had purchased such a policy approximately three weeks after the charging party's discharge. The jury returned a verdict for the EEOC and awarded the charging party three months of back pay. In addition, the court ordered the defendant to maintain insurance that covers drivers 40 or older.

Court Invalidates State Law Requiring Older Workers to Pass Medical Examinations

Striking down a State law that required employees age 70 or older to pass a medical examination, the court of appeals for the First Circuit reversed the district court's grant of summary judgment for the defendants and remanded the case to the district court with instructions to enter summary judgment for the Commission. *See EEOC* v. *Commonwealth of Massachusetts*, No. 92–1696 (1st Cir.). The court held that the State law and the ADEA are in conflict and, under the preemption doctrine, the State law is preempted because it is a physical impossibility to comply with both statutes. The court also held that the State statute was not based on a reasonable factor other than age and was not part of a *bona fide* employee benefit plan.

In *EEOC* v. *Watergate at Landmark Condominium,* No. 92–1224–A (E.D. Va.), the Commission alleged that because of the charging party's age, 63, the defendant discharged her from the position of Director/Tennis Pro of its tennis club and failed to hire her as Manager of the club. Following a 1-day trial, the jury returned a ver-

dict for the Commission. The Commission's evidence showed that charging party, who had worked for the defendant as Director/Tennis Pro for 13 years, was the most qualified applicant for the newly created Manager position, and that residents of the condominium, who played a significant role in the tennis club, had stated that the charging party was too old to run the tennis club. The jury found that the defendant's violation of the ADEA was willful and awarded the charging party $63,820 in back pay and an equal amount as liquidated damages. The court awarded the charging party an additional $93,011 in front pay and $6,104 in attorney's fees.

ADEA Preempts State Law That Revoked Tenure of Older Teachers

Challenging an Illinois State law that revoked the tenure of public school teachers and placed them on annual contracts when they reached age 70, the Commission won a major victory for older workers in this case litigated by the Chicago legal unit. *See EEOC* v. *State of Illinois and Bourbonnais Elementary Board of Education*, No. 88–CV–2261 (C.D. Ill.). The court granted summary judgment in EEOC's favor on liability, finding that changing the teachers's status to employees at will violated the ADEA and that the ADEA preempted the State law. The court also found that the State's violation was willful because the State was aware by March 23, 1988, that it was in violation of the ADEA, but made no effort to repeal the statute until January 1, 1989.

Court Strikes Down Annuity Program Requiring Older Workers to Forfeit Employer Contributions

Ruling that the employer's violation was willful under the ADEA, the district court struck down the defendant's annuity investment program, which required employees who worked past age 65 to forfeit some or all of the employer's contributions to the plan. *See EEOC* v. *Jefferson County Board of Education,* No. 91–C–1248–S (N.D. Ala.) In this case litigated by the Birmingham legal unit, the court granted summary judgment on liability to the Commission, finding that the investment program on its face violated section 4(i) of the ADEA. The court also determined that the program could not survive under the exemption in section 4(f)(2) for *bona fide* employee benefit plans either. First, the court found that the program constituted a subterfuge to evade the purposes of the ADEA because a purpose of the plan was to replace older workers with younger workers. In addition, the court held that the program encouraged the involuntary retirement of older workers.

Consent Decree Requires Employer to Pay Retroactive Pension Contributions

The Dallas legal unit obtained a favorable consent decree requiring an employer to maker retroactive retirement contributions to the pension plans of four individuals who alleged they were fired because they were over age 50. *See EEOC* v. *Schindler Elevator Corporation, et al.,* No. 3:90–CV–1407–P (N.D. Tex.). The decree provides for $218,763.73 in relief, including back pay, interest and the additional pension contributions.

EEOC Resolves Case Alleging Forced Retirement of NFL Game Officials

Successfully resolving allegations that the National Football League unlawfully transferred game officials to off-field positions and forced them to retire at age 60, the New York legal unit obtained a consent decree providing $235,000 in back pay for three individuals. *See EEOC* v. *National Football League,* No. 91–CIV–5447 (S.D.N.Y.).

Similarly, in fiscal year 1992, 33.3 percent of suits filed under the ADEA alleged discriminatory discharge, 23.3 percent alleged hiring discrimination, 5.8 percent alleged discrimination in promotions, and 8.3 percent alleged layoff or recall discrimination.

Thirty cases of national origin discrimination and 15 cases of religious discrimination were brought in fiscal year 1993, compared with 24 cases of national origin and 13 cases of religious discrimination filed in fiscal year 1992. Predominant among the claims made in fiscal year 1993 national origin discrimination cases were discharge, at over 53 percent of claims; hiring, at 7 percent of claims; harassment based on national origin at over 11 percent of claims; and terms and conditions of employment, at slightly more than 9 percent of claims. (See Table 12, below.)

TABLE 12. FREQUENCY OF UNLAWFUL PRACTICES ALLEGED IN FY 1993 AGE LAWSUITS

Practice	No.	Percent
Discharge	58	42.0
Hiring	26	18.8
Layoff	13	9.4

TABLE 12. FREQUENCY OF UNLAWFUL PRACTICES ALLEGED IN FY 1993 AGE LAWSUITS—Continued

Practice	No.	Percent
Retirement	11	8.0
Promotion	6	4.3
Benefits	2	1.4
Demotion	1	0.7
Recall	1	0.7
Other	20	14.5
Total	138	100.0

Total exceeds total age discrimination suits filed because suits often contain multiple claims.

IV. Appellate Services

A. SUMMARY OF SELECTED APPELLATE BRIEFS FILED

Baker & EEOC v. *Delta,* 9th Cir. Nos. 92–55044, 92–55048, 92–55049 Brief as Appellant Filed 11/15/92

Eight former Delta pilots filed an ADEA action in the district court alleging that Delta discriminated on the basis of age because it required its flight crew to retire at age 60 and prohibited captains from downbidding to flight engineer positions. The pilots also argued that Delta was a successor to their former employer, Western, and therefore was bound by a pre-existing injunction to honor downbids that had been granted prior to Delta's merger with Western. The EEOC intervened. To defend its treatment of the age 60 pilots, Delta argued that age 60 was a *bona fide* occupational qualification necessary to the safe operation of its aircrafts and that its rejection of the pilots' downbids was because its company policy prohibited two-step downbidding and therefore was justified by a reasonable factor other than age. The jury rendered a verdict against Delta on the BFOQ defense and in its favor on the RFOA defense.

Argued: The district court abused its discretion when it excluded relevant evidence that was pertinent to the plaintiffs' contention that Delta's policy against two-step downbidding could not be a reasonable factor other than age. Exclusion of the evidence adversely affected plaintiffs' right to show that age was a determining factor in the formulation of the policy and that Delta's alleged safety concerns were pretextual. Alternatively, if the district court properly excluded plaintiffs' evidence, then the district court's admission of an earlier Delta brief was an abuse of discretion. The brief raised matters that had no direct bearing on the issue in the case and its admission prejudiced plaintiffs' substantive rights because the brief was Delta's only evidence that the policy against two-step downbidding existed, which was critical to Delta's RFOA defense. Finally, the district court failed to properly analyze the successorship question and to apply controlling law.

Tindall v. *Doe Run Investment Holding Corp., Burch* v. *Doe Run Investment Holding Corp.,* E.D. Mo. Nos. 4:93–CV–00831 & 4:93–CV–00759 (ELF) Brief as Amicus Curiae Filed 8/2/93

These are cases challenging a companywide reduction-in-force undertaken in 1991 by the Doe Run Investment Holding Corp. The plaintiffs allege that they were selected for discharge on the basis of their age. The defendants have moved for summary judgment in both cases, arguing that waivers executed by the plaintiffs of their ADEA rights bar their claims. The defendants did not provide the information required by the Older Workers' Benefit Protection Act for waivers in conjunction with "employment termination programs." 20 U.S.C. § 6269(1)(H). The defendants argue that subsection (H) does not apply to involuntary reductions, but only to retirement and other exit incentives in which employees are given the choice whether to leave, and an inducement to do so.

Argued: The language of § 626(f)(1)(H) on its face applies to "exit incentive[s] or other employment termination program[s] offered to a group or class of employees." Here, Doe Run offered a standard severance benefit to employees subject to the RIF, and required them to execute a waiver of claims in exchange. The legislative history is specific and explicit that subsection (H) applies to both exit incentives and involuntary reductions, and the congressional purpose, to give employees subject to a mass downsizing the information necessary to determine whether they might have an ADEA claim, applies with equal force in both contexts. Doe Run's argument would nullify the intent of Congress in an entire class of cases.

Gately v. *Massachusetts,* 1st Cir. No. 92–2485 Brief as Amicus Curiae Filed 2/12/93

Until 1991, Massachusetts had four separate units of State law enforcement officers: the State police, with a mandatory retirement age of 50, and three smaller units, with a mandatory retirement age of 65. In the mid-'80s the First Circuit twice upheld the State police age-50 policy as a BFOQ. In 1991, the State reorganized these four units into one department of State police, with a mandatory retirement age of 55. Some members of the three smaller units brought this action, claiming that the State violated the ADEA when it lowered the requirement age applicable to them from 65 to 55. The district court granted preliminary injunctive relief, and the State appealed. The State argued that plaintiffs' claim was barred on two grounds: first, that the First Circuit's earlier decisions upholding the age-50 policy precluded this challenge on *stare decisis* grounds; and second, that section 4(j) of the ADEA authorizes them to apply a retirement age as low as 50 to State police.

Argued: The earlier decisions upholding the age-50 policy cannot bar this challenge because the State itself, by raising the age, has admitted that the facts supporting those earlier holdings have since changed. Further, section 4(j) does not allow a State to lower the age at which it requires a class of employees to retire.

B. SUMMARY OF SELECTED APPELLATE DECISIONS

2. ADEA

Hazen Paper Co. v. *Biggins,* 113 S. Ct. 1701 (1993)

The Supreme Court vacated and remanded the case to the court of appeals for the First Circuit for reconsideration of whether the evidence showed that the employer discriminated against Walter Biggins on the basis of his age. The Court found that the court of appeals had relied improperly on evidence that Hazen Paper Co. discharged Biggins because his pension was about to vest. The Court did not adopt a blanket rule against reliance on so-called "age proxies" as evidence of age discrimination, but it did say that reliance on an age-linked characteristic does not itself constitute a violation of the ADEA. It did not reach the question of whether a disparate impact claim could be raised under the ADEA, and if so, whether use of an "age proxy" could be a neutral rule with a disparate impact on the basis of age. The Court reaffirmed the standard for willfulness it adopted in *Trans World Airlines, Inc.* v. *Thurston,* 469 U.S. 111 (1985), and applied the "knowing or reckless disregard" standard to cases of individual disparate treatment. The United States and the EEOC participated in the case as *amicus curiae.*

EEOC v. *Local 350, Plumbers and Pipefitters,* 982 F.2d 1305 (9th Cir.), amended 998 F.2d 641 (1992)

The Ninth Circuit reversed the district court's grant of summary judgment for Local 350 and invalidated the union's policy of refusing to allow retired members to seek work through its hiring hall while they were receiving pension benefits. The court held that the ADEA is violated when there is "a very close connection between age and the factor on which discrimination is based," in this case, retirement status. In rejecting Local 350's argument that the cause of the discrimination was not age, but the individual's choice to retire, the court stated that it was "unwilling to draw so fire a line when determining causation." The court also held that it was discriminatory to require any older workers to choose between alternative sources of income and using the hiring hall while not requiring younger workers to make that choice. Also, the court rejected Local 350's view that the policy was based on a reasonable factor other than age, inasmuch as the justification "rests on retirement, a status closely related to age."

EEOC v. *Commonwealth of Massachusetts,* 987 F.2d 64 (1st Cir. 1993)

The First Circuit reversed the district court's grant of summary judgment for the defendants and remanded the case to the district court with instructions to enter summary judgment for the EEOC. The court of appeals rejected the district court's reliance on *Gregory* v. *Ashcroft,* holding that absent an ambiguity in the language of the ADEA, traditional preemption standards should apply. Because the state law, requiring medical exams as a condition of continued employment for employees age 70 and older, conflicts with the ADEA, the state law is preempted. The court also held that the state statute was not exempt from ADEA coverage because it was not based on a reasonable factor other than age and it was not part of a *bona fide* employee benefit plan.

Baker & EEOC v. *Delta Air Lines, Inc.,* 6 F.3d 632 (9th Cir. 1993)

In a unanimous decision, the Ninth Circuit reversed in part and affirmed in part the district court's rulings, and remanded this ADEA case for retrial. Reversing the district court, the Ninth Circuit held that Delta was a successor to Western Air Lines and therefore bound by the *Criswell I* injunction imposed against Western that would have permitted appellants, former Western pilots Baker and Stunz, to

fly as second officers beyond age 60. The court also held that the district court abused its discretion when it refused to admit exhibits that constituted "the only documentary evidence establishing Appellants' claim that the two-step downbidding rule never existed and that, if the policy did exit, it was based on age." The court affirmed the district court, holding that other exhibits regarding one-step downbidding were properly excluded on relevancy and confusion grounds and that Delta's exhibit 692, the FAA brief expressing safety concerns about downbidding, was properly admitted. The court reversed the district court's denial of JNOV on the finding that Delta's age-60 rule constituted a willful violation, reasoning that Delta acted in good faith when it relied on a case affirming a jury's finding that Delta's age-60 policy was lawful.

Gately v. *Massachusetts,* 2 F.3d 1221 (1st Cir. 1993)

This ADEA action challenges a 1991 Massachusetts statute that consolidated four units of State law enforcement officers into one Department of State Police, and lowered the mandatory retirement age applicable to the members of the three smaller units from 65 to 55. The district court granted a preliminary injunction prohibiting Massachusetts from enforcing the latter provision. The First Circuit affirmed the district court's order in a decision that agreed with the position advanced by the EEOC as *amicus curiae.* The court of appeals held that plaintiffs' challenge to the 1991 act was not barred by the stare decisis effect of *Mahoney* v. *Trabucco,* 738 F.2d 35 (1st Cir. 1984), because the BFOQ finding in the earlier case was "fact-intensive," and plaintiffs here had submitted evidence of changed circumstances. Nor, the court held, was plaintiffs' challenge barred by § 4(j) of the ADEA, the temporary exemption for state law enforcement officers. While that section allows states to enforce mandatory retirement ages in effect in 1983, it prohibits reducing them. The court also affirmed the district court's finding of irreparable harm, rejecting Massachusetts' argument that plaintiffs had to meet the higher standard enunciated in *Sampson* v. *Murray,* 415 U.S. 61 (1974).

EEOC v. *Fond du Lac Band of Lake Chippewa* 986 F.2d 246 (8th Cir. 1993)

A divided panel of the Eighth Circuit affirmed the district court's decision holding that the ADEA does not apply to an Indian tribe employer. The EEOC sought relief for an elderly member of Fond du Lac, who was denied employment with a construction company owned and operated by Fond du Lac, in favor of a much younger, caucasian worker. The panel majority acknowledged that the broad terms of the Act could extend to tribal employees and that there was no specific treaty right that would be abrogated by applying the ADEA in this case. However, the majority ruled that Fond du Lac retained inherent rights of self-government that would be infringed if it were subject to the ADEA. The court held that there was not a sufficiently clear indication of congressional intent to overrule tribal rights.

V. Field Office Litigation—Selected Suits Filed and Selected Suits Resolved

ATLANTA DISTRICT OFFICE

Atlanta filed 22 lawsuits, including 8 subpoena enforcement actions, in fiscal year 1993; all suits filed on the merits were on behalf of an individual or individuals.

Of the suits filed on the merits, 9 were filed under Title VII and 5 under the ADEA.

Atlanta resolved 7 lawsuits, including 3 subpoena enforcement actions, in addition to 1 presuit settlement, in fiscal year 1993, and recovered $94,000 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

Atlanta Dairies, Inc. No. 1:93–CV–1038–HTW (N.D. Ga. filed May 13, 1993)—age (62); involuntary retirement.

Atlantic Southeast Airlines No. 1:93–CV2110–RHH (N.D. Ga. filed September 16, 1993)—age (60); involuntary retirement.

Freuhauf Trailer Corporation No. 1:93–CV–0430–GET (N.D. Ga. filed February 24, 1993)—age (63); discharge.

Ringier America, Inc. No. CV 193–011 (S.D. Ga. filed January 13, 1993)—age (61); layoff, failure to reinstate.

United Dominion Industries, Inc. No. 1:93–CV–1667–MHS (N.D. Ga. filed July 23, 1993)—age (63); discharge.

BALTIMORE DISTRICT OFFICE

Baltimore filed 39 lawsuits, including 5 subpoena enforcement actions and 12 reporting/recordkeeping violations in fiscal year 1993. Of the suits filed on the merits, 20 were on behalf of an individual or individuals, and 2 on behalf of a class.

Of the suits filed on the merits, 17 were filed under Title VII, 4 under the ADEA, and 1 under the Equal Pay Act.

Baltimore resolved 20 lawsuits in fiscal year 1993, and recovered $600,655.49 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

Central Virginia Area Agency on Aging No. 93–0047–L (W.D. Va. filed June 14, 1993)—age (54); failure to hire.

General Electric and Martin Marietta Corporation, as a successor No. 2:93–CV–809 (E.D. Va. filed August 9, 1993)—age (61); failure to hire.

Mayor and City Council of Cumberland, Maryland No. MJG–92–3293 (D. Md. Filed November 20, 1992)—age (64); discharge.

Westinghouse Electric Corporation No. MJG–93–1004 (D. Md. Filed April 2, 1993)—class; age (over 40); lay-off, involuntary retirement.

Suits Resolved

B. ADEA

Bowie State University No. HAR–92–2137 (D. Md. filed July 31, 1992)—age (60 or over); failure to reclassify to a higher position, discharge; March 15, 1993 settlement agreement in which defendant agreed that it would not violate the ADEA by discriminating against employees over 40, would not retaliate against charging party or any other persons who communicated with the Commission, and will consider charging party for future employment.

National Car Rental Systems, Inc. No. WN–89–3223 and S–89–2504 (D. Md. filed November 21, 1989)—age (56); discharge; June 28, 1993 settlement agreement providing $175,000 in back pay for six individuals and notice posting.

Pan American Development Foundation No. 90–2392–HHG (D.D.C. filed September 28, 1990)—age (66), retaliation; constructive discharge; February 24, 1993 consent decree providing $7,500 in back pay and interest for one individual and notice posting.

S & G Concrete Company No. HAR–92–2265 (D. Md. filed August 13, 1992)—age (58); discharge; February 17, 1993 settlement agreement providing $30,000 in back pay for one individual.

Temporary Living Communities Corporation, a division of National Loan Service Center f/k/a Comprehensive Marketing Systems, Inc. No. 92–0739 (D.D.C. filed March 26, 1992)—age (62); constructive discharge; September 13, 1993 consent decree providing $30,000 in back pay for one individual and notice posting.

Watergate at Landmark Condominium No. 92–1224–A (E.D. Va. filed August 27, 1992)—age (63); discharge, failure to hire; April 29, 1993 jury verdict awarding $220,651 in front pay, back pay, and liquidated damages.

BIRMINGHAM DISTRICT OFFICE

Birmingham filed 13 lawsuits, including 1 subpoena enforcement action, in fiscal year 1993; of the suits filed on the merits, 10 were on behalf of an individual or individuals, and 2 on behalf of a class.

Of the suits filed on the merits, 9 were filed under Title VII and 3 under the ADEA.

Birmingham resolved 19 lawsuits, including 1 subpoena enforcement action, in addition to 2 presuit settlements, in fiscal year 1993, and recovered $448,070.95 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

International Systems, Inc. No. 93–0148–CB–C (S.D. Ala. filed February 26, 1993)—age (51); failure to rehire.

The Kent Corporation No. CV–92–P–2659–S (N.D. Ala. filed November12, 1992)—age (70); transfer, reassignment.

Millard Refrigerated Services Atlanta, Inc. No. CV93–AR–0993–M (N.D. Ala. filed May 18, 1993)—age (62); failure to hire, discharge.

Suits Resolved

B. ADEA

John C. Calhoun Community College No. CV–90–H–00397–HE (N.D. Ala. filed March 6, 1990)—age (63), retaliation; discharge; November 24, 1992 consent decree providing $20,000 in back pay and liquidated damages for one individual, reinstatement and notice posting.

Fountain Construction, Inc. No. J91–0727(W)(C) (S.D. Miss. filed December 12, 1991)—age (64); failure to hire; November 5, 1992 settlement agreement providing total relief of $7,000 for one individual and notice posting. (Charging party received an additional $7,000 through private settlement with respondent).

The Kent Corporation No. CV–92–P–2659–S (N.D. Ala. filed November 12, 1992)—age (70); transfer, reassignment; August 25, 1993 consent decree providing front pay in the amount of $14,345 for one individual.

See also, below, Community Convalescent Center.

D. Title VII/ADEA

Community Convalescent Center No. 92–0449–AHC (S.D. Ala. filed June 1, 1992)—breach of negotiated settlement agreement age (62), race (white); discharge, terms and conditions of employment; March 31, 1993 consent decree providing $450 in back pay for one individual.

CHARLOTTE DISTRICT OFFICE

Charlotte filed 28 lawsuits, including 5 subpoena enforcements actions, in fiscal year 1993; of the suits filed on the merits, 19 were on behalf of an individual or individuals, and 4 on behalf of a class.

Of the suits filed on the merits, 19 were filed under Title VII, and 4 under the ADEA.

Charlotte resolved 28 lawsuits, including 9 subpoena enforcement actions and 1 temporary restraining order, in fiscal year 1993 and recovered $273,505.78 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

City of Gastonia No. 3:93CV307–MU (W.D.N.C. filed September 15, 1993)—age (61), retaliation; demotion.

Burnham Service Company, Inc. No. 3:92–CV–369–P (W.D.N.C. filed October 2, 1992)—class; age (52 and 59); failure to recall.

Shelby City Schools No. 4:93CV63 (W.D.N.C. filed April 30, 1993)—age (62); job assignment, wages.

U.S. Textiles Corporation No. 1:93CV154 (W.D.N.C. filed August 12, 1993)—age (40, 51, 52 and 53); failure to hire.

Suits Resolved

B. ADEA

Burnham Services Company, Inc. No. 3–92–CV–369–P (W.D.N.C. filed October 2, 1992)—class; age (50 and 59); failure to recall; July 29, 1993 settlement agreement providing $6,000 in back pay and liquidated damages for one individual.

North Carolina Department of Human Resources, a division of Youth Services No. 91–491–CIV–5–BO (E.D.N.C. filed July 29, 1991)—age (54); discharge, failure to rehire; October 15, 1992 settlement agreement providing $22,000 in back and front pay for one individual.

Thomasville City Schools, Thomasville, North Carolina No. C–90–122–S (M.D.N.C. filed March 5, 1990)—age (62); failure to hire; June 3, 1993 settlement agreement providing $13,500 in back pay for one individual.

CHICAGO DISTRICT OFFICE

Chicago filed 31 lawsuits, including 4 subpoena enforcement actions and 1 reporting/recordkeeping violation, in fiscal year 1993; of the suits filed on the merits, 21 were on behalf of an individual or individuals, and 5 on behalf of a class.

Of the suits filed on the merits, 15 were filed under Title VII, 1 under the Americans with Disabilities Act, 7 under the ADEA, 1 under the Equal Pay Act, 1 under Title VII and the ADEA, and 1 under Title VII and the Equal Pay Act.

Chicago resolved 33 lawsuits, including 7 subpoena enforcement actions, in fiscal year 1993, and recovered $1,371,154.21 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

City of Des Plaines and City of Des Plaines Fire Department No. 92–C–7328 (N.D. Ill–ED filed November 5, 1992)–age (65); involuntary retirement.

Dukane Corporation No. 92–C–8279 (N.D. Ill.–ED filed December 22, 1992)—age (59); discharge.

Egg Store, Inc. No. 93–C–1950 (N.D. Ill.–ED filed April 1, 1993)—age (62); discharge.

Graham Hospital Association No. 93–1348 (C.D. Ill. filed September 13, 1993)—age (over 65); benefits.

Landau and Heyman, Inc. No. 93–C–5411 (N.D. Ill.–ED filed September 2, 1993)—age (64), retaliation; terms and conditions of employment, discharge.

Lea-Ronal, Inc. No. 93–C–2950 (N.D. Ill.–ED filed May 14, 1993)—age (59); failure to hire.

E. Title VII/ADEA

William Rainey Harper College No. 93–C–4914 (N.D. Ill.-ED Filed August 13, 1993)—age (40), national origin (non-Hispanic); failure to hire.

Suits Resolved

B. ADEA

Deere & Company No. 92–C–4036 (C.D. Ill.-RD filed May 11, 1992)—retaliation; failure to rehire; December 17, 1992 consent decree providing $28,700 in back pay for one individual.

Francis W. Parker School No. 91–C–4674 (N.D. Ill. filed July 25, 1991)—age (40 and over); failure to hire; July 25, 1992 unfavorable court order.

G–K–C, Inc., et al. No. 89 C 8693 (N.D. Ill. filed December 21, 1989)—age (70); discharge; November 10, 1992 order of dismissal.

State of Illinois No. 86–C–7214 (N.D. Ill. filed September 24, 1986)—age (40 and over); failure to hire; October 2, 1992 settlement agreement providing $25,000 in back pay for five individuals.

Dukane Corporation No. 92–C–8279 (N.D. Ill.-ED filed December 22, 1992)—age (59); discharge; May 26, 1993 consent decree providing $52,500 in back pay and liquidated damages for one individual.

State of Illinois and Fraternal Order of Police, Troopers Lodge No. 41 No. 92–C–2108 (/f/ 92–C–2883, N.D. Ill.) C.D. Ill. filed May 21, 1990)—class; age (60); involuntary retirement; February 16, 1993 unfavorable court order.

Spiegel, Inc., and Otto Versand GMBH No. 90–C–6363 (N.D. Ill.–ED filed October 31, 1990)—class; age (over 40); discharge; May 14, 1993 settlement agreement providing $52,262 in back pay for nine individuals.

Spiegel, Inc., and Otto Versand GMBH No. 90–C–4208 (N.D. Ill.–ED filed July 24, 1990)—class; age (over 40); discharge; June 14, 1993 order of dismissal, no monetary relief.

CLEVELAND DISTRICT OFFICE

Cleveland filed 22 lawsuits in fiscal year 1993; all suits were filed on the merits—20 were filed on behalf of an individual or individuals, and 2 were filed on behalf of a class.

Of these, 11 were filed under Title VII, 10 under the ADEA, and 1 under Title VII and the Equal Pay Act.

Cleveland resolved 16 lawsuits in fiscal year 1993, and recovered $288,062.20 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

B & P Wrecking Company, Inc. and Paxton Equipment Company, Inc. No. 3:92CV7649 (N.D. Ohio filed November 20, 1992)—age (59 and 62); layoff.

Electronic Control Systems, Inc. No. 1:93–CV–525 (N.D. Ohio filed March 9, 1993)—age (70); involuntary retirement.

Frontier Fruit & Nut Company No. 5:92CV2469 (N.D. Ohio filed November 19, 1992)—age (42); failure to hire.

Hupp Industries, Inc. No. 1:93CV–1107 (N.D. Ohio filed May 25, 1993)—age (58); permanent layoff.

Libbey-Owens-Ford Company No. 3:93CV7540 (N.D. Ohio filed September 27, 1993)—age (58); failure to hire.

Odgen Services Corporation No. 3:92CV7657 (N.D. Ohio filed November 24, 1992)—age (51); discharge.

Rochester Midland Corporation No. 1:93–CV–0148 (N.D. Ohio filed January 21, 1993)—age (63); discharge.

The Marsh Foundation No. 3:93CV7547 (N.D. Ohio filed September 29, 1993)—age (58); discharge.

The Rickelman Masonry Company, Inc. No. 1:92CV–2312 (N.D. Ohio filed November 2, 1992)—age (53); layoff.

VME Americas, Inc. No. 1:92CV2470 (N.D. Ohio filed November 19, 1992)—age (62); layoff.

Suits Resolved

B. ADEA

B&C Machine Company No. 5:91CV2270 (N.D. Ohio filed November 8, 1991)—age (54); failure to recall; December 29, 1992 settlement agreement providing $9,000 in back pay and interest for one individual.

TMK Corporation d/b/a Frontier Fruit & Nut Company No. 5:92CV2469 (N.D. Ohio filed November 19, 1992)—age (42); failure to hire; September 13, 1993 consent decree providing $1,750 in back pay for one individual.

State of Ohio Rehabilitation Services Commission No. C2–91–726 (S.D. Ohio filed September 6, 1991)—age (52); failure to hire; July 9, 1993 summary judgment in favor of defendant.

The Rickelman Masonry Company, Inc. No. 1:92CV–2312 (N.D. Ohio filed November 2, 1992)—age (53); layoff; December 21, 1992 consent decree providing $5,693.12 in back pay for two individuals.

Rochester Midland Corporation No. 1:93–CV–0148 (N.D. Ohio filed January 21, 1993)—age (63); discharge; August 30, 1993 dismissal/settlement agreement providing $19,671.79 in back pay for one individual.

DALLAS DISTRICT OFFICE

Dallas filed 17 lawsuits, including 3 subpoena enforcement actions, in fiscal year 1993; of the suits filed on the merits, 12 were on behalf of an individual or individuals, and 2 on behalf of a class.

Of the suits filed on the merits, 10 were filed under Title VII and 4 under the ADEA.

Dallas resolved 19 lawsuits, including 4 subpoena enforcement actions, in addition to 2 presuit settlements, in fiscal year 1993 and recovered $3,232,550.96 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

American Airlines, Inc. No. 4–93CV–203–A (N.D. Tex. filed March 26, 1993)—class; age (over 40); failure to hire.

Raudin McCormick, Inc. No. 3–93–CV1819–D (N.D. Tex. filed September 10, 1993)—age (69 and 72); failure to hire.

Tecc Corporation No. 3–93CV0602–G (N.D. Tex. filed March 25, 1993)—age (69); discharge.

Woodcraft Furniture No. 93–C–828E (N.D. Okla. filed September 13, 1993)—age (63), recordkeeping violation; failure.

Suits Resolved

B. ADEA

City of Tulsa No. 92–C–468–E (N.D. Okla. filed May 23, 1992)—age (64); failure to hire; November 3, 1992 consent decree providing $107,500 in back pay and injunctive relief for one individual.

Enserch Corporation No. CA3–90–2412–X (N.D. Tex. filed October 17, 1990)—age (58); failure to hire; October 30, 1992 settlement agreement providing $21,500 in back pay for one individual.

Manville Sales Corporation and Manville Corporation No. 4:88CV0905–K (N.D. Tex. filed December 14, 1988)—age (55); discharge; November 24, 1992 adverse jury verdict.

Schindler Elevator Corporation, et al. No. 3:90–CV–1407–P (N.D. Tex. filed June 14, 1990)—age (over 50); discharge; April 2, 1993 consent decree providing $218,763.73 in back pay, interest and retroactive retirement contributions for four individuals.

Southwest Airlines Company No. 3:89–CV–2238–P (N.D. Tex. filed October 5, 1990)—class; age (53); failure to hire; September 3, 1993 consent decree providing $1,665,000 in back pay for charging party and 29 class members.

Thomson Newspaper Inc. d/b/a Marshall News Messenger No. 2–92–CV028 (E.D. Tex. filed March 6, 1992)—age (50); discharge; March 2, 1993 settlement agreement providing $218,200 in back pay and front pay for one individual.

West Texas Printing Company No. 692CV0001–W (N.D. Tex. filed January 3, 1992)—age (57); discharge; December 8, 1992 consent decree providing $11,000 in back pay for one individual.

C. Title VII/ADEA

Recognition Equipment, Inc. No CA3–90–0491–G (N.D. Tex. filed June 29, 1990)—age (43); sex (female), race (black), retaliation; layoff, discharge; October 1, 1992 settlement agreement providing $52,500 in back pay for one individual.

DENVER DISTRICT OFFICE

Denver filed 8 lawsuits, including 1 subpoena enforcement action, in fiscal year 1993; of the suits filed on the merits, 6 were on behalf of an individual or individuals, and 1 on behalf of a class.

Of the suits filed on the merits, 4 were filed under Title VII, 1 under the ADEA, 1 under Title VII and the ADEA, and 1 under Title VII and the Equal Pay Act.

Denver resolved 6 lawsuits, including 1 subpoena enforcement action, in addition to 1 presuit settlement, in fiscal year 1993 and recovered $95,510.35 in monetary benefits for victims of employment discrimination.

Suits Filed

Merchants Association d/b/a Westminister Mall Company.

C. Title VII/ADEA

Westminister Mall Merchants Association d/b/a Westminister Mall Company No. 93–M–333 (D. Colo. filed February 11, 1993)—age (72), national origin (Hispanic), recordkeeping violation; discharge.

Suits Resolved

B. ADEA

N.P. Dodge Management Company No. CV–90–O–354 (D. Neb. filed May 25, 1990)—age (60); discharge; October 23, 1992 settlement agreement providing $10,000 in back pay for one individual.

Pro Transport and Leasing, Inc. No. A2–91–186 (D.N.D. filed November 7, 1991)—age (70); discharge; June 8, 1993 judgment providing $4,536 in back pay for one individual.

DETROIT DISTRICT OFFICE

Detroit filed 21 lawsuits, including 2 subpoena enforcement actions, in fiscal year 1993; all suits filed on the merits were on behalf of an individual or individuals.

Of the suits filed on the merits, 11 were filed under Title VII, 1 under the Americans with Disabilities Act, and 7 under ADEA.

Detroit resolved 21 lawsuits, including 3 subpoena enforcement actions and 1 reporting violation, in fiscal year 1993, and recovered $95,002.05 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

American Telephone & Telegraph Company, a New York Corporation, and Communications Workers of America No. 92CV76754DT (E.D. Mich. filed November 20, 1992)—age (55); denied training, reassigned to another position.

Dana Commercial Credit Corporation No. 92CV76272DT (E.D. Mich. filed October 23, 1992)—age (45); discharge.

Kalwall Corporation No. 92CV40510FL (E.D. Mich. filed October 26, 1992)—age (61); discharge.

National Delivery Service, Inc. No. 93CV73577DT (E.D. Mich. filed August 24, 1993)—retaliation; discharge.

Regency Oakbrook Ltd. f/k/a Regency Windsor Management, Inc. No. 1:93CV361 (W.D. Mich. filed May 10, 1993)—age (62); discharge.

Regional Group, Inc. d/b/a WGRD Radio No. 1:93–CV–691 (W.D. Mich. filed August 27, 1993)—age (52); discharge.

Roberta's, Inc. No. 93–74058 (E.D. Mich. filed September 27, 1993)—age (62); discharge.

C. Americans with Disabilities Act

H. Hirsch Sons Company d/b/a Hirschfield Steel Center No. 93CV10259BC (E.D. Mich. filed September 3, 1993)—disability (degenerative disc disease); discharge.

Suits Resolved

B. ADEA

Bob Maxey Lincoln-Mercury Sales, Inc. No. 91–CV–72625 DT (E.D. Mich. filed May 31, 1991)—class; age (51); failure to hire, advertising violation; November 5, 1992 consent decree providing $500 in back pay for one individual.

Dana Commercial Credit Corporation No. 92CV76272DT (E.D. Mich. filed October 23, 1992)—age (45); discharge; February 24, 1993 order of dismissal with prejudice.

Kalwall Corporation No. 92–CV–40510–FL (E.D. Mich. filed October 26, 1992)—age (61); discharge; November 30, 1992 order of dismissal.

Transition Mold Corporation and Superior Plastic, Inc., a successor corporation No. 91CV71784 DT (E.D. Mich. filed April 22, 1992)—age (54); layoff; October 26, 1992 consent decree providing $9,500 in back pay for one individual.

HOUSTON DISTRICT OFFICE

Houston filed 16 lawsuits in fiscal year 1993; all suits were filed on the merits—14 were filed on behalf of an individual or individuals, and 2 were filed on behalf of a class.

Of these, 14 were filed under Title VII, and 2 under the ADEA.

Houston resolved 14 lawsuits in fiscal year 1993 and recovered $229,936.01 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

Ford Motor Credit Company No. H–93–2190 (S.D. Tex. filed July 20, 1993)—age (45); failure to hire.

North Star Steel Texas, Inc. No. 1:93CV432 (E.D. Tex. filed September 3, 1993)—age (73); terms and conditions of employment.

Suits Resolved

B. ADEA

Aristech Chemical Corporation No. H–91–3565 (S.D. Tex. filed December 5, 1991)—age (61); discharge; March 5, 1993 consent decree providing $27,500 in back pay and liquidated damages for one individual and notice posting.

Loral Space Information Systems No. H–92–1255 (S.D. Tex. filed April 22, 1992)—age (52); failure to hire; August 26, 1993 dismissal without prejudice, no monetary relief.

See also, below, Fina Oil and Chemical Co.

C. Title VII/ADEA

Fina Oil and Chemical Co. No. 1:91CV901 (E.D. Tex. filed November 13, 1991)—age (56), national origin (Hispanic); continuous denial of training, transfer of job responsibilities, discharge; August 31, 1993 consent decree providing $40,000 in back pay for one individual.

INDIANAPOLIS DISTRICT OFFICE

Indianapolis filed 13 lawsuits in fiscal year 1993; all suits were filed on the merits—9 were filed on behalf of an individual or individuals, and 4 were filed on behalf of a class.

Of these, 3 were filed under Title VII, 6 under the ADEA, and 4 under Title VII and the Equal Pay Act.

Indianapolis resolved 120 lawsuits, including 1 subpoena enforcement action, in fiscal year 1993 and recovered $211,263.83 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

Crown Point Community School Corporation, Board of Trustees of the Crown Point Community School Corporation and Crown Point Education Association No. 2:93–CV–RL (N.D. Ind. filed August 16, 1993)—class; age (61 or over); benefits.

Ellas Construction Company, Inc. No. H93–53 (N.D. Ind. filed February 19, 1993)—age (60); discharge.

Regency Windsor Management, Inc. No. IP92–1692C (S.D. Inc. filed December 7, 1992)—age (56); discharge.

The Town of New Chicago and the Board of Metropolitan Police Commissioners of the Town of New Chicago. No. 2:93CV–107–JM (N.D. Ind. filed April 1, 1993)—age (71); involuntary retirement.

Trade Winds Rehabilitation Center, Inc. No. H92–0372 (N.D. Ind. filed November 16, 1993)—age (61); discharge.

Waffle House Lebanon, Inc. No. IP93–251C (S.D. Ind. filed February 24, 1993)—age (53); discharge.

Suits Resolved

B. ADEA

Regency Windsor Management, Inc. No. IP92–1692C (S.D. Ind. filed December 7, 1992)—age (56); discharge; July 21, 1993 consent decree providing $4,000 in damages for one individual, favorable letter of reference, and notice posting.

LOS ANGELES DISTRICT OFFICE

Los Angeles filed 10 lawsuits, including 1 temporary retraining order, in fiscal year 1993; of the suits filed on the merits, 6 were on behalf of an individual or individuals, and 3 on behalf of a class.

Of the suits filed on the merits, 5 were filed under Title VII, and 4 were filed under the ADEA.

Los Angeles resolved 10 lawsuits, including 1 temporary restraining order, in fiscal year 1993 and recovered $276,936.73 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

KCAL TV, Inc. No. CV 93–2926 RMT (CTx) (C.D. Cal. Filed May 20, 1993)—age (49); discharge.

Ginsburg, Stephan, Oringher & Richman No. CV 93 3799 (LGB) (Bx) (C.D. Cal. filed June 28, 1993)—age (67); failure to hire.

Southwestern Cable Television No. CV 92–1639B (CM) (C.D. Cal. filed October 23, 1992)—class; age (40 and over); failure to hire.

Housing Resources Management, Inc. No. CV 92–7003 ER (SRX) (C.D. Cal. filed November 24, 1992)—age (59); failure to promote.

Suits Resolved

B. ADEA

Housing Resources Management, Inc. No. CV 92 7003 ER (JRX) (C.D. Cal. filed November 24, 1992)—age (58 and 59); failure to promote; April 19, 1993 settlement agreement providing $7,541.89 in back pay for two individuals.

MEMPHIS DISTRICT OFFICE

Memphis filed 23 lawsuits, including 1 subpoena enforcement action, in fiscal year 1993; of the suits filed on the merits, 18 were on behalf of an individual or individuals, and 4 on behalf of a class.

Of the suits filed on the merits, 15 were filed under Title VII, 5 under the ADEA, and 2 under Title VII and the Equal Pay Act.

Memphis resolved 18 lawsuits, including 1 subpoena enforcement action and 1 temporary restraining order, in fiscal year 1993 and recovered $1,268,840.21 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

Allen Petroleum d/b/a Okee Dokee No. 18 No. CIV–2–93–46 (E.D. Tenn. filed February 5, 1993)—age (54); discharge.

Hendrix College No. LRC–93–529 (E.D. Ark. filed July 28, 1993)—age (56), recordkeeping violation; failure to retain records.

Labinal Components and Systems, Inc. and Northern Technologies Manufacturing Corporation No. J–C–92–296 (E.D. Ark filed November 12, 1992)—class; age (40 and over); failure to hire.

Whithall School District #27 No. PBC–C–92–709 (E.D. Ark filed November 12, 1992)—age (49), retaliation; failure to hire.

Union County, Arkansas No. 92–1150 (W.D. Ark filed November 18, 1992)—age (46, 59, 63 and 69); constructive discharge.

Suits Resolved

B. ADEA

Airport Properties, Inc. No. 3–92–0299 (M.D. Tenn. filed March 30, 1992)—age (53); discharge; January 28, 1993 consent decree providing $15,906.65 in back pay, interest and liquidated damages for one individual, injunction prohibiting age discrimination.

Commerical Management d/b/a McMahon Properties, Inc. No. 92–2056 (W.D. Ark. filed March 18, 1992)—age (60); failure to promote; June 25, 1993 consent decree providing $13,290 in back pay for one individual, injunction prohibiting discrimination on the basis of age.

Harvey Industries, Inc. d/b/a Harve Engineering and Manufacturing Corporation No. 92–6003 (W.D. Ark. filed January 9, 1992)—age (61), retaliation; failure to hire; November 5, 1992 consent decree awarding $47,127.40 in back pay for one individual.

MIAMI DISTRICT OFFICE

Miami filed 26 lawsuits, including 9 subpoena enforcement actions, in fiscal year 1993; of the suits filed on the merits, 13 were on behalf of an individual or individuals, and 4 on behalf of a class.

Of the suits filed on the merits, 12 were filed under Title VII and 5 under the ADEA.

Miami resolved 18 lawsuits, including 5 subpoena enforcement actions, in addition to 1 presuit settlement, in fiscal year 1993 and recovered $924,531.93 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

ABC Liquors, Inc. No. 93–679–CIV–ORL–22 (M.D. Fla. filed August 17, 1993)—age (72); discharge.

H.I. Development Corporation, Inc. No. 92–2797–CIV–MOORE (S.D. Fla. filed December 9, 1992)—age (62); discharge.

Humana Inc., d/b/a Humana Hospital-Daytona Beach No. 93–168–CIV–ORL–18 (M.D. Fla. filed March 9, 1993)—age (64); constructive discharge.

Ironhorse No. 93–8504–CIV–ZLOCH (S.D. Fla. filed September 30, 1993)—age (58); advertising, failure to hire.

Oil, Chemical and Atomic Workers International Union No. 93–464–CIV–ORL–22 (M.D. Fla. filed June 15, 1993)—class; age (68); denied opportunity to seek elective office in union.

Suits Resolved

B. ADEA

Aircraft Services International, Inc. No. 92–8063–CIV–ZLOCH (S.D. Fla. filed February 5, 1992)—breach of conciliation agreement; October 26, 1992 settlement agreement providing $5,000 in back pay for one individual and notice posting.

E.M.I. Entertainment World, Inc., a Delaware Corporation, f/k/a SBK Entertainment World, Inc. No. 90–1764–CIV–MARCUS (S.D. Fla. filed June 25, 1990)—age (64); discharge; April 15, 1993 consent decree and settlement agreement providing $500,000 in back pay and liquidated damages for one individual.

Newham Plastering, Inc. No. 90–942–CIV–ORL–18 (M.D. Fla. filed December 17, 1990)—age (64); discharge; October 22, 1992 judgment providing $254,445.87 in back pay, interest and liquidated damages for one individual.

Quail Creek Country Club, Inc. No. 90–119–CIV–FTM–99 (M.D. Fla. filed May 2, 1990)—retaliation; discharge; November 20, 1992 consent decree providing $42,500 in back pay and liquidated damages for one individual, reinstatement, injunction against retaliation, reporting requirements, and notice posting.

Steinmart, Inc. No. 92–93–CIV–ORL–22 (M.D. Fla. filed January 27, 1992)—age (53); failure to hire; February 4, 1993 adverse jury verdict.

MILWAUKEE DISTRICT OFFICE

Milwaukee filed 15 lawsuits in fiscal year 1993; all suits were filed on the merits—13 were filed on behalf of an individual or individuals, and 2 were filed on behalf of a class.

Of these, 9 were filed under Title VII, 6 were filed under the ADEA.

Milwaukee resolved 17 lawsuits in fiscal year 1993 and recovered $464,288.92 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

Hartz Foods, Inc. No. 4–93–476 (D. Minn. filed May 10, 1993)—age (59); discharge.

K-Mart Apparel Corporation No. 3–92–727 (D. Minn. filed October 27, 1992)—age (44), retaliation; failure to promote.

Northwest Airlines, Inc. and Airline Pilots Association, International (Rule 19 defendant) No. 3–93–547 (D. Minn. filed August 19, 1993)—class; age (50 and over); failure to hire.

Royal Insurance Company No. 4–92–CV1030 (D. Minn. filed October 22, 1992)—age (58); transfer, discharge.

Svedala Industries, Inc. f/k/a Boliden Allis, Inc. and d/b/a Svedala, Inc. or Mineral Processing Systems, and Svedala, Inc. No. 93–C–1095 (E.D. Wis. filed June 2, 1993)—intervention; class; age (54 and older); involuntary retirement, constructive discharge.

Wendell's Inc. No. 4–92–1170 (D. Minn. filed December 2, 1992)—age (56); discharge.

Suits Resolved

B. ADEA

City of Minneapolis No. 4–92–84 (D. Minn. filed January 27, 1992)—age (59), retaliation; harassment, hostile working environment; April 6, 1993 consent decree providing $3,221.84 in back pay and compensatory damages for one individual.

LaCrescent School District No. 300 No. 4–91–861 (D. Minn. filed October 29, 1991)—age (55); failure to hire; May 20, 1993 consent decree providing injunctive relief.

Northome/Industrial Independent School District No. 363 No. 5–92–19 (D. Minn. filed February 3, 1992)—age (60), retaliation; failure to hire; April 8, 1993 consent decree providing $30,000 in full back pay for one individual.

Wendell's Inc. No. 4–92–1170 (D. Minn. filed December 2, 1992)—age (56); discharge; February 9, 1993 consent decree providing $40,000 in back pay, interest and liquidated damages for one individual.

C. Title VII/ADEA

White Castle System, Inc. No. 4–9–973 (D. Minn. filed December 10, 1991)—age (41), retaliation; failure to hire; December 21, 1992 consent decree providing $4,000 in back pay for one individual.

NEW ORLEANS DISTRICT OFFICE

New Orleans filed 15 lawsuits, including 6 subpoena enforcement actions and 5 recordkeeping/reporting violations, in fiscal year 1993; of the suits filed on the merits, 3 were on behalf of an individual or individuals, and 1 was on behalf of a class.

All suits on the merits were filed under Title VII.

New Orleans resolved 13 lawsuits, including 4 subpoena enforcement actions and 3 reporting violations, in fiscal year 1993 and recovered $37,363.67 in monetary benefits for victims of employment discrimination.

NEW YORK DISTRICT OFFICE

New York filed 28 lawsuits, including 4 subpoena enforcement actions, in fiscal year 1993; of the suits filed on the merits, 19 were on behalf of an individual or individuals, and 5 on behalf of a class.

Of the suits filed on the merits, 11 were filed under Title VII, 1 under the Americans with Disabilities Act, and 12 were filed under the ADEA.

New York resolved 28 lawsuits, including 4 subpoena enforcement actions, in fiscal year 1993 and recovered $1,349,235.09 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

American International Group and Morefare Estates No. 93–CV–6390 (S.D.N.Y. filed September 13, 1993)—age (45 and 54); discharge.

Amherst Central School District No. 93–CIV–0326 (W.D.N.Y. filed April 12, 1993)—age (46); failure to hire.

Commonwealth of Massachusetts No. 92–12622Y (D. Mass. filed November 2, 1992)—class; age (over 60); discharge.

Doremus & Company No. 93–CIV–3169 (S.D.N.Y. filed May 11, 1993)—age (58); discharge.

Ethan Allen, Inc., Ethan Allen Furniture Orleans Division No. 92–327 (D. Vt. filed October 26, 1992)—age (64); discharge.

HMK Enterprises, Inc. No. 92–12583 (D. Mass. filed October 27, 1992)—age (54); discharge.

Jack Sherman Toyota, Inc. No. 93–CV–807 TJM (N.D.N.Y. filed June 21, 1993)—age (58); discharge.

Johnson & Higgins, Inc. No. 93–CV–5481 (S.D.N.Y. filed August 5, 1993)—class; age (60 and 62); mandatory retirement.

Kidder Peabody & Company Inc. No. 92–9243 (S.D.N.Y. filed December 23, 1992)—class; age (over 40); discharge.

New York State; New York State Division of State Police No. 93–CV–0477A (W.D.N.Y. filed June 1, 1993)—class; age (over 40); failure to permit taking of examination.

New York City Health & Hospitals Corporation No. 93–CV–6818 (S.D.N.Y. filed September 29, 1993)—age (59); discharge.

The New York Cherokee Corporation No. 92–CIV–8800 (S.D.N.Y. filed December 8, 1992)—age (56, 73 and 75), retaliation; discharge.

Suits Resolved

A. Title VII

B. ADEA

AMF, Inc. and Minstar, Inc. No. 88–1050 (W.D.N.Y. filed September 29, 1988)—age (45); layoff; December 21, 1992 settlement agreement providing $125,000 in back pay for one individual.

City of Medford Department of Public Works No. 91–12824K (D. Mass filed October 30, 1991)—age (65 and 66); advertising, failure to hire; March 11, 1993 consent decree providing $83,610.05 in back pay for two individuals, reinstatement and posting of corrective notices.

Consolidated Edison Company No. 92–CIV–5951 (S.D.N.Y. filed August 7, 1992)—class; age (49); terms and conditions of employment; March 5, 1993 settlement agreement whereby defendant ceased policy of requiring medical exams (stress test) as condition of employment for individuals age 40 and above.

First Northern Mortgage Corporation No. CV–91–3925 (E.D.N.Y. filed October 8, 1991)—age (61), retaliation; discharge; March 29, 1993 default judgment providing $24,108.79 in back pay for one individual.

Monroe County, Office of County Attorney No. CV–90–0652L (W.D.N.Y. filed June 25, 1990—age (53); discharge; May 5, 1993 consent decrees providing $10,000 in back pay for an individual.

National Football League (NFL) No. 91–CIV–5447 (91–C–1289 and 91–C–2135) (S.D.N.Y. filed August 13, 1991)—class; age (60); terms and conditions of employment, demotion, involuntary transfer, involuntary retirement; February 18, 1993 consent decree providing $235,000 for three individuals.

Plymouth Lamston Stores Corporation No. 92–CIV–2793 (S.D.N.Y. filed April 17, 1992)—age (65); transfer, discharge; February 8, 1993 court order upheld by bankruptcy court providing $168,566.38 in back pay for one individual.

The Institute of Electrical and Electronics Engineers, Inc. No. 92–CIV–0867 (S.D.N.Y. filed February 4, 1992)—age (63); discharge; May 12, 1993 consent decree providing $62,500 in back pay for one individual.

C. Title VII/ADEA

Async Corporation No. 92–CIV–2790 (S.D.N.Y. filed April 20, 1992)—age (42), race (black); failure to hire; May 4, 1993 consent decree providing $55,000 in back pay for one individual.

PHILADELPHIA DISTRICT OFFICE

Philadelphia filed 40 lawsuits, including 9 subpoena enforcement actions in fiscal year 1993; of the suits filed on the merits, 29 were on behalf of an individual or individuals, and 2 on behalf of a class.

Of the suits filed on the merits, 16 were filed under Title VII, 14 under the ADEA and 1 under Title VII and the Equal Pay Act.

Philadelphia resolved 28 lawsuits, including 8 subpoena enforcement actions, in addition to 1 presuit settlement, in fiscal year 1993, and recovered $538,529.65 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

Braddock Medical Center No. 93–0990 (W.D. Pa. filed June 23, 1993)—retaliation; denial of reinstatement, failure to rehire.

Children's Hospital No. 93–1613 (W.D. Pa. filed September 30, 1993)—class; age (65 and over); terms and conditions of employment.

CIC Corporation/Runyon Music, Inc. No. 93–1524 (WGB) (D.N.J. filed April 7, 1993)—class; age (70 and 79); involuntary retirement, discharge.

Citizens First National Bank of New Jersey No. 93–1229 (D.N.J. filed March 22, 1993)—age (61); discharge.

Equitable Resources No. 93–1478 (W.D. Pa. filed September 3, 1993)—age (53); failure to promote.

Famous Supply Company a/k/a The Famous Manufacturing Company No. 93–0698 (W.D. Pa. filed May 7, 1993)—age (62); discharge.

Insurance Company of North America (Cigna Companies) No. 93–CV–3476 (E.D. Pa. filed June 29, 1993)—age (48); layoff, failure to rehire.

M.H. Detrick Company No. 93–1569 (MTB) (D.N.J. filed April 13, 1993)—age (49); discharge.

Martin Oil Company No. 93–72J (W.D. Pa. filed March 8, 1993)—age (43); permanent layoff.

MECO International, Inc. No. 93–1319 (W.D. Pa. filed August 10, 1993)—age (47); discharge.

Medical Center of Ocean County No. 92–4352 (CSF) (D.N.J. filed October 8, 1992)—retaliation; discharge.

Neward Board of Education No. 93–4360 (MTB) (D.N.J. filed September 30, 1993)—age (52); harassment.

The Equitable Life Assurance Society of the United States No. 92–CV–5215 (JHR) (D.N.J. filed December 4, 1992)—retaliation; discharge.

Westinghouse Electric Corporation No. 93–0581 (W.D. Pa. filed April 13, 1993)—age (60); involuntary retirement.

Suits Resolved

B. ADEA

Concurrent Computer Corporation No. 92–219 (MLP) (D.N.J. filed January 10, 1992)—age (47); discharge; August 17, 1993 summary judgment in favor of defendant.

General Electric Company No. 92–CV–1120 (E.D. Pa. filed February 25, 1992)—age (57); discharge; September 9, 1993 settlement agreement providing reinstatement for one individual.

Hugin Sweda, Inc. No. 90–2648 (JAP) (D.N.J. filed July 5, 1990)—age (40 and 53); layoff; October 8, 1992 settlement agreement providing $200,000 in back pay for two individuals.

ITT Avionics Division, ITT Corporation No. 92–793 (MTB) (D.N.J. filed February 20, 1992)—age (60); discharge; July 10, 1993 order granting summary judgment to defendant.

Pope & Talbot WIS, Inc. No. 3:CV–92–1122 (M.D. Pa. filed August 18, 1992)—age (62); failure to hire; January 22, 1993 settlement agreement providing $17,690.14 in back pay for one individual.

Southeastern Pennsylvania Transportation Authority No. 92–CV–3927 (E.D. Pa. filed July 7, 1992)—class; age (40 and over); failure to hire; July 26, 1993 settlement agreement providing $37,500 in back pay and reinstatement for one individual.

The Equitable Life Assurance Society of the United States No. 92–CV–5215 (JHR) (D.N.J. filed December 4, 1992)—retaliation; discharge; August 9, 1993 settlement agreement providing $12,500 in back pay for one individual.

PHOENIX DISTRICT OFFICE

Phoenix filed 26 lawsuits, including 2 subpoena enforcement actions, in fiscal year 1993; of the suits filed on the merits, 17 were on behalf of an individual or individuals, and 7 on behalf of a class.

Of the suits filed on the merits, 19 were filed under Title VII, 3 under the ADEA, and 2 under Title VII and the ADEA.

Phoenix resolved 19 lawsuits, including 4 subpoena enforcement actions, in addition to 3 presuit settlements, in fiscal year 1993 and recovered $251,157.89 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

California Micro Devices Corporation No. 93–1024 PHX SMM (D. Ariz. filed June 1, 1993)—age (62); layoff, discharge.

T&J Jewelry, Inc. No. CIV92–1948 PHX EHC (D. Ariz. filed October 19, 1992)—age (65 and 68); wages, discharge.

Bell Gas, Inc. No. CIV92–1320 JP (D.N.M. filed November 18, 1992)—age (69); discharge.

C. Title VII/ADEA

JB's Restaurants, Inc. No. 93–0773–S–C (D.N.M. filed June 24, 1993)—age (60), race (black); failure to promote, terms and conditions of employment, constructive discharge.

SER, Jobs for Progress, Inc. No. CIV92–0968 HB (D.N.M. filed August 24, 1993)—age (63), sex (female); failure to promote.

Suits Resolved

B. ADEA

Albuquerque Publishing Company No. 90–0258 M (D.N.M. filed March 14, 1990)—age (67); discharge; July 13, 1993 settlement agreement providing $15,000 in back pay and interest for three individuals.

Bell Gas, Inc. No. CIV–92–1320 JP (D.N.M. filed November 18, 1992)—age (69); discharge; June 11, 1993 consent decree providing $10,482.73 in back pay and interest for one individual and notice posting.

T&J Jewelry, Inc. No. CIV–92–1948 PHX EHC (D. Ariz. filed October 19, 1992)—age (65 and 68); wages, discharge; July 30, 1993 consent decree providing $15,250 in back pay and interest for two individuals.

SAN ANTONIO DISTRICT OFFICE

San Antonio filed 21 lawsuits in fiscal year 1993; all suits were filed on the merits—18 were filed on behalf of an individual or individuals, and 3 were filed on behalf of a class.

Fourteen cases were filed under Title VII, 5 under the ADEA, 1 under Title VII and the ADEA, and 1 under Title VII and the Equal Pay Act.

San Antonio resolved 13 lawsuits in fiscal year 1993 and recovered $91,332.51 in monetary benefits for victims of employment discrimination.

B. ADEA

Conquest Airlines Corporation No. A–93–CA–402JN (W.D. Tex. filed July 7, 1993)—age (46); failure to hire, recordkeeping violation.

Electrolux Corporation/Electrolux, Inc. No. EP–92–CA–342(B) (consolidated with No. EP–92–CA–144(B) filed May 8, 1992) (W.D. Tex. filed November 6, 1992)—age (63); layoff.

KGBT–TV, L.P. NO. B–93–177 (S.D. Tex. filed August 31, 1993)—age (67), retaliation; discharge.

Union Carbide Chemicals & Plastics Company, Inc. No. V–92–058 (S.D. Tex. filed November 12, 1992)—age (49); failure to hire.

Winns Stores, Inc. No. SA–892–CA–1210 (W.D. Tex. filed December 31, 1992)—age (74); harassment, constructive discharge.

Electrolux Inc./Electrolux Corporation Nos. EP–92–CA–144(B) and EP–92–CA–342(B) (W.D. Tex. filed May 8, 1992 and November 6, 1992)—age (62); terms and conditions of employment, layoff; March 1, 1993 consent decree providing $22,500 in back pay for one individual.

County of Hidalgo No. M–92–078 (S.D. Tex. filed April 7, 1992)—age (66); discharge; October 22, 1992 consent decree providing $9,000 in back pay for one individual.

Winn's Stores, Inc. No. SA–92–CA–1210 (W.D. Tex. filed December 2, 1992)—age (74); constructive discharge; March 22, 1993 consent decree providing $134.79 in back pay for one individual.

SAN FRANCISCO DISTRICT OFFICE

San Francisco filed 10 lawsuits in fiscal year 1993; all suits were filed on the merits - 8 were filed on behalf of an individual or individuals, and 2 were filed on behalf of a class.

Eight cases were filed under Title VII, 1 under the ADEA, and 1 under Title VII and the Equal Pay Act.

San Francisco resolved 14 lawsuits, in addition to 1 presuit settlement, in fiscal year 1993 and recovered $1,866,179.24 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

Naismith Dental Corporation No. C–93–0134–WHO (N.D. Cal. Filed January 13, 1993)—age (70); discharge.

American Airlines, Inc. No. C–92–20477–SW (N.D. Cal. Filed July 28, 1992)—age (59); failure to hire; April 21, 1993 settlement agreement providing $15,000 in back pay and liquidated damages for one individual.

Grumman Systems Support Corporation No. C–92–2273MHP (N.D. Cal. Filed June 17, 1992)—age (52); failure to hire; February 24, 1993 consent decree providing $60,000 in back pay and liquidated damages for one individual.

Loftin Associates, Inc. d/b/a Ormsby House Hotel/Casino No. CV–N–90 593–H DM (D. Nev. filed December 21, 1990)—age (62); discharge, failure to rehire; November 13, 1992 consent decree providing $30,000 in back pay for one individual.

Naismith Dental Corporation No. C–93–0134 WHO (N.D. Cal. filed January 13, 1993)—age (70); discharge; May 18, 1993 settlement agreement providing $32,500 in back pay and liquidated damages for one individual.

See also, below, Transworld Placement, Inc. d/b/a Interplace.

C. Title VII/ADEA

Transworld Placement, Inc. d/b/a Interplace No C–91–0694–SAW (N.D. Ca. filed March 11, 1991)—class; race, sex, national origin, age; recordkeeping violation; failure to refer for employment, failure to hire; October 5, 1992 consent decree providing comprehensive injunctive relief with recordkeeping and reporting requirements, $2,000,000 settlement fund which includes a back pay distribution of an estimated $1,420,000 to 3,271 class members, $35,000 in back pay and liquidated damages for two individuals, and $100,000 in compensatory damages for members of a class of African Americans represented by a private intervenor.

Aeronautical Radio, Inc. and ARINC Inc. No. 92–00364 SPK (D. Hawaii filed June 8, 1992)—age (59); sex (male); failure to promote; May 24, 1993 settlement agreement providing $35,556 in back pay for one individual.

SEATTLE DISTRICT OFFICE

Seattle filed 15 lawsuits in fiscal year 1993; all suits were filed on the merits—14 were filed on behalf of an individual or individuals, and 1 was filed on behalf of a class.

Fourteen cases were filed under Title VII and 1 under the ADEA.

Seattle resolved 18 lawsuits in fiscal year 1993 and recovered $590,182.16 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

Pape' Lift, Inc. d/b/a Hyster Sales Company No. 93–11RE (D. Or. filed January 4, 1993)—age (60); discharge.

Cashmere Valley Bank No. CS–92–0136–WFN (E.D. Wash. filed March 30, 1992)—age (65); mandatory retirement; October 19, 1992 consent decree providing $50,000 in back pay, interest, benefits and liquidated damages for one individual, as well as posting, internal complaint procedure, management training and reports for three years on training and compliance.

Ratelco Properties Corp. d/b/a Ratelco, Inc. No. 92–636–WD (W.D. Wash. filed April 15, 1992)—age (59); failure to hire; January 25, 1993 settlement agreement providing $30,000 in back pay for one individual, establishment of policy prohibiting age discrimination, internal complaint procedure, supervisory training and notice posting.

Wyeth-Ayerst Laboratories No. C91–1620 Z (W.D. Wash. filed November 20, 1991)—age (57); terms and conditions of employment; June 23, 1993 consent decree providing $17,500 in back pay for one individual.

ST. LOUIS DISTRICT OFFICE

St. Louis filed 22 lawsuits, including 3 subpoena enforcement actions and 1 reporting/recordkeeping violation, in fiscal year 1993; of the suits filed on the merits, 12 were on behalf of an individual or individuals, and 6 on behalf of a class.

Of the suits filed on the merits, 11 were filed under Title VII, 6 under the ADEA, and 1 under Title VII and Equal Pay Act.

St. Louis resolved 21 lawsuits, including 1 subpoena enforcement action, in addition to 4 presuit settlements, in fiscal year 1993 and recovered $20,997,108.40 in monetary benefits for victims of employment discrimination.

Suits Filed

B. ADEA

ANR Freight Systems, Inc. No. 4:92CV002041GFG (E.D. Mo. filed October 8, 1992)—age (59); discharge, failure to rehire.

Hettich Manufacturing, L.P. No. 93–0517–CV–W–1 (E.D. Mo. filed May 26, 1993)—age (54 and 58); failure to reassign, layoff.

McDonnell Douglas Corporation No. 4:93CV00526 (E.D. Mo. filed March 1, 1993)—class; age (55 and over); layoff, involuntary retirement.

Normandy School District No. 4:93CV001413–ELF (E.D. Mo. filed June 16, 1993)—age (52); discharge, failure to rehire.

Pea Ridge Iron Ore Company, Inc. No. 4:93CV001413–ELF (E.D. Mo. filed June 16, 1993)—age (52); discharge, failure to rehire.

Synergy Gas Corporation No. 93–0758–CV–W–3 (W.D. Mo. filed August 10, 1993)—age (61); discharge.

C. Title VII/Equal Pay Act

Signet Graphic Products, Inc. No. 4:92CV002373ELF (E.D. Mo. filed November 25, 1992)—class; sex (female); wages.

B. ADEA

Caruthersville Shipyard, Inc. No. 4:92CV01008 (E.D. Mo. filed May 27, 1992)—age (72); discharge; May 28, 1993 settlement agreement providing $35,000 in back pay and interest for three individuals.

City of St. Louis Employee Retirement System Board of Trustees, et al. No. 91–2003–C–7 (E.D. Mo. filed September 30, 1991)—class; age (60 and over); pension benefits; February 1, 1993 consent decree providing $443,355.68 in back pay and pension enhancement for 38 individuals.

Golf Discount of St. Louis, Inc. No. 4:92CV00767 (E.D. Mo. filed April 23, 1992)—age (54); failure to hire, recordkeeping violations; November 25, 1992 consent decree providing $13,008.45 in back pay, pre-judgment interest and liquidated damages.

Hettich Manufacturing, L.P. No. 93–0517–CV–W–1 (W.D. Mo. filed May 26, 1993—age (54 and 58); failure to reassign, layoff; September 15, 1993 consent decree providing $160,000 in back pay, front pay, and liquidated damages for two individuals.

McDonnell Douglas Corporation No. 4:93CV00526 (E.D. Mo. filed March 1, 1993)—class; age (55 and over); layoff, involuntary retirement; August 12, 1993 consent decree providing $20,100,000 in back pay and pension enhancement for approximately 940 class members.

Normandy School District No. 4:93CV01433 JCH (E.D. Mo. filed June 17, 1993)—age (59); failure to promote; August 16, 1993 consent decree providing $14,044.62 in back pay and liquidated damages for one individual.

Plattner's Modern Department Stores, Inc. No. 4:92CV00836 (E.D. Mo. filed April 30, 1992)—age (40 and 56), retaliation; reduced severance benefits, discharge; January 22, 1993 consent decree providing $14,500 in back pay and liquidated damages for three individuals.

ITEM 19. FEDERAL COMMUNICATIONS COMMISSION

We are pleased to report that we have expanded our outreach to recruitment activities. Through our contacts within organizations such as Forty Plus of Greater Washington we have been successful in employing several individuals who have brought great breadth of experience to the FCC.

ITEM 20. FEDERAL TRADE COMMISSION

STAFF SUMMARY OF FEDERAL TRADE COMMISSION ACTIVITIES AFFECTING OLDER AMERICANS—1994 REPORT

This report discusses the Federal Trade Commission's activities of particular significance for older consumers in fiscal year 1994. The first section of the report describes activities relating to the health concerns of older consumers. Older consumers in general experience more health problems and therefore may be more vulnerable to injury from anticompetitive conduct in health care markets or from misleading claims made about the health related benefits of a product or service. The second section discusses Commission law enforcement activities of particular importance to older consumers in other areas. The final section of the report addresses the Commission's relevant consumer education initiatives that may benefit the elderly. The report also includes discussion of some calendar year 1994 developments that fall within fiscal year 1995.

HEALTH RELATED ACTIVITIES

While health care is a subject of concern for all of our citizens, it is of disproportionate concern to the aging. A substantial portion of the Commission's antitrust law enforcement activity is aimed at ensuring that competition among providers of health care goods and services is not unlawfully impaired. This activity contributes both to cost containment and to the maintenance of quality in health care. Similarly, a significant portion of the Commission's consumer protection work helps to ensure that consumers are not harmed by false or deceptive claims for health related benefits of various products or services.

ANTITRUST GUIDANCE TO PRIVATE ACTORS

Last year's report noted that the rapid evolution of health care markets, in response to pressures for cost containment, had created concerns that uncertainty about the impact of antitrust enforcement in this sector might impede efficient, procompetitive combinations and collaborations. In response to these concerns, the Commission and the Department of Justice Antitrust Division had jointly issued, in September 1993, their Statements of Antitrust Enforcement Policy in the Health Care Area. These statements defined "antitrust safety zones" for health care activity in various areas; these "safety zones" identified conduct that will not be challenged, absent extraordinary circumstances, by the agencies. Additionally, for conduct falling outside these "safety zones," the statements explained how the agencies will analyze the conduct to determine its legality. Finally, the statements highlighted the availability of Commission advisory opinion and Justice Department Antitrust Division business review procedures and, for the first time, adopted time limits for agency answers to most health industry requests.

Subsequently, in September 1994, the Commission and the Antitrust Division issued updated and expended Statements of Enforcement Policy. The new statements include policies covering three new areas, and expand the "antitrust safety zones" for several others. As with the 1993 statements, the new and updated policy guidelines are intended to clarify what health care providers *can* do together with little or no antitrust risk.

One of the new statements describes a rule-of-reason framework for analyzing hospital joint ventures formed to provide specialized clinical or other expensive health care services such as open-heart surgery. This statement does not include an antitrust safety zone because the agencies felt they did not yet have enough experience with such joint ventures to define one.

Another new statement covers the collective provision of fee related information by health care providers to purchasers of health care services. A safety zone is available if: (1) The collection of the information is managed by a third party; (2) any information that is shared among competing providers is at least 3 months old—although information provided only to purchasers may be current; and (3) information shared among the providers aggregates data for at least five providers, with no individual provider's data representing more than 25 percent of the reported statistic on a weighted basis, and the aggregation of data is such that recipients cannot identify the prices charged by any individual provider.

The third new statement covers multiprovider networks, which may include providers that otherwise compete, as well as providers offering complementary or unrelated services. One example is a physician-hospital organization. A wide variety of such networks are beginning to appear, and they may present vertical as well as horizontal antitrust issues. Because such organizations are relatively new, again the agencies determined that they lack the experience needed to define a safety zone. Therefore, the policy statement is limited to a description of the framework within which such ventures will be analyzed.

The new statements also broaden the safety zone for physician network joint ventures that are nonexclusive, because they are less likely to foreclose competition than exclusive joint ventures, and broaden some other provisions as well. In the attempt to flush out the policy statements in the context of concrete facts, Commission staff has provided substantial guidance in the form of advisory opinions analyzing proposed ventures on a case-by-case basis.

HEALTH CARE REGULATION

The staff of the Commission continued in 1994 to monitor restraints imposed by existing or proposed regulations and actions that could raise costs to consumers by reducing competition in the health care industry without providing countervailing benefits to consumers. As part of the Commission's competition advocacy program,[1] Omission staff testified before the Vermont legislature on a proposal to exempt certain cooperative agreements among health care providers from antitrust oversight. Staff testified that such a proposal runs a risk of encouraging or permitting agreements that could reduce choices of and raise prices for health care services.

ANTITRUST LAW ENFORCEMENT IN THE HEALTH CARE SECTOR HOSPITAL MERGERS

As in other industries, the Commission challenges only those mergers that it has reason to believe are likely to have anticompetitive results, and it seeks a remedy that is carefully tailored to eliminate only the anticompetitive part of the transaction while allowing the remainder to proceed.

In 1994, the Commission initiated new enforcement actions against eight hospital mergers. The Commission authorized the staff to seek a preliminary injunction against four: Sisters of Charity Health Care Systems/Parkview Episcopal Medical Center; HealthTrust Inc./Holy Cross Health Services of Utah; Lee Memorial Hospital/Cape Coral Hospital; and Port Huron Hospital/Mercy Hospital. The Sisters of Charity/Parkview transaction was abandoned, and no complaint was filed. The HealthTrust/Holy Cross transaction was resolved with a consent agreement before a complaint was filed. With respect to Lee Memorial, the Commission challenged the acquisition by a municipal hospital of its only significant competitor. The parties claimed that the acquisition was immunized under the State action doctrine by a State statute that permitted the hospital to acquire property. Although the district court and a panel of the Eleventh Circuit Court of Appeals accepted that argument, the transaction was abandoned and the hospital was purchased by an entity that did not raise competitive problems. The Port Huron case is still pending resolution at this time.

In addition, the Commission issued a final consent order involving Columbia Healthcare Corporation's acquisition of HCA Hospital Corporation of America. This case in particular demonstrated the Commission's sharply focused approach to antitrust remedies. These two multi-hospital chains owned 87 and 72 hospitals respectively. When they proposed to merge, the Commission, after surveying some 17 local overlaps, remained concerned only about the overlap in the area of Augusta, Georgia. As part of a settlement agreement the two firms agreed to divest the HCA hospital in that market. The Commission did not challenge other aspects of the merger.

[1] Staff advocacy comments and testimony are authorized by the Commission but are not substantively approved by the Commission and do not necessarily reflect the views of the Commission or any individual Commissioner.

The Commission also accepted and made final a consent order in connection with Columbia/HCA Healthcare Corp.'s subsequent acquisition of Medical Care America, Inc. The consent order requires the divestiture of an outpatient surgical center in Anchorage, Alaska.

Near the end of 1994, the Commission accepted for public comment two more consent agreements in hospital merger cases. In Charter Medical Corporation's acquisition of National Medical Enterprise's psychiatric facilities, Charter agreed to modify its purchase agreement to delete acquisition of the NME facilities in four geographic markets—Atlanta, Memphis, Orlando, and Richmond—in which the Commission alleged that the acquisition would substantially lessen competition in the psychiatric care market. The second such consent agreement held particular significance for aging citizens. In the merger of HEALTHSOUTH Rehabilitation Corporation, the Nation's leading operator of rehabilitation hospitals and other rehabilitation facilities, totaling about 240 in 34 States, with ReLife Inc., which operates more than 40 rehabilitation facilities in 12 States, HEALTHSOUTH agreed to divest a hospital in one market and to terminate management contracts to operate rehabilitation units at hospitals in two other markets. The Commission alleged that competition in rehabilitation services would otherwise be substantially reduced in these markets.

Finally, in Adventist Health System, a case that was litigated before the Commission and discussed initially in last year's report, the Commission heard the matter on appeal from a decision by an administrative law judge and dismissed the complaint after finding that the evidence developed at trial did not support complaint counsel's geographic market definition.

PHYSICIAN CONDUCT

During 1994, the Commission accepted one consent agreement for public comment and issued one final consent order in cases alleging anticompetitive joint conduct by physicians. The Commission accepted and made final a consent order with Trauma Associates of North Broward, Inc., and 10 surgeons in Broward County, Florida, settling charges that they illegally conspired to fix the fees they were paid for their services at the trauma centers at two area hospitals. The Commission alleged that when the North Broward Hospital District refused to meet the group's unlawful joint demands, the surgeons staged a walkout, forcing one of the centers to close. The order requires the dissolution of Trauma Associates within 180 days, and, prior to its dissolution, Trauma Associates is required to give copies of the settlement to any entity with whom it has entered into contract negotiations for trauma surgical services since its inception. In addition, the order prohibits the surgeons from entering into any agreements of the type at issue in the future.

In the other case, the Commission accepted an agreement with the medical staff of Good Samaritan Regional Medical Center in Phoenix, Arizona. The agreement was to settle charges that the staff members conspired to boycott, or threaten to boycott, the hospital, to include it to end its ownership interest in the Samaritan Physicians Center, a multi-specialty physicians' clinic that would have competed with the medical staff. Under the agreement, members of the medical staff would be prohibited from agreeing, or attempting to agree, to prevent or restrict the services offered by Good Samaritan, the Samaritan Physicians Center, or any other health care provider.

MERGERS IN MANUFACTURE AND DISTRIBUTION OF PHARMACEUTICALS AND MEDICAL DEVICES

It has been reported that the roughly 13 percent of our population over the age of 65 consumes more than a third of all prescription drugs dispensed, and that this percentage is increasing. This report confirms that the pharmaceutical and medical device industries have disproportionate impact on older citizens. The Commission was quite active during 1994 in the role of protecting competition in this area, focusing on oversight of merger activity in both the manufacturing and distribution sectors.

In the manufacturing sector, Roche Holding Ltd.'s proposed acquisition of Snytex Corp. raised concerns in the market for drug abuse testing products. A consent order issued in 1994 requires Roche to divest the Syntex subsidiary engaged in that market. The Commission also took action in 1994 regarding the acquisition of Rugby-Darby Group by Marion Merrell Dow, Inc., which eliminated competition between the only two FDA-approved producers of dicyclomine, a medication used in the treatment of irritable bowel syndrome. The final consent order requires Marion to license its dicyclomine formulations and production technology to a third party. In addition, the consent order requires Marion to contract-manufacture dicyclomine

for that third party while that party awaits FDA approval to sell its own dicyclomine.

The Commission accepted for comment a consent agreement with the American Home Products Corporation (AHP), settling charges that its $9.7 billion acquisition of American Cyanamid Company (Cyanamid) could substantially lessen competition in the U.S. market for tetanus and diptheria vaccines, for certain biotechnology drugs used in treating cancer, and for research for a vaccine to treat rotavirus, a diarrheal disease that causes thousands of children's deaths annually. Under the agreement, AHP would divest its tetanus and diptheria vaccine business to a Commission-approved buyer, and manufacture the vaccines for the buyer, under contract, while the buyer awaits Food and Drug Administration approval to manufacture them. In addition, AHP would license Cyanamid's rotavirus vaccine research to a Commission-approved licensee and provide the licensee with certain technical assistance. The order would also require that AHP change a previously-established licensing agreement to assure that it does not obtain competitively-sensitive data about a class of drugs used in chemotherapy.

In early December, the Commission accepted for comment a consent agreement with Wright Medical Technology, Inc., to settle charges that Wright's proposed acquisition of Orthomet, Inc., would eliminate potential competition in the market for the sale of orthopaedic implants used in human hands. In addition, the Commission alleged that actual competition between the companies in research and development for such implants would be eliminated. The proposed settlement would restore competition by requiring Wright to transfer to the Mayo Foundation, the licensor of the implant technology to Orthomet, a complete copy of all assets relating to Orthomet's business of researching and developing these implants, enabling the Mayo Foundation either to find another nonexclusive license in addition to Wright, or to grant an exclusive license to an entity other than Wright.

Also, in late December, the Commission accepted for comment a consent agreement to settle charges arising from the planned acquisition of Zenith Laboratories by IVAX Corporation. The two companies are the only marketers of a generic drug used to treat patients with chronic cardiac conditions—verapamil in the extended-release form—in the U.S. market. Under the agreement, IVAX would be prohibited from acquiring any rights to market or sell the drug pursuant to Zenith's exclusive distribution agreement with G.D. Searle & Co. Separately, Zenith and Searle have terminated their agreement and Zenith has agreed to transfer its customers to Searle, or to a firm that Searle designates. The settlement would help to ensure that two independent competitors will remain in the market.

In November 1994, the Commission accepted for comment a consent agreement affecting competition at both the production and distribution levels of the pharmaceutical industry. Eli Lilly and Company agreed to settle Commission charges that its approximately $4 billion acquisition of McKesson Corporation and its prescription management business, PCS Health Systems, Inc., would substantially lessen competition in the manufacture and distribution of pharmaceuticals. The settlement would require Lilly to take steps, including the establishment of an open formulary, to ensure that Lilly drugs are not given unwarranted preference over those of its competitors in connection with the pharmacy-benefit management services Lilly will provide to health insurers and others as a result of the acquisition. Lilly also agreed to build a "fire wall" between its pharmaceutical sales business and PCS's pharmacy benefits management business to ensure that one division of the company does not gain access to sensitive information about competitors' drugs from another division.

The Commission challenged three mergers at the retail level to protect competition in the prescription pharmaceutical industry. In August, the Commission issued a final consent order in connection the TCH Corp.'s acquisition of the PayLess drug store chain. TCH already owned the Thrifty and Bi-Mart drug store chains. To resolve its competitive concerns, the Commission required the divestiture of drug stores in six towns. In the second case of that type, the Commission issued a final consent order in connection with Revco D.S., Inc.'s acquisition of Hook-SupeRx, Inc. That consent order required divestitures in three geographic markets. In the third such case, the Commission accepted for public comment a consent order that would resolve concerns over Rite Aid Corporation's acquisition of LaVerdiere's Enterprises, Inc. The consent order would require the divestiture of retail pharmacy assets in three towns.

CONSUMER PROTECTION IN HEALTH RELATED MATTERS—HEARING AIDS

In 1994, the Commission filed order-enforcement actions against two of the largest hearing-aid manufacturers in the United States. On January 25, 1994, the Commission filed a complaint charging Dahlberg, Inc., maker of the "Miracle-Ear" brand

of hearing aids, with violating a 1976 FTC order by making numerous allegedly false and unsubstantiated claims about its Miracle-Ear "Clarifier," purportedly a "noise-suppression" hearing aid. These claims included assertions that the Clarifier focuses its amplification on sounds the user wants to hear, such as speech, and reduces all unwanted background noise. The action against Dahlberg currently is in litigation. The Commission also obtained an $825,000 civil penalty as part of a settlement with Beltone Electronics Corporation, filed in court on December 20, 1994, resolving alleged violations of a 1976 FTC order. The alleged violations included false and unsubstantiated claims that Beltone's ClearVoice and Voice Enhancer hearing aids focus amplification on sounds the user wants to hear, such as speech, and do not amplify background noise.

HEALTH CLAIMS FOR FOOD AND DIETARY SUPPLEMENTS

Consumers rely on the truthfulness of health claims for food and dietary supplements when making purchasing decisions. Senior citizens, because of special dietary requirements or other health concerns, may be particularly vulnerable to misleading claims for such products. The Commission continues to be active in this area, and, since last year, it has taken several important steps.

In the administrative litigation against Stouffer Foods, the Commission upheld an administrative law judge's finding in 1993 that Stouffer's low sodium claims in advertisements for its "Lean Cuisine" line of frozen-food entrees were false and misleading. The Commission also approved final consent orders against Eggland's Best, Inc. (alleged claims that Eggland's eggs will not increase consumers' serum cholesterol, and that they are superior to regular eggs in this respect); Haagen-Dazs Company, Inc. (alleged low-fat and calorie claims for frozen yogurt products); and, Presto Food Products, Inc. (alleged misrepresentations about the amount of total fat or saturated fat in Mocha Mix and Mocha Mix Lite liquid nondairy creamer products). In addition, the Commission staff is actively investigating approximately 20 possible deceptive food advertisements.

In addition, in 1994, the Commission issued a food advertising enforcement policy statement which explained how the Commission would apply its laws to food advertising in light of the Nutritional Labeling and Education Act of 1990 and the food labeling regulations promulgated by the Food and Drug Administration (FDA) and the Department of Agriculture to implement that legislation. The enforcement policy statement describes how the Commission will harmonize its advertising enforcement policy with the requirements of other agencies responsible for food labeling in order to provide a consistent Federal approach to food advertising and labeling regulation.

In the area of dietary supplements, the Commission filed an administrative complaint against Metagenics, Inc., challenging allegedly exaggerated osteoporosis prevention and bone rebuilding claims for its calcium supplement; entered a settlement with RN Nutrition regarding similar claims for the same product; and accepted a consent agreement with Bee-Sweet, Inc., regarding advertising claims that the company's bee pollen products could treat several physical ailments including anemia, allergies, arthritis, and arteriosclerosis, as well as weight problems. Litigation with Schering Corporation over allegedly unsubstantiated weight loss and health benefit claims for its fiber supplement was also resolved through settlement. The Commission's complaint against National Dietary Research, challenging claims for purported weight loss and cholesterol reduction products, was withdrawn from adjudication pending approval of a consent agreement with the company.

In 1994, the Commission also charged General Nutrition Corporation (GNC), the largest retailer of nutritional supplements in the United States, with violating two previous Commission cease and desist orders by failing to substantiate claims of health benefits for more than 40 products. Included among the challenged representations were claims that GNC's nutritional supplements could cure, treat, prevent, or reduce the risk of developing diseases (including arthritis); would be of benefit in the prevention, relief or treatment of tiredness, listlessness, or fatigue; would assist in weight loss; or would prevent or retard hair loss. The Commission accepted a $2.4 million civil penalty (the largest ever obtained in a Commission advertising case) in a settlement with GNC. The GNC case was closely followed by a $1.4 million settlement with L & S Research Corp. for allegedly deceptive claims regarding weight-loss and muscle-building products.

The Dietary Supplement Health and Education Act of 1994 was enacted in October. As with the Nutrition Labeling and Education Act of 1990, this law applies only to the labeling, not advertising of supplements. Within its own statutory mandate, however, the FTC will maintain a consistent enforcement policy, just as it has done in the area of food advertising.

OVER-THE-COUNTER DRUGS AND MEDICAL DEVICES

Senior citizens rely heavily on the truthfulness of advertising claims for over-the-counter (OTC) drugs and medical devices. While the Commission has primary responsibility for ensuring that advertising for these products is truthful and non-deceptive, the FDA exercises primary jurisdiction with respect to the labeling of such products and their safety.

Pursuant to a stipulated permanent injunction involving vision-improvement claims for "pinhole" eyeglasses, including claims that wearing Vision Clear Glasses can effectively cure or correct any vision problem, a consumer redress program has made $425,000 available to purchasers of these devices. The Commission has also accepted a consent agreement with Olsen Laboratories settling charges regarding arthritis-treatment claims made in infomericials for a product entitled "Eez-Away Relief." During the last year the Commission issued a final consent order against the remaining individual respondent in Synchronal, Corp., which was charged with making unsubstantiated claims in infomercials for a baldness remedy and a cellulite reduction product. A redress program in the Synchronal case has made $3.5 million available to consumers who purchased these products.

Finally, FTC staff has worked closely with the staff of the FDA in considering the nature of appropriate claims for drugs that may be "switched" from prescription to OTC status. The FDA is in the process of evaluating certain drugs that have been available only with a prescription to determined whether they are appropriate for OTC availability—for consumers to use without the supervision of a health care professional. As the switch of such drugs is approved and they become available to consumers without a prescription, the FTC assumes primary responsibility for ensuring the accuracy of their advertising. In order to maximize the Commission staff's ability to evaluate claims for switched products, a few FTC employees have been designated to attend both public and non-public FDA advisory committee meetings on drugs being considered for switch to OTC status.

DIET AND WEIGHT LOSS PRODUCTS AND SERVICES

Older consumers invest heavily in the weight loss industry. The Commission has continued to be active in this area, and has taken numerous actions involving weight loss clinics or programs. These cases include the settlements mentioned above with Schering Corp., GNC, L & S Research Corp., and Bee-Sweet, Inc., and the proposed consent agreement with National Dietary Research, all of which included purported weight loss products. The Commission has also obtained a permanent injunction against Silueta Distributors, which had advertised its cream and tablets through Spanish language commercials, claiming that the products would break down or eliminate cellulite or fat. Silueta also will pay $169,339 in consumer redress to purchasers of these products.

Many older consumers purchase services from diet clinics. In 1994, the Commission continued its investigations of national and regional weight loss programs, focussing on the extent to which these firms may have made unsubstantiated claims about the safety and success of their programs. In fiscal year 1994, the Commission issued final consent orders against three marketers of commercial low-calorie diet programs (Nutri/System, Diet Center, Inc, and Physicians Weight Loss Centers). These orders are in addition to six consent orders with very-low-calorie diet programs that the Commission issued in 1992 and 1993. In addition, the Commission filed for comment and later issued as final consent orders in three additional matters involving marketers of low-calorie diet programs (Doctors Medical Weight Loss Centers, Quick Weight Loss Centers, and Doctors Weight Loss Centers—Texas). The Commission's administrative complaints against Weight Watchers and Jenny Craig issued in 1993 remain in litigation.

The weight loss orders the Commission issued and each of the agreements accepted for comment set out detailed requirements for substantiation and disclosure when weight loss and weight loss maintenance success claims are made. The core requirements of these orders contain the obligation, when claims of successful maintenance are made, to include—factural disclosures of the average weight loss maintained; how long program participants have maintained the loss; the representatives of the successful participants in terms of the overall participant population; and a statement that "For many dieters, weight loss is temporary." In addition, the orders with the very-low-calorie diet companies contain requirements that safety claims be accompanied by a disclosure that physician monitoring is necessary to minimize the potential for health risks.

Furthermore, many of these orders contain additional requirements that the companies warn customers about the importance of adhering to the diet protocol and consuming all of the food prescribed to avoid health consequences associated with

rapid weight loss; that testimonials used in advertising for these programs either be representative of the results generally realized from participation in the program or, if not, be properly qualified in a clear and prominent manner as to the limited applicability of the experience of the consumer used in the testimonial; and that claims as to the price of these programs not fail to reveal any other mandatory costs.

NON-HEALTH RELATED ACTIVITIES

FUNERAL SERVICES

The Commission's Funeral Rule increases consumer access to accurate information about prices, options, and legal requirements before consumers make funeral arrangements. The Commission has filed 42 enforcement actions charging violations of the rule since the rule became effective in 1984. The Commission filed four such actions during fiscal year 1994. In one case involving a Houston, Texas, company that markets insurance-funded, pre-need funeral arrangement plans nationwide, the Commission alleged violations of both the Funeral Rule and of the FTC's Cooling Off Rule, which applies to door-to-door sales. In this instance, the FTC alleged that the company failed to provide consumers with general price lists and itemized statements of funeral goods and services selected, both of which are required by the Funeral Rule. In addition, the company typically made the sales presentation in the consumer's home but allegedly failed to provide consumers with a written notice regarding their cancellation rights, thus violating the FTC's Cooling Off Rule.

In addition to prohibitions against future violations of the rule, the consent agreements reached in most of these cases require payment of a civil penalty. The Commission obtained $178,000 in civil penalties paid pursuant to consent agreements files during 1994.

The Funeral Rule required the Commission to begin a reevaluation of the rule no later than 4 years after its effective date. That proceeding was completed in 1994, and the Commission promulgated an amended rule that: (1) retains the rule's primary itemization, price and other disclosure requirements, with only minor modifications; (2) expressly prohibits the imposition of any nondeclinable fees (such as so-called "casket handling fees" that sometimes have been charged when a casket is not purchased from the funeral director but instead from a third-party) in addition to the already permitted nondeclinable fee for basic services of funeral director and staff; (3) deletes the affirmative telephone disclosure that required funeral directors, in certain circumstances, to inform telephone callers that price information is available over the phone, while retaining the rule's existing obligation to give price and other information over the telephone to consumers who request it; and (4) makes a series of corrective changes designed to facilitate compliance and consumers' understanding of their rights under the rule. The amended rule became effective on July 19, 1994.

A funeral directors' group filed a petition for review of the amended Commission rule, challenging the most controversial amendment that prohibits providers from charging any nondeclinable fee in addition to the nondeclinable fee for services of funeral director and staff already permitted by the rule. That provision was designed to preclude so-called "casket handling fees" charged only to consumers who purchased caskets from third parties, such as cemeteries that sell caskets in competition with funeral homes, rather than from the funeral home. The amendment is important, because "casket handling" fees were being used by funeral directors to impede competition wherever third-party casket sellers tried to enter a market. The Third Circuit Court of Appeals upheld the amendment on October 17, 1994, and no further review of the decision was sought.

The Commission continues to review mergers and acquisitions in order to maintain competition in the funeral services and cemetery industry. Recently, the Commission accepted for public comment a consent agreement with Service Corporation International, the largest owner and operator of funeral homes and cemeteries in North America, to settle charges that SCI's proposed acquisition of Uniservice Corporation, the parent company of a group of funeral homes and cemeteries in Oregon and Washington, would substantially lessen competition for funerals and perpetual care cemetery services in and around Medford, Oregon. Under the settlement agreement, SCI would be permitted to acquire Uniservice but must keep all of the assets and operations of Uniservice's Medford facilities—two funeral homes, a cemetery, and a crematory—separate from its own until they can be sold to a buyer approved by the Commission. In addition, the proposed settlement would require SCI, for 10 years, to obtain FTC approval before acquiring any interest in funeral homes or cemeteries in Jackson County, Oregon.

Commission staff submitted comments on a Louisiana proposal that would prohibit removal of the body of a deceased person from the State unless it was first embalmed (or cremated). Staff concluded that the proposal would limit consumer choice and impair competition by requiring consumers to purchase services they neither need nor want and could increase the costs borne by residents of other States arranging funerals for their relatives who die in Louisiana. Staff also submitted comments to the Pennsylvania legislature on a bill that would require deposit into a trust fund of all or nearly all of the proceeds of pre-need sales of funeral and cemetery goods and services. Cautioning the legislature about the proposal, the staff of the Commission suggested allowing pre-need sellers to post a performance bond, under which a third-party guarantor would agree to pay the contract amount if the seller did not deliver at the time of need.

MAIL OR TELEPHONE ORDER MERCHANDISE

The Commission's Mail Order Rule requires sellers to make timely shipment of orders; give options to consumers to cancel an order and receive a prompt refund or to consent to any delay in delivery; have a reasonable basis for any promised shipping dates (the rule presumes a 30-day shipping date when no date is promised in an advertisement); and make prompt refunds. In issuing the original Mail Order Rule in 1975, the Commission noted that those consumers with mobility problems, including older consumers, frequently order by mail. During the proceeding to amend the rule to cover telephone sales, the American Association of Retired Persons (AARP) provided evidence indicating that a significant percentage of persons age 65 and older order products and services by telephone and, therefore, that the amendment would benefit its members. Amendments extending coverage of the rule to telephone sales became effective on March 1, 1994.

The Commission staff works closely with industry members and trade associations to obtain compliance with the rule, and it initiates law enforcement actions where appropriate. During 1994, the courts entered four consent decrees resolving alleged rule violations, resulting in judgments for civil penalties totalling $216,000.

In one of these cases, the Commission charged that the Haband Company, which directed advertising to older Americans in such publications as *American Legion, Modern Maturity,* and *Saving Social Security,* substituted merchandise materially different from that ordered without obtaining the consumers' prior consent, in violation of the rule. Although the company permitted consumers to return the merchandise at no cost, the company's substitution practices could be especially different for elderly consumers, who might be less willing or able to make returns than younger persons. The consent decree prohibits unauthorized substitutions and required the company to pay a $49,000 civil penalty.

USED CAR SALES

The Used Car Rule requires that used car dealers display "Buyers Guides" on the windows of their cars to tell consumers whether the vehicle comes with a warranty or is sold "as is." These warranty disclosure requirements can be of particular benefit to older consumers, who may be on fixed incomes and therefore need to purchase less expensive used cars and who also may be less able to meet sudden, unexpected repair expenses. In 1994, the Commission entered a consent decree against one used car dealer for rule violations, obtaining $20,000 in civil penalties. Investigations of other dealers are ongoing.

As part of its systematic review of all current Commission regulations and guides, the Commission requested public comments in 1994 on, among other things, the economic impact of and the continuing need for the rule; possible conflict between the rule and State, local or other Federal laws; and the effect on the rule of any technological, economic, or other industry changes. At the same time, the Commission also solicited comments on the impact of the rule on small businesses, as mandated by the Regulatory Flexibility Act, 5 U.S.C. § 601 *et seq.* The Commission will determine whether it should propose any changes to the rule following review of the comments that were received.

DOOR-TO-DOOR SALES

The Cooling-Off Rule requires that consumers be given a 3-day right to cancel certain sales occurring away from the seller's place of business (often known as "door-to-door sales"). In addition, the Commission, in some administrative cease and desist orders against companies engaged in door-to-door sales, has required companies to allow consumers the right to cancel purchases. The rule and these orders can particularly benefit older Americans who are retired and at home and who may be exposed more frequently to high pressure sales tactics by door-to-door or other sellers.

In December 1993, the court issued a consent order and judgment for a civil penalty of $10,000, against Lonnie Divine (doing business as Union Circulation Company), a national clearinghouse and a door-to-door seller of magazine subscriptions, to resolve alleged violations of the Cooling-Off Rule. In addition, the Commission is conducting litigation against Budget Marketing, Inc., a nationwide telemarketer of magazines, for alleged violations of an existing cease and desist order. The litigation arose from many complaints from elderly citizens who believed that they had been tricked into paying hundreds of dollars for multi-year magazine subscriptions. Other investigations are ongoing.

As part of its systematic review of all current Commission regulations and guides, the Commission requested public comments in 1994 on, among other things, the economic impact of and the continuing need for the Cooling-Off Rule; possible conflict between the rule and State, local or other Federal laws; and the effect on the rule of any technological, economic, or other industry changes. Comments from both buyers and sellers' representatives were submitted. All of the comments stated that the rule provides important protections for consumers and favored retaining the rule. AARP commented that the rule is especially needed to protect older consumers who are most vulnerable to unscrupulous door-to-door sellers. The Commission will determine whether it should propose any changes to the rule following its complete review of the comments that were received.

ENERGY COSTS

The cost of heating and cooling one's home can be especially burdensome to older consumers. Retired individuals, who tend to spend more time at home than working individuals, may have less opportunity to lower their home heating or cooling requirements during the day. In addition, the elderly, being more susceptible to hypothermia, are often counselled to maintain a higher temperature in their homes than younger persons might comfortably tolerate. Those on fixed incomes also may face greater relative economic burdens in meeting energy costs.

Property insulated homes can maintain more constant temperatures and can save consumers substantial amounts on heating and cooling costs. The Commission's R-value Rule assists consumers by requiring that sellers of insulation accurately disclose the "R-value," or insulating effectiveness, of such products. The rule also requires installers and new home sellers to give consumers a written disclosure of the type and R-value of the insulation installed; requires retailers to make specific information available at the point-of-sale to consumers who purchase insulation for do-it-yourself installation; and requires advertisers to include important disclosures in advertisements that contain specific claims. This rule will be reviewed during 1995, and its economic and other impact examined. Public comment will be sought.

The Commission also has investigated the accuracy of claims of the insulating effectiveness, known as "U-value," of windows and doors used in homes. Insulating effectiveness of such products is often determined by independent laboratories following government-approved test methods. State and local governments then use the U-value test results to determine if windows and doors comply with State and local building codes. The Commission filed a consent decree in Federal court in 1994, settling charges that an organization that sets test standards, including energy efficiency or U-value standards for windows, sliding glass doors skylights and similar products, had deceptively accredited a testing laboratory to test the energy efficiency of windows and similar products.

The Commission's Appliance Labeling Rule also enables consumers to reduce energy costs by requiring sellers to disclose the energy usage of major household appliances. The rule requires disclosure, based on standardized tests, of specific energy consumption, efficiency, or cost information for covered products in catalogs. It also requires information at the point-of-sale in the form of an "EnergyGuide" label or fact sheet, or in an industry directory. The labels include the energy consumption or efficiency figure, a range showing the highest and lowest energy consumption or efficiencies for all similar appliance models, and, at the bottom of the label for some products, the estimated annual operating cost of the appliance based on specified assumptions. Because energy-efficient appliances cost less to run over the life of the product, the rule enables those elderly consumers who may be on limited incomes to keep down monthly expenses for running major home appliances. Compliance with the rule is generally high, and the industry is largely self-policing through certification programs maintained by the several large trade associations that represent most manufacturers.

On October 1993, pursuant to the Energy Policy Act of 1992 ("EPA 92"), the Commission amended the Appliance Labeling Rule to include four plumbing products: showerheads, kitchen and lavatory faucets, water closets (toilets), and urinals. The

amended rule requires sellers to disclose the water-usage of these products in terms of both gallons and liters per flush, minute or cycle (except where the size of the product would make it impractical to include the metric measure). The information must be displayed both on the products themselves and on their packaging and labeling, as well as in catalog advertising point-of-sale promotional materials for them. The amendments took effect on October 25, 1994. The disclosures will assist purchasers in selecting replacement plumbing products that save money by reducing water consumption.

In May 1994, pursuant to EPA 92, the Commission also amended the Appliance Labeling Rule to include three categories of lamp products (light bulbs or tubes) in the rule—general service fluorescent, medium base compact fluorescent, and general services incandescent (including spot lights and flood lights). For the lamp products types most commonly used in the home, general service incandescent light bulbs and medium base compact fluorescent tubes, the rule requires that package labels clearly and conspicuously disclose: (1) light output, in lumens; (2) energy used, in watts; (3) design volts (if different from 120 volts); (4) average life, in hours; (5) the number of bulbs or tubes in the package; and (6) an Advisory Statement explaining how to select the most energy efficient lamp that meets the purchaser's needs. The purpose of these disclosures is to give consumers information they need to purchase the most energy efficient lamps that meet their needs. Although energy used in residences for lighting is relatively small in comparison to that used for heating and cooling, saving on unnecessary energy costs by using more efficient lighting products can be particularly important to those who are on fixed incomes. The amendments become effective in May 1995.

The Commission also has conducted investigations under its Fuel Rating Rule (formerly known as the Octane Rule), which establishes standard procedures for determining, certifying, and posting octane ratings on gasoline pumps. Accurate certification and posting of octane ratings deter distributors and retailers from deceptively selling lower octane fuel as higher octane fuel. This rule may benefit retired persons who have the time for leisure activities involving car travel, but who also may be on limited budgets. In 1994, the Commission obtained four consent decrees resolving alleged Fuel Rating Rule violations, which included a total of $287,500 in civil penalties. The Commission also continues to monitor performance claims for gasoline of a particular octane rating. In 1994, it approved a final consent agreement with Unocal Corp., and its advertising agency, Leo Burnett Co., requiring the company to mail a corrective notice to all Unocal credit card customers who had received bill inserts with challenged performance claims. Staff is investigating other marketers of gasoline as well, with regard to performance and environmental benefit claims.

Amendments to the Fuel Rating Rule, issued pursuant to EPA 92, became effective on October 25, 1993. The Commission adopted the amendments to include alternative liquid automotive fuels such as methanol and ethanol, among others. The amended rule requires sellers of alternative liquid automotive fuels to determine, certify, and post an "automotive fuel rating" consisting of the common name of the fuel along with a disclosure of the amount, expressed as a minimum percentage by volume, of the principal component of the fuel. Sellers are permitted to disclose other components, if they desire.

CREDIT FRAUD

Credit fraud continues to affect consumers of all ages and walks of life. However, it is particularly harmful to the elderly who generally live on fixed incomes, may be using credit to augment their income, and therefore, are more likely to be susceptible to credit scams.

Among other things, the Commission has taken action against fraudulent marketers of secured credit cards. In May 1993, the Commission filed a complaint charging American Standard Credit Systems and its officers with deceptively marketing secured Visa and MasterCard credit cards. According to the complaint, American Standard Credit Systems ran advertisements in Sunday newspapers throughout the country stating that anyone could receive a Visa or MasterCard credit card by calling "900" telephone numbers at a cost of $10 per call. However, the company failed to tell consumers that an application fee of $65 to $80 was required, that not everyone would be approved to receive a credit card, and if approved, each consumer would have to deposit at least $300 with the card issuer. As a result, the complaint alleged, many consumers who called the advertised "900" number either did not bother to apply for a credit card or were denied credit. Last year, the Commission's litigation ended successfully when the court granted summary judgment in favor of the Commission, and the individual defendants agreed to a $2 million judgment.

In December 1994, the Commission filed an action against 10 companies and four individuals for unfair practices in the selling of credit card numbers. The Commission charged these defendants with selling lists of consumers' credit card numbers to direct marketers, who in turn billed consumers' accounts without authorization. In January the court entered consent decrees banning these defendants from providing confidential credit card account information to third parties and requiring them to ensure that future clients for other credit-related lists do not engage in the same or similar practices. In addition, the defendants are required to pay a total of $292,000 in consumer redress.

In the past few years, the Commission also has worked closely with Federal and State law enforcement agencies to combat "advance-fee loan" scams. In these scams, companies "guarantee" loans to consumers in exchange for an advance fee, typically ranging from $100 to several hundred dollars. After taking consumers' money, the companies frequently disappear. In August 1994, the Commission filed a complaint against Southland Consultants alleging that the company promised that consumers who paid $189 were guaranteed to receive a loan, whereas in fact, numerous consumers neither received the promised loans nor were given refunds. In January of this year, the defendants agreed to pay up to $100,000 in consumer redress to settle the Commission's charges.

The Commission continues to bring enforcement actions against credit repair companies that promise to "clean up" consumers' bad credit histories. In addition, in November 1994, the Commission hosted a Credit Repair Summit with Federal, State, and local law enforcement agencies, credit bureau representatives, and public interest groups to invigorate local law enforcement efforts and find alternatives to case-by-case enforcement by the Federal Government against the countless small operators in the field.

DEBT COLLECTION

Each year the Commission receives thousands of consumer complaints regarding harassing and abusive behavior by debt collectors. Often these letters come from the elderly. In March of this year, Payco American Corporation ("Payco"), one of the Nation's largest debt collection agencies, agreed to pay a $500,000 civil penalty to settle allegations that it violated the Fair Debt Collection Practices Act ("FDCPA"). The Commission's lawsuit, filed in August 1993, charged, among other things, that Payco illegally revealed consumer debts to third parties; used obscene or profane language; telephoned debtors at times and places known to be inconvenient to the consumers being contacted; and made several misrepresentations to consumers. In addition to the $500,000 civil penalty, the settlement prohibits Payco from violating the FDCPA in the future, and requires the company to give notice to all employees who are responsible for debt collection that they may be held liable individually if they are found to be violating the FDCPA.

INVESTMENT FRAUD

Investment frauds frequently victimize the public through false promises of large returns on "safe" investments. While these frauds harm all investors, they can also particularly hurt older investors, who are vulnerable to fraudulent operators and often ill-prepared to recoup the losses. Some investment fraud firms have bilked individual consumers of $5,000 to $20,000 or much more by promising large returns for investments in art works, motion picture film cels, gold mines, gemstones, precious metals, rare coins, oil and gas leases, cellular telephone licenses, or wireless cable licenses and partnerships. These firms usually employ telephone room salespersons who use high-pressure, polished sales pitches.

In fiscal year 1994, the Commission filed eight cases in Federal district court involving such schemes. In all of these cases, the Commission secured preliminary or permanent orders halting the challenged conduct.

In addition to the cases filed, the NAAG–FTC Telemarketing Complaint System, which is maintained by the Commission, has been used by Federal and State law enforcement agencies to identify potential scams and file actions against fraudulent telemarketers. For example, the data base has been cited as the source of information used to obtain the criminal indictment of 42 individuals and companies by the Postal Inspection Service and the U.S. Attorney in Pittsburgh, Pennsylvania. The charges involved gemstone investment scams, many of which were directed to the elderly, individuals and entities located outside the United States but selling to U.S. citizens.

OTHER TELEMARKETING FRAUD

The Commission continues its enforcement actions against fraudulent telemarketers. Many of these cases involved the sale of goods and services of special interest to older consumers, including prize contests, credit opportunities, health products, deceptive charity solicitations, and various home products.

The Commission also combines its efforts with those of various State and other Federal agencies to combat telemarketing fraud. The Commission has worked closely with State attorneys general, the U.S. Postal Service, the FBI, and other law enforcement agencies in bringing actions against fraudulent telemarketers. Another example of this concerted Federal/State effort is the series of regional conferences on telemarketing fraud which the Commission began in 1993. During 1994 regional conferences were held in Atlanta, Chicago, Dallas, Boston, Cleveland, Seattle, and Los Angeles. These conferences included city and State prosecutors, State attorneys general, regional Postal Inspectors, offices of the regional U.S. Attorneys, the Federal Bureau of Investigation, and others. Each of the meetings produced a specific agenda for organized and coordinated approaches to investigating and prosecuting Telemarketing in the region.

Because many of the telemarketers that target American consumers are actually located in other countries, the Commission has begun to address the globalization of telemarketing fraud. For example, in September 1994, the Commission and Canada's Bureau of Competition Policy co-sponsored a conference in Ottawa for officials at the Federal, provincial, and local levels who are concerned with fraudulent telemarketing in North America.

PRIZE PROMOTIONS

The elderly frequently are victimized by prize promotion schemes, where telemarketers either make unsolicited calls or mail notification cards to consumers stating that they have won a valuable prize, such as a vacation, car, cash, or jewelry. Promotional sweepstakes are the most numerous single category of complaints in the NAAG/FTC Telemarketing Fraud Database.

Last year, the Commission filed suit in district court against Gem Merchandising Corporation and its principals. The Commission charged Gem with operating a nationwide telemarketing operation that sells a medical alert system and other merchandise by fraudulently promising to consumers that they would receive an award such as a $10,000 cashier's check, a "vacation," a big screen television, or a $2,500 cashier's check if they purchased the product. In fact, Gem allegedly misrepresented the value of the prizes and the likelihood that consumers would receive a particular prize. In addition, the promised "vacation" was actually a vacation voucher that required the consumer to pay substantial sums to purchase minimum stays at selected hotels and pay additional surcharges if they wanted to travel during peak or holiday seasons. The case is still in litigation.

The Commission also obtained settlements in the lawsuits that had been filed early in 1993 against other clusters of telemarketing companies. Sierra Pacific Marketing, Inc., and S.E.C. Enterprises, Inc., as well as their principals and related companies, had been charged with falsely representing to consumers that they had won valuable prizes, and then using a variety of misrepresentations to persuade the consumers to purchase vitamins, "environmentally safe" cleaning products, water purifiers, and other products. The defendants allegedly used techniques particularly successful with elderly consumers. These techniques included placing repeated calls to those who initially declined to purchase. In some cases, calls were made on a daily or weekly basis or even several times in an hour. Moreover, consumers allegedly were threatened with legal action when they tried to cancel an order. In February 1994, the Commission obtained $1 million in redress from Sierra Pacific and in April, another $900,000 from S.E.C. Enterprises. In addition, several of the principals were permanently banned from participating in, or assisting others to run, prize promotion businesses.

In 1994, the Commission also filed suit against Nishika, Ltd., a Nevada telemarketing firm charged with operating a deceptive prize promotion scheme, in which consumers were "guaranteed" to win a valuable prize, such as a new car, $1,250 or more in cash, a television/stereo system, or a vacation travel package. However, in order to receive the prize, the consumer had to authorize a "one time" charge of up to $700 on their credit cards. Consumers later received merchandise that was often of limited value, along with their prize, which in almost all cases, was a vacation voucher that contained a number of onerous conditions and additional costs. Nishika allegedly misrepresented the value of the merchandise and prizes, as well as the likelihood that the consumer would receive a specific prize. The case is still in litigation.

"RECOVERY ROOM" OPERATIONS

The past year has also seen an increase in "recovery room" scams. These so-called recovery rooms contact consumers who have been victims of prior telemarketing scams, most often sweepstakes schemes which particularly target the elderly. The pitch typically used by recovery room telemarketers makes reference to the consumer's prior victimization, sympathetically warns the consumer not to fall for unscrupulous telemarketing schemes again, and then falsely represents that, for an upfront fee, the recovery room will assist the consumer in obtaining a refund of the amount the consumer initially lost. In fact, the recovery room is simply bilking consumers one more time and will not engage in any such "recovery" efforts on their behalf.

During 1994, the Commission filed several cases involving such recovery rooms. For example, in October 1994, the Commission filed a case in federal district court against Refund Information Services, a Nevada-based telemarketing company that allegedly preyed on elderly consumers who had previously lost money to fraudulent sweepstakes or prize-promotion promoters. The company and its principals were charged with misrepresenting that they could recover lost money for consumers and that they had a successful record in recovering money for consumers. The defendants also were charged with misrepresenting a connection with Government authorities, such as the Federal Trade Commission. Consumers paid fees ranging from $200 to as much as $800 for the defendants' services, but allegedly got nothing of value in return. The case is still in litigation.

"TELEFUNDING" SCAMS

Another increasingly popular fraudulent scheme that strikes the elderly is deceptive "telefunding." Legitimate telefunders raise funds for bona fide charities through telephone solicitation campaigns. Fraudulent or deceptive telefunders, however, raise funds for themselves or for nonexistent or phony charities, although sometimes they may use the names of bona fide charities in their solicitations. The Commission has brought a number of cases in Federal district court challenging allegedly deceptive telefunding. In these cases, often the telemarketers entice consumers with the promise of extravagant prizes in return for a donation to the purported charity.

In one case, consumers throughout the country donated as much as $3,500 each in response to a "telefunding" scheme operated by Regeneration & Renewing, Inc. d/d/a AWARE, and 18 other defendants based primarily in Las Vegas. The FTC complaint alleged that the defendants combined false statements that consumers would receive valuable prizes with falsehoods about the charitable activities the donations would support. The defendants also allegedly misrepresented the need to make a donation in order to receive a prize and the tax deductibility of the contributions. The case is still pending.

The case involving AWARE illustrates the Commission's "root" approach to combating telemarketing fraud, in which the FTC maximizes its resources by targeting not only boilerrooms, but also by charging the "root" defendants who provide the support network that supplies products, prize inducements, proven deceptive sales pitches, lists of consumers, and access to a credit-card payment system or some other similar means of obtaining payment. In the AWARE investigation, the compliant also named several defendants who allegedly helped promote the scheme by providing donor leads, customer service support or cheap prizes.

In another telefunding case, Heritage Publishing Company, an Arkansas for-profit company that raises funds on behalf of charitable organizations, agreed to pay $200,000 to settle FTC charges that it misrepresented the percentage of donations that go to nonprofit entities and misrepresented that funds would be earmarked for activities in the donors' own localities.

WORK-AT-HOME SCHEMES

Many consumers, including the elderly, are looking for opportunities to increase their income, often by working at home. During 1994, the Commission brought a number of cases involving companies that misrepresented the amount of income consumers could expect to earn. In one action, the FTC filed suit in Federal district court against an Illinois company, Pase Corporation, alleging that the company and its principals had used deceptive advertisements and mailings in connection with several of their work-at-home business opportunities. Among those business opportunities were a program that offered consumers payment for tabulating and forwarding to the company responses to classified ads in local papers, a program promising to pay for compiling and typing names and addresses, and a program offering payment for responses to postcards mailed on behalf of the defendants. In early

1995, two of the individual defendants agreed to pay $16,400 collectively to settle the FTC charges. The case is still pending against the remaining defendants.

"900" NUMBERS

The Telephone Disclosure and Dispute Resolution Act of 1992 directed the Commission to promulgate rules governing the advertising and operating of 900-number (or pay-per-call) services, as well as billing and collection procedures for these services. The FTC's 900-Number Rule became effective on November 1, 1993. The rule requires cost and other disclosures in advertisements for 900 numbers and in preambles to pay-per-call services costing more than $2. Callers who hang up within 3 seconds of a signal or tone indicating the conclusion of the preamble cannot be charged for the call. The rule prohibits the use of 800 numbers (or other toll-free numbers) for pay-per-call services. In addition, the rule requires certain disclosures for billing statements for 900-number calls and establishes procedures for the correction of billing errors.

Since the rule became effective, the Commission staff has closely monitored compliance with its requirements. In 1994, the Commission brought its first action alleging violations of the 900-Number Rule. The complaint alleged that American TelNet, Inc., illegally used 800 numbers for pay-per-call services, then billed unwary consumers and businesses for calls made from their phones to psychic and sex lines. The FTC also charged that American TelNet illegally referred callers to 800 numbers to international or 900 numbers without making proper price disclosures. American TelNet agreed to pay $2.5 million as part of the settlement agreement.

PROPOSED TELEMARKETING SALES RULE

In August 1994, Congress passed the Telemarketing and Consumer Fraud and Abuse Prevention Act, 15 U.S.C. § 1601 *et seq.* This Act requires the Commission to promulgate regulations: (1) defining and prohibiting deceptive and abusive telemarketing acts or practices; (2) prohibiting telemarketers from engaging in a pattern of unsolicited telephone calls that a reasonable consumer would consider coercive or an invasion of privacy; (3) restricting the hours of the day and night when unsolicited telephone calls may be made to consumers; and (4) requiring disclosure of the nature of the call at the start of an unsolicited call made to sell goods or services. The statute expressly authorizes the Commission to include within the rule's coverage entities that "assist or facilitate" deceptive telemarketing practices, including credit card laundering. Moreover, the statute authorizes State law enforcement officials to enforce the rules issued by the Commission. The Act requires the Commission to finalize the Telemarketing Rule by August 16, 1995.

CONSUMER EDUCATION ACTIVITIES AFFECTING OLDER CONSUMERS

The Commission, through its Office of Consumer and Business Education, is involved in preparing and distributing a variety of consumer publications and broadcast materials. Many of the subjects are of significant interest to older consumers.

1994 EDUCATION ACTIVITIES

In 1994, the Commission in conjunction with the National Association of Attorneys General (NAAG) and the American Association of Retired Persons (AARP) conducted a multi-media campaign on Telephone Scams and Older Consumers. The campaign describes some common telephone scams, tells consumers what they can do to protect themselves, and where to go for more help and information. The television audience for this campaign was projected at 3 million, and the radio audience was estimated to be 21 million. The Commission distributed 72,000 copies of the brochure in the last 3 months of FY 1994.

Another brochure, "Telemarketing: Reloading and Double-Scamming Frauds," was prepared in cooperation with Call For Action (CFA), an international, nonprofit consumer hotline which operates in conjunction with radio and television broadcasters. The brochure explains that consumers who have lost money to a fraudulent telemarketer can expect to have that same or another telemarketer try to take advantage of them again. It also explains how such scams work, what precautions consumers can take to avoid becoming a victim, and where to go with a complaint about a telemarketer. More than 45,000 copies of the brochure were distributed in 1994.

The FTC, in cooperation with the Direct Marketing Association and AARP, updated "Shopping by Phone or Mail" to reflect revisions to the FTC Mail or Telephone Order Merchandise Rule. The brochure explains how the rule covers goods ordered by mail, telephone, computer, and fax machine. It also explains consumer protections under the Fair Credit Billing Act when consumers pay by credit card. Since

its original release in 1975, more than 344,000 copies of the brochure have been requested.

In 1994, the Commission also produced "Invention Promotion Firms." The brochure tells consumers how to spot some common signs of trouble, how to protect themselves, and what to do if they are victimized by an unscrupulous invention promotion firm. More than 55,000 requests for this publication have been filled.

The FTC worked with the American Academy of Ophthalmology, the National Association of Optometrists and Opticians, and the Opticians Association of America to produce a brochure called, "Eye Wear." It explains consumer rights under the Prescription Release Rule and provides information about various types of eye care professionals. It also gives some suggestions about selecting an eye care specialist and shopping for eye exams, eyeglasses, and contact lenses. The FTC distributed 27,000 copies of the brochure in 1994.

The Commission, in cooperation with the American Bar Association's Public Education Division, produced "Credit and Divorce." This brochure explains what action consumers who have recently been through a divorce, or are contemplating one, may want to take concerning credit issues. It specifically discusses individual and joint accounts and users on accounts, listing the advantages and disadvantages of each. More than 21,000 copies of the publication were requested in 1994.

"Varicose Vein Treatments" was prepared with technical assistance from the American Venous Forum. The brochure defines varicose and spider veins, who gets them, what causes them, and the available treatments to eliminate them. More than 63,000 copies of the brochure have been distributed by the Commission.

ONGOING EFFORTS AGAINST TELEMARKETING SCAMS AND OTHER FRAUDS

"Sweepstakes Scams: When Winners Lose Money," warns consumers about fraudulent telemarketers who pose as representatives of major sweepstakes. The brochure advises consumers to use caution if they are told to pay money before delivery of an item, or provide a credit card number to claim a prize. The brochure stresses that legitimate sweepstakes do not require consumers to pay anything to collect a prize. The FTC has distributed more than 55,000 copies of the publication since its release in late 1993.

"900 Numbers: New Rule Helps Consumers" describes the legal protections consumers have under the Telephone Disclosure and Dispute Resolution Act and the FTC 900-Number Rule. The brochure also tells what to watch for in 900 numbers and what consumers should do if caught in a 900-number scam. In 1994, the publication was translated into Spanish. Nearly 70,000 copies of the English and Spanish versions were distributed in 1994.

"Telephone Investment Fraud" explains how this type of fraud works, describes a typical sales pitch, and offers tips to help consumers avoid losing their money. The brochure also lists government agencies and business organizations that register, investigate, or monitor companies and individuals who offer investment opportunities. Since its release in 1987, the Commission has filled more than a quarter of a million requests for the publication in English and Spanish.

"Prize Offers," produced in cooperation with Call for Action, discusses promotions that use deceptively-advertised prizes, advises consumers how to avoid being victimized, and suggests how to handle complaints. Since its release in 1983, the Commission has distributed nearly 358,000 copies of the brochure.

The FTC also continued to distribute existing brochures concerning various aspects of telemarketing fraud. Over the past 6 years, for example, the Commission has filled requests for more than half a million copies of publications, such as "Magazine Telephone Scams," "Scams by Phone," and "Telemarketing Travel Fraud."

INFORMATION ABOUT OTHER CONSUMER SERVICES AND PRODUCTS

The Commission also continues its efforts to provide information about other kinds of marketplace services and products that could be of special importance to older consumers.

"Personal Emergency Response Systems (PERS)," prepared in cooperation with AARP, explains the electronic device that assists persons in summoning help in an emergency. The publication describes how a PERS works and what to consider when shopping for a system. The brochure also discusses purchasing, renting, and leasing options. The FTC has distributed nearly 18,000 copies of the brochure since its release in 1993.

"How to Take the Scare Out of Auto Repair" is the print component of a multimedia education campaign conducted by the Commission in conjunction with NAAG and the American Automobile Association (AAA). The booklet provides tips on selecting a good technician, helps consumers ask the right questions, identifies com-

mon vehicle troubles, and explains how consumers can better handle any problem that might arise with their autos. NAAG, AAA and the FTC are distributing the booklet, and the Commission alone has distributed more than 76,000 copies of the publication since its release in late 1993. This campaign also included the production and distribution of a video news release by satellite to television stations, and radio public service announcements to 425 radio stations nationwide.

"Fire Detectors" explains two types of detectors—smoke detectors and heat detectors—and briefly discusses home sprinkler systems. "Negative Option Plans for Books, Records, Videos . . ." describes how negative option plans work, explains consumers' rights under the FTC's Negative Option Rule, and suggests things to consider before consumers subscribe to such plans. The Commission has filled more than 100,000 orders for these two publications since their release in 1991.

FUNERALS

During 1994, the Commission continued its educational efforts with regard to funeral goods and services. "Caskets and Burial Vaults" discusses the uses of these items and protective claims that may be made about them. It mentions the option of pre-planning a funeral and lists organizations to contact for additional information. Consumers have requested more than 42,000 copies of the brochure since 1992.

"Funerals: A Consumer Guide" continues to be a popular brochure. It explains the Funeral Rule and lists business, professional, and consumer groups that provide information on how to make funeral arrangements and the available options. During 1994, the FTC filled requests for 29,000 copies of the brochure, bringing total distribution since 1984 to more than half a million copies.

HEALTH

"Facts About Weight Loss Products and Programs" is the print component to a cooperative multi-media effort with NAAG and the Food and Drug Administration. The brochure provides information to help consumers avoid weight-loss scams, encourages consideration of the costs and consequences to dieting decisions, and offers sensible weight maintenance tips. Since its release in 1992, the Commission has filled more than 87,000 consumer requests. The joint effort also sponsored a video news release, sent to television stations by satellite, and radio public service announcements, sent to 500 radio stations and networks nationwide.

"Food Advertising Claims" provides information to help consumers interpret fat, "no" or "low" cholesterol, and "light" claims in food advertising and labeling. The publication was translated into Spanish in 1994. Nearly 14,000 copies of the English and Spanish versions were distributed in 1994.

During 1994, the Commission continued its distribution of two health-related publications produced in cooperation with AARP. "Hearing Aids" describes the two basic types of hearing loss: conductive an sensorineural. It also offers purchase suggestions for hearing aids and outlines Federal and State standards for their sale. "Healthy Questions" explains how to select and use the services of health care professionals. The Commission filled more than 22,000 requests for these publications in 1994.

The Commission's own consumer brochure, "Health Claims: Separating Fact from Fiction," addresses specific aspects of health fraud. The FTC has distributed more than 200,000 copies of this brochure in English and Spanish since its release in 1986.

HOUSING

"Getting a Loan: Your Home as Security" explains the "right of rescission" under the Federal Truth in Lending Act. The right of rescission gives consumers 3 business days to reconsider personal loan agreements when they use their principal home as security. Since its release in 1981, the FTC has filled nearly 200,000 requests.

The Commission continues to distribute other housing-related brochures that may be of special interest to older consumers: "Real Estate Brokers" and "How to Buy a Manufactured Home," produced with the Manufactured Housing Institute.

EDUCATION ABOUT CREDIT AND FINANCIAL MATTERS

"Secured Credit Card Marketing Scams" explains the differences between a secured and unsecured credit card, describes how marketing scams are used to sell secured credit cards, and tells how to recognize and avoid deceptive credit card offers. It also lists some organizations that offer additional consumer credit informa-

tion and assistance. More than 45,000 consumers have requested the publication since its release in late 1993.

During 1994, the Commission continued to distribute credit publications that may be especially useful to widows and older persons who may have difficulty obtaining credit. "Women and Credit Histories" explains two Federal laws—the Equal Credit Opportunity Act (ECOA) and the Fair Credit Reporting Act—that give consumers specific rights to help protect their credit histories and make it easier to get credit. Since the brochure was released in 1978, nearly 423,000 copies have been distributed.

"Credit and Older Americans," produced in 1987, explains the anti-age-discrimination provisions of the ECOA. Since its release, nearly a quarter of a million copies have been distributed.

"Credit Repair Scams," a brochure and video news release produced by the FTC in cooperation with NAAG, warns consumers about fraudulent credit repair companies that claim, for a fee, they can erase bad credit and remove bankruptcy and liens from credit files. The brochure and video tell consumers how to spot credit repair scams, what information is in a credit report, and how consumers can correct mistakes themselves. The FTC has filled nearly 180,000 requests for this publication in English and Spanish.

Other credit publications that may be useful to the elderly include: "Fix Your Own Credit Problems," "Lost or Stolen: Credit and ATM Cards," and "Buying and Borrowing: Cash in on the Facts." "Fix Your Own Credit Problem" is a how-to publication that also cautions consumers about credit repair clinics. The FTC has distributed more than half a million copies of this publication in English and Spanish during the last seven years. "Lost or Stolen: Credit and ATM Cards," which discusses card-holder liability in the event of such loss, has been distributed to more than 290,000 consumers since 1987. "Buying and Borrowing," a summery of information about buying on credit, layaway, and by phone and mail, has been distributed to more than 135,000 consumers over the past 7 years.

During 1994, the Commission continued its print education campaign on financial issues. "Reverse Mortgage," prepared in cooperation with AARP and the National Center for Home Equity Conversion, explains how reverse mortgages work for consumers who are house-rich and cash-poor. More than 155,000 copies of this publication have been disseminated since its release in 1991.

In 1990, the FTC and AARP produced "Facts About Financial Planners." This booklet provides information to help consumers decide if they need a financial planner and offers guidelines for selecting a good planner. The publication also lists sample questions to ask a planner during the initial interview. Nearly 198,000 copies of the booklet have been distributed.

The FTC and AARP also developed "Money Matters." This booklet explains how to select and use the professional services of lawyers, accountants, financial planners, real estate brokers, and tax preparers. The Commission has filled more than 80,000 requests for the publication since its release in 1986.

CONCLUSION

This report reviews Commission programs that may be of particular concern to older consumers and their families. Through the combination of law enforcement and consumer education described above, the Commission strives to ensure a vigorous, fair, and competitive marketplace for all consumers.

ITEM 21.—GENERAL ACCOUNTING OFFICE

GAO's work in aging reflects the continuing importance of Federal programs for older Americans. The Census Bureau has estimated that there are over 33 million older Americans today, and, by the year 2020, that number will exceed 53 million. Because the elderly are one of the fastest growing segments of today's society, the Congress faces many issues involving income security and health policy in which the Federal Government will play an important role. These issues range from demographic changes affecting the traditional structure and role of the family to financing and provision of health care, long-term care, Social Security, and pensions.

Our work during fiscal year 1994 covered a range of issues, including Federal Government activities in employment, health care, housing, income security, and veterans' issues. Some Federal programs such as Social Security and Medicare are directed primarily at older Americans. Other Federal programs target older Americans as one of several groups served, such as Medicaid or Federal housing programs. We have organized the summaries of our fiscal year 1994 reports and related products accordingly.

In the appendixes, we describe four types of GAO activities that relate to older Americans:

Reports on policies and programs directed primarily at older Americans (see app. I),

Reports on policies and programs that affect older Americans as one of several target groups (see app. II),

Congressional testimonies on issues related to older Americans (see app. III), and

Ongoing work on issues related to older Americans (see app. IV).

The issues addressed by these products and ongoing work are presented in table 1. The table shows that health and income security were the leading issues addressed among reports focused primarily on older Americans. Health and veterans were the leading issues that affected both older Americans and other groups.

TABLE 1: GAO ACTIVITIES RELATING TO THE ELDERLY IN FISCAL YEAR 1994

Issue	Reports focused on the elderly	Reports with elderly as one of several target groups	Testimonies	Ongoing work as of 9/30/94
Employment	0	2	0	0
Health	16	20	13	26
Housing	0	7	1	0
Income Security	10	6	8	8
Social Services	3	1	0	0
Veterans	0	17	5	21
Other	1	6	1	0
Total	30	59	28	55

Appendix I provides summaries of 30 issued reports on policies and programs directed primarily at older Americans. We include in this section reviews of health, income security, social services, and other issues.

Appendix II provides summaries of 59 reports in which older Americans were one of several target groups for specific Federal policies. Many of these policies are generally financed in conjunction with services to other populations. For example, Medicaid finances nursing homes and other types of long-term care, as well as medical care for poor persons of all ages.

Appendix III describes 28 testimonies given during fiscal year 1994 on subjects focused on older Americans. We testified most often on health issues.

In appendix IV, we have listed 55 studies related to older Americans that were ongoing as of September 30, 1994.

APPENDIX I—FISCAL YEAR 1994 GAO REPORTS ON ISSUES PRIMARILY AFFECTING OLDER AMERICANS

During Fiscal Year 1994, GAO issued 30 reports on issues primarily affecting older Americans. Of these, 16 were on health, 10 on income security, 3 on social services, and 1 on other issues.

HEALTH ISSUES

Health Insurance for the Elderly: Owning Duplicate Policies Is Costly and Unnecessary (GAO/HEHS–94–185, Aug. 3, 1994)

Owning multiple health insurance policies to supplement Medicare is both costly and unnecessary. GAO estimated that about 3 million elderly Medicare beneficiaries paid about $1.8 billion in 1991 for policies that probably involved duplicate coverage. Many of these people had supplemental coverage through employer-sponsored plans. About 500,000 other Medicare beneficiaries who were also eligible for Medicaid because of limited incomes spent about $190 million on unnecessary supplemental insurance. Although retirees with employer-sponsored coverage generally do not need to buy a Medigap policy, many employers with retiree health plans are increasing cost-sharing or tightening eligibility requirements. Such changes may make an employer-sponsored plan less attractive. In addition, the employer may terminate the plan. Federal Medigap requirements provide a one-time "open season" for people to buy Medigap insurance, regardless of health status, within 6 months of enrolling in Medicare part B. If a retiree's employee-sponsored plan is changed or canceled

after the open season, the retiree has lost the guaranteed access to a Medigap plan. To alleviate this potential problem, the Congress would have to revise the law.

Long-Term Care Reform: States' Views on Key Elements of Well-Designed Programs for the Elderly (GAO/HEHS–94–227, Sept. 6, 1994)

The state agencies agree widely on the key components of well-designed programs for the elderly. State agencies believe that an elderly person's ability to perform activities of daily living is the best way to identify persons with the greatest need for services, although states do not uniformly define such activities. To determine service needs, state agencies generally agree that case/care management, a standard assessment instrument, and involvement of the elderly person in the process are most useful. State agencies report that the largest number of severely disabled elderly persons need nonmedical services, such as personal care. State agencies agree that a variety of cost control methods are effective, although there is less consensus about which specific methods work best. Regarding the private-sector role in long-term care, state agencies believe that the private-sector role could probably reduce government costs, and government interventions might spur private-sector activity.

Long-Term Care: Other Countries Tighten Budgets While Seeking Better Access (GAO/HEHS–94–154, Aug. 30, 1994)

In the United States, the number of people age 65 and older will exceed 20 percent of the total population by the year 2030, up from 12.5 percent in 1990. Public and private spending for long-term care has risen dramatically during the past decade—exceeding $100 billion for fiscal year 1993—and is projected to continue this upward trend. At the same time, there is considerable consumer dissatisfaction with the cost of and access to this care. To varying degrees, other countries also face aging populations, cost pressures, and service delivery problems. This report reviews the provision of long-term care in Canada, Germany, Sweden, and the United Kingdom. GAO examines (1) the financing and cost-containment measures these countries use to control public spending for long-term care and (2) administrative and delivery approaches the countries use to expand the range of and access to services.

Long-Term Care: Private Sector Elder Care Could Yield Multiple Benefits (GAO/HEHS–94–60, Jan. 31, 1994)

Today, about 6 million older Americans need help living at home because of their disabilities. The demand for this kind of assistance is expected to increase significantly in the future, with upwards of 10 million persons needing help by 2020. Most disabled elderly receive this care from family members and friends, primarily women. Yet greater geographic dispersion of families, smaller family sizes, and the large numbers of women who work outside the home are straining the ability of caregivers. Some companies are responding to the needs of their workers with policies and programs, known as "elder care," to help ease work and caregiving conflicts. This report evaluates (1) the extent and nature of company practices now offered to help employees who look after the elderly, (2) planned changes in these practices, and (3) the potential of company practices to further support informal caregivers.

Long-Term Care: Status of Quality Assurance and Measurement in Home and Community-Based Services (GAO/PEMD–94–19, Mar. 31, 1994)

This report examines how quality is ensured and measured in home and community-based long-term care services for elderly persons with disabilities. These services range from skilled nursing services to help with activities such as bathing, dressing, shopping, and meal preparation. GAO answers the following questions: How is "quality" defined for home and community-based long-term care services? What measures are now being used to monitor or ensure quality?

Long-Term Care: Support for Elder Care Could Benefit the Government Workplace and the Elderly (GAO/HEHS–94–64, Mar. 4, 1994)

Today, about 6 million older Americans living at home need help with day-to-day activities, such as eating, bathing, shopping, and house cleaning. Most disabled elderly get all their care informally, from family members and friends, mainly women. Greater geographic dispersion of families, small families, and more women working outside the home are straining the ability of informal caregiving. Some private and public-sector employers are now providing assistance known as "elder care" to alleviate work and caregiving conflicts. This assistance may include leave policies, alternative work schedules, and referral services to help employees care for their elderly relatives. Little is known nationwide about the extent and content of elder care generally—and even less is known about elder care in government, which employs 18 million people or 15 percent of the workforce. This report evaluates (1) the extent

and nature of government practices facilitating elder care; (2) planned changes in these practices; and (3) their potential to further support informal caregivers.

Medicare and Medicaid: Many Eligible People Not Enrolled in Qualified Medicare Beneficiary Program (GAO/HEHS–94–52 Jan. 20. 1994)

The Qualified Medicare Beneficiary Program pays many out-of-pocket expenses for Medicare recipients whose incomes are not quite low enough to qualify them for regular Medicaid benefits. The number of people enrolled has steadily increased since the program began in 1989, but a substantial portion of those eligible has yet to sign up—despite repeated efforts by government and advocacy groups to publicize the program. Many believe that people have not enrolled because of the perceived welfare stigma associated with means-tested programs and because of the complicated application process. Many also believe that authorizing the Social Security Administration (SSA) to make program eligibility determinations would help overcome these factors and boost enrollment. Although SSA might be able to increase enrollment, GAO believes that this concept should be tested before it is generally adopted. Finally, some State part A buy-in practices delay or preclude enrollment of Qualified Medicare Beneficiary Program and regular Medicaid beneficiaries in part A. This, in turn, can place some beneficiaries at a disadvantage relative to beneficiaries in other States.

Medicare: Beneficiary Liability for Certain Paramedic Services May Be Substantial (GAO/HEHS–94–122BR, Apr. 15, 1994)

Volunteer ambulance companies often transport Medicare patients to hospitals. In some cases, the patient may require the services of a paramedic trained in advanced life support services. GAO found that Medicare contractors rely on States to certify ambulance companies for participation in the Medicare program, and States set their own certification requirements. Most volunteer ambulance companies do not charge for their services or have their own paramedics. Medicare does not pay separately for paramedics, who are covered only if they are an integral part of the ambulance service. Although data are limited, GAO believes that the potential liability of Medicare beneficiaries for paramedic services may be substantial. For example, two providers of paramedic services in Connecticut charged Medicare patients in excess of $600,000. The Health Care Financing Administration (HCFA) has tried to minimize this liability by allowing ambulance companies to submit a single bill to Medicare for both the ambulance and paramedic services. Because volunteer ambulance companies seldom bill for services, however, this arrangement may not help patients minimize their liability. HCFA officials have agreed to reexamine their policy but as of March 1994 had not yet reached a decision on this matter.

Medicare: Better Guidance Is Needed to Preclude Inappropriate General and Administrative Charges (GAO/NSIAD–94–13, Oct. 15, 1993)

GAO found that $1.1 million of $2.6 million in administrative expenses claimed by the Hospital Corporation of America (HCA) in its Medicare cost report was either unallowable, questionable, or unsupported. In a recently completed review of administrative expenses and employee fringe benefit costs claimed by hospitals and corporate offices in their Medicare cost reports, the Inspector General at the Department of Health and Human Services found more than $50 million in unallowable and questionable expenses. He concluded that a lack of explicit guidance in Medicare cost principles was at least a contributing factor to this problem. Similarly, the general nature of the Medicare cost principles was a major reason why HCA included inappropriate costs in its report. Medicare cost principles, for example, do not specifically address many of the costs that GAO questioned, such as liquor, flowers, gifts, entertainment, Christmas parties, and scholarships for employee children. In GAO's view, the cost principles contained in the Federal Acquisition Regulation and in Office of Management and Budget Circular A–21 provide useful guidance on allowable general and administrative expenses.

Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS–94–119, Sept. 2, 1994)

During the 1980s, the per capita costs of providing health care to the elderly under Medicare increased 59 percent, even after adjusting for inflation. To slow this cost spiral, the Congress allowed Medicare to contract with health maintenance organizations (HMO) under an alternative payment system. Medicare's traditional fee-for-service payment method created incentives for overuse of medical care because providers could boost their incomes by encouraging greater use of services. By contrast, HMOs receive an up-front fixed monthly fee for each patient's care instead of a fee for each service. Government researchers and outside analysts, however, have claimed that HMOs can be more expensive than fee-for-service care. These an-

alysts argue that beneficiaries enrolled in Medicare HMOs are healthier (and less costly to care for) than beneficiaries in the fee-for-service sector and that Medicare payments to HMOs do not fully reflect these differences in costs. In addition to this problem, industry representatives and other analysts claim that Medicare payment rates are too low in some areas and show unjustifiably wide variation across geographic boundaries. This report examines Medicare's HMO rate setting methodology to determine the existence and the magnitude of these problems and to review proposed solutions. Specifically, GAO discusses the impact of favorable selection and rate variation on the ability of the Medicare risk contract program to yield cost savings.

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS–94–35, Mar. 2, 1994)

Given soaring U.S. health care costs and shrinking budgets for many government programs, the Congress is concerned that Medicare pay only for appropriate medical services without compromising the quality of care provided to beneficiaries. One of the several ways that Medicare ensures proper payments is through the medical review function performed by contractors—called carriers—who process and pay claims for physician services, diagnostic tests, and other Medicare part B services. Review activities are designated to prevent spending on inappropriate, medically unnecessary, or excessive services. This report assesses a HCFA demonstration that involves medical review operations at five carriers: three of these were given added management flexibility and funding to enhance their medical review function and two served as comparisons. This report discusses whether (1) the improved medical review activities at the demonstration carriers produced measurable savings or benefits to the claims process; (2) more medical review funding for other carriers would be cost-effective; and (3) HCFA's medical review oversight needs improvement.

Medicare: HCFA's Contracting Authority for Processing Medicare Claims (GAO/HEHS–94–171, Aug. 2, 1994)

Since 1966, HCFA has awarded most contracts to process claims under Medicare parts A and B without competition, has renewed them annually, and has compensated contractors on a cost-reimbursement basis. Periodically, the Congress has directed HCFA to experiment with other types of contracts to reduce administrative costs. Earlier experiments had mixed results, but current experiments indicate that different types of contracts may reduce costs. While HCFA's current authority provides opportunities to achieve administrative efficiencies, it may be useful for the Congress to direct HCFA to evaluate new approaches that could lead to a more competitive environment. Any changes, however, should avoid problems that have occurred in the past. The role that the Blue Cross and Blue Shield Association (the national trade association for independent Blue plans) plays in coordinating part A contracting activities with individual Blues plans may limit the need for HCFA resources to perform these activities. However, HCFA has not evaluated the Association's performance since 1989, even though HCFA paid the Association over $21 million during that period. In GAO's view, HCFA needs to regularly assess the Association's performance, just as it does for other contractors, to ensure that the Medicare program is being managed efficiently.

Medicare: Impact of OBRA–90's Dialysis Provisions on Providers and Beneficiaries (GAO/HEHS–94–65, Apr. 25, 1994)

To control soaring Medicare costs, the Congress has required that, in some cases, employer-sponsored group health plans covering Medicare beneficiaries pay medical claims before Medicare begins to foot the bill. Since 1981, such a requirement has been in place for patients with advanced kidney disease, which requires regular dialysis or a kidney transplant. The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) extended the period during which these plans must pay before Medicare kicks in. The OBRA extension of the plans' obligation as primary payers has increased the amount that providers received for dialysis by an estimated $41 million per year. This increase occurred because employer-sponsored plans generally paid dialysis providers more than the cost-based Medicare rates. Although the additional revenue is relatively small when viewed in the aggregate, boosting total provider revenues for dialysis by amount 1.8 percent, it represents pure profit for providers. The extension should not affect most kidney patients' out-of-pocket expenses because provisions insulate patients with dual coverage from being singled out for increased out-of-pocket expenditures.

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS–94–42 Apr. 28, 1994)

Medicare overpayments of millions of dollars are being made because of inadequate safeguards by contractors who process Medicare claims and inattention by HCFA. Carriers use inaccurate or incomplete data in compiling statistical reports profiling doctors and other providers. Their focused reviews to identify irregular billing patterns and unusual spending trends suffer from HCFA's failure to spell out appropriate analysis methods and outcome measures. As a result, HCFA cannot be sure that Medicare carriers are systematically targeting providers or services that most warrant attention. Shortcomings in carriers' claims review activities exist, in part, because HCFA lacks meaningful requirements for—and the data needed to measure—carriers' postpayment review performance. Shortcomings also persist because funds earmarked for postpayment review have not kept pace with the growth in Medicare claims or as a percentage of the carriers' overall administrative budget.

Medicare: Shared System Conversion Led to Disruptions in Processing Maryland Claims (GAO/HEHS–94–66, May 23, 1994)

Since 1989, HCFA has tried to reduce administrative costs by urging Medicare contractors to share claims processing system software and hardware with other contractors. In October 1991, Blue Cross and Blue Shield of Maryland began using claims processing software developed by another contractor. For more than a year after the system conversion, Medicare payments to Maryland physicians were frequently late and often contained errors, resulting in unanticipated costs of more than $5 million. The Maryland contractor has yet to realize any of the anticipated annual savings of more than $600,000 in administrative costs. Poor management by Blue Cross and Blue Shield of Maryland and poor decisions by HCFA contributed to the contractor's costly and turbulent shared system conversion. In particular, HCFA and the Maryland contractors did not allow enough time to plan the effort and scheduled the conversion during a period of Medicare program changes requiring major computer system modifications. The Maryland contractor's experience provides valuable lessons for the future, especially given HCFA's plan to convert the 14 systems that the contractor now uses to a single automated claims processing system. HCFA needs to ensure that planning and testing time for major system changes are adequate and not compromised by its desire to achieve administrative savings.

Medigap Insurance: Insurers' Compliance With Federal Minimum Loss Ratio Standards, 1988–91 (GAO/HEHS–94–47, Feb. 7, 1994)

From 1988 through 1991, the market for Medicare supplemental insurance—commonly called Medigap—grew by more than 50 percent; premiums rose from about $7 billion to $11 billion. In the first half of this period, Medigap insurers' loss ratios rose, and the 1991 aggregate loss ratios were about at their 1988 levels—80 percent for policies sold to individuals and 90 percent for group policies. The loss ratios for individual policies represent a dramatic improvement from the early 1980's when the Federal minimum standards became effective and aggregate loss ratios were about 60 percent. The premiums associated with companies whose aggregate loss ratios did not meet the Federal minimum standards fell from $388 million in 1988 to $206 million 3 years later. Although this decline suggests that insurers' compliance with the loss ratio standards improved during the 4-year period, some companies did not meet the minimum loss ratio standards in every State in which they did business. The premiums collected by these companies steadily declined during the period, from $126 million in 1988 to $35 million in 1991.

INCOME SECURITY ISSUES

D.C. Pension Benefits: Comparison With Selected State and Local Government Pension Plans (GAO/HRD–94–18, Nov. 4, 1993)

After surveying 40 public employee retirement plans, GAO concludes that the District of Columbia's retirement plans for police officers, firefighters, teachers, and judges generally provide benefits that are comparable to those offered by other public retirement plans. District police officers and firefighters receive pensions that are slightly higher (as a percent of final salary) than the average provided by similar plans, while District teachers' pensions are slightly lower. District judges' pensions are higher than the average of other plans. Any comparison of public pension plan benefits in complicated, however, because survivor benefits, disability benefits, and cost-of-living adjustment provisions vary among plans. The District's cost-of-living adjustment provision—retirement annuities are increased twice yearly by the full

amount of the rise in the consumer price index—is more generous than provisions of other plans.

District's Workforce: Annual Report Required by the District of Columbia Retirement Reform Act (GAO/GGD–94–64, Mar. 31, 1994)

The Federal Government makes annual payments to the District of Columbia retirement fund for police officers and firefighters. To encourage the District government to control disability retirement costs, these payments must be reduced when the disability retirement rate exceeds a certain limit. GAO concludes that no reduction is required in the fiscal year 1995 payment to the fund.

Insurance Ratings: Comparison of Private Agency Ratings for Life/Health Insurers (GAO/GGD–94–204BR, Sept. 29, 1994)

Private rating agencies can play an important role in providing consumers with information about insurers' financial health. Concerns have arisen, however, about the usefulness of these ratings to consumers. This report (1) compares the rating systems of the five major raters of life/health insurers—A.M. Best, Duff & Phelps, Moody's, Standard and Poor's, and Weiss Research—over the period August 1989 to June 1992 and (2) determines which raters were first to report the vulnerability of financially impaired or insolvent insurers.

Pension Plans: Stronger Labor ERISA Enforcement Should Better Protect Plan Participants (GAO/HEHS–94–157, Aug. 8, 1994)

The Department of Labor's Pension and Welfare Benefits Administration (PWBA) is responsible for enforcing provisions of the Employee Retirement Income Security Act of 1974 (ERISA), the Federal program to protect an estimated 200 million participants and beneficiaries of private pension and welfare plans, as well as the $2.5 trillion in assets held by those plans. A review of Labor's enforcement program shows improvements since 1986, but also the need to strengthen enforcement by taking steps to ensure maximum use of investigative resources. PWBA has never evaluated its current enforcement strategy; such an evaluation is needed to determine whether PWBA is focusing on the right issues and whether the strategy produces the greatest results. In addition, PWBA has done little to assess the effectiveness of computer targeting programs developed to systematically select pension and welfare plans for investigation of potential fiduciary violations. The enforcement program also can be strengthened by increasing the use of penalties authorized by ERISA to deter plans from violating the law.

Proposal to Strengthen H.R. 3396 (GAO/HEHS–94–181R, June 24, 1994)

Pursuant to a congressional request, GAO provided information on options that would strengthen H.R. 3396. GAO noted that (1) H.R. 3396 would improve funding for many underfunded pension plans, (2) H.R. 3396 should be strengthened so that sponsors of poorly funded plans are required to contribute more than the ERISA minimum requirements, (3) the Pension Benefit Guaranty Corporation (PBGC) needs to determine what threshold defines a poorly funded plan so that the risks of benefit loss are reduced and plan contributions are increased, (4) PBGC believes that strengthening H.R. 3396 is unnecessary and that the minimum ERISA contribution will be sufficient to move plans to full funding, (5) funding mechanisms are needed to ensure that a plan's funding ratio will not fall too low because hidden liabilities can deteriorate a plan's funding rapidly, and (6) a reasonable threshold to define a underfunded plan would be 75 to 85 percent.

Social Security Administration: Risks Associated With Information Technology Investment Continue (GAO/AIMD–94–143, Sept. 19, 1994)

SSA's proposed acquisition of intelligent workstations, that is, personal computers and local area networks, has not been driven by plans to identify how and where SSA can best use its new technology and other resources to handle increasing workloads and improve public service. SSA ultimately plans to introduce a system of more than 90,000 personal computers and 27,000 local area networks at a cost of billions of dollars. GAO has encouraged and supported recent SSA efforts to reengineer its disability determination process and set overall service delivery goals because they are important steps in identifying future resource needs. However, national implementation of intelligent workstations and local area networks is proceeding independently of these initiatives and at risk because SSA has not adequately defined its technology needs.

Social Security Disability: Most of Gender Difference Explained (GAO/HEHS–94–94, May 27, 1994)

Under the Social Security Disability Insurance Program, older women are allowed benefits at a lower rate than are older men. For example, in 1988, 39 percent of female applicants aged 55 to 64—compared with 50 percent of the male applicants of the same age—were allowed benefits. However, GAO found that this difference does not necessarily point to bias in the system. Rather, most of the difference could be explained by gender difference in impairments and demographic characteristics and by the rules for determining disability.

Social Security Retirement Accounts (GAO/HEHS–94–226R, Aug. 12, 1994)

Pursuant to a congressional request, GAO reviewed proposed legislation to create a system of individual Social Security retirement accounts (ISSRA), focusing on the (1) implications of H.R. 306 on the retirement income of individuals and (2) key differences between H.R. 306 and the 1990 proposal. GAO noted that (1) ISSRA could be integrated with the Social Security benefit structure and, given favorable market conditions, could improve retirement incomes; (2) although both proposals include a 2-percent payroll tax diversion, H.R. 306 would deplete Social Security trust fund contingency reserves; (3) under the 1990 proposal, the ISSRA program would end when the projected Old Age and Survivors Insurance (OASI) cost rate would rise to equal the income rate, except for the accumulation and payment of interest; (4) H.R. 306 proposes a permanent ISSRA scheme that would require future payroll tax increases or benefit reductions; (5) since H.R. 306 does not provide for benefit reductions to account for the diversion of payroll tax revenues, individuals will generally receive a higher total retirement income; and (6) under H.R. 306, the ISSRA program would effectively become a mandatory defined contribution supplement to Social Security.

Social Security: Sustained Effort Needed to Improve Management and Prepare for the Future (GAO/HRD–94–22, Oct. 27, 1993)

Failure to meet the SSA's management challenges could have serious consequences. SSA provides benefits to about 47 million people today, and it will have to provide benefits and services to many more people in the future. The baby boomers are aging, and, beginning in 1995, Social Security earning and benefits statements will be required for all workers. SSA is already seeing the effects of a significant rise in disability cases, an area already plagued by major processing delays. This third in a series of GAO reports examines SSA's current operations and its preparations for the future. GAO concludes that if SSA cannot establish the necessary long-range plans, efficiently manage computer-systems modernization, address workforce needs, and control its finances, it risks significant deterioration in its ability to serve the public efficiently and effectively. GAO summarized this report in testimony before the Congress; see Social Security Administration: SSA Needs to Act Now to Assure World-Class Service, by Jane L. Ross, Associate Director for Income Security Issues, before the Subcommittee on Social Security, House Committee on Ways and Means (GAO/T–HRD–94–46, Oct. 28, 1993).

Social Security: Trust Funds Can Be More Accurately Funded (GAO/HEHS–94–48, Sept. 2, 1994)

Each year, the Social Security trust funds are credited with revenues derived from income taxes paid on Social Security benefits. But do they get the right amount? GAO reports that the Social Security trust fund's revenues could be increased by recognizing additional taxes identified through the Internal Revenue Service's (IRA) efforts to locate underreported taxable income and through better detection of underreported tax-exempt interest. Recognizing additional taxes identified by IRS could have boosted the trust funds by more than $200 million in tax revenue and investment income for tax years 1984 to 1989. Further, data from the Federal Reserve and the Investment Company Institute indicate that taxpayers may have underreported an estimated $7.2 billion in tax-exempt income on their 1989 tax returns.

SOCIAL SERVICES ISSUES

Older Americans Act: Title III Funds Not Distributed According to Statute (GAO/HEHS–94–37, Jan. 18, 1994)

The Administration on Aging's (AOA) method of allocating funds under title III of the Older Americans Act is inconsistent with the law's basic requirement that funds be distributed to states in a manner proportionate to their elderly populations. Funds must be allotted proportionally among the States except that no

State is to receive less than the minimum set by law. AOA's current method of computing allotments ensures that the minimums are met but in a way that fails to achieve proportionality among States not subject to the minimum grant requirements. Among the distorting effects of AOA's method are that the amounts allotted per elderly person are not equal in similarly populated States, and States with more rapidly growing elderly populations are underfunded. The required method avoids or minimizes both effects.

Older Americans Act: The National Eldercare Campaign (GAO/PEMD–94–7, Feb. 23, 1994)

In April, 1991, AOA launched a multiyear initiative called the National Eldercare Campaign. AOA used about $14 million of $26 million in title IV discretionary funds to support the campaign's various components. The largest portion of these funds went to a new community outreach effort, Project CARE. Under this national coalition-building demonstration program, each state was required to establish three local coalitions. At the end of 15 months, virtually all States had three local coalitions in place. A majority of coalitions had generated some resources, and about 70 percent of the coalitions were providing a service to the elderly. The campaign differs from earlier AOA initiatives in that it seeks to expand not only the Aging Network but also the resources available to them. Usually, AOA initiatives were of 12- to 24-months duration and limited to research, demonstration, and technical assistance. By the end of fiscal year 1992, about 200 coalitions had joined the Aging Network and had developed programs and services for the elderly. Although this is a significant change in both the mission and structure of the Aging Network, the success of this campaign ultimately depends upon the coalitions' ability to sustain themselves beyond the 3-year funding period.

Older Americans Act: Funding Formula Could Better Reflect State Needs (GAO/HEHS–94–41, May 12, 1994)

In response to congressional concerns that current title III allocations do not fully reflect indicators of states' needs, GAO examined the interstate funding formula of the current Older Americans Act of 1965. This formula allocated more than $770 million in Federal title III dollars in fiscal year 1993 among the 50 States and the District of Columbia. GAO concludes that the Congress should modify the formula for distributing title III money to better target those elderly persons with the greatest social and economic needs. In this report, GAO (1) develops equity standards appropriate to evaluating the allocation of title III assistance to the States, (2) uses these standards to create alternative formulas under which funds might be distributed more equitably, (3) shows how each of the alternatives would redistribute funding among the States, and (4) explores ways of phasing in a new formula to moderate the degrees of funding changes in a single year.

OTHER ISSUES

Aging Issues: Related GAO Reports and Activities in Fiscal Year 1993 (GAO/HRD–94–73, Dec. 22, 1993)

GAO's work on aging issues reflects the continuing importance of Federal programs for older Americans. The 1990 Census reported more than 31 million older Americans, and that number is expected to top 53 million by 2020. A multitude of public policy issues are linked to the graying of America. GAO's reports and testimony during 1993 addressed many of these subjects, including Federal programs relating to employment, health care, housing, income security, and veterans affairs. This handy reference guide summarizes issued reports and testimony and lists jobs that were ongoing as of September 1993.

APPENDIX II—FISCAL YEAR 1994 GAO REPORTS ON ISSUES AFFECTING OLDER AMERICANS AND OTHERS

GAO issued 59 reports in fiscal year 1994 on policies and programs in which older Americans were one of several groups. Of these, 2 were on employment, 20 on health, 7 on housing, 6 on income security, 1 on social services, 17 on veterans, and 6 on other issues.

EMPLOYMENT ISSUES

EEOC's Expanding Workload: Increases in Age Discrimination and Other Charges Call for New Approach (GAO/HEHS–94–32, Feb. 9, 1994)

The amount of time a person may have to wait for the Equal Employment Opportunity Commission (EEOC) to process a discrimination charge under the non-

discrimination laws could more than double and approach 21 months by fiscal year 1996. The current trend of a steadily increasing workload without commensurate increases in resources is expected to continue. Former and current EEOC officials and civil rights experts have suggested several options that they believe could improve the Federal Government's ability to enforce employment nondiscrimination laws. The one mentioned most often is increased use of alternative dispute resolution approaches, such as mediation. GAO recommends that the Congress convene a panel of experts to review this and other options for improvement. Because resources are scarce, EEOC officials doubt that EEOC will initiate substantially more systemic charges or litigate significantly under the nondiscrimination laws.

Employment Discrimination: How Registered Representatives Fare in Discrimination Disputes (GAO/HEHS–94–17, Mar. 30, 1994)

To work in the security industry, registered representatives—mainly stockbrokers—must agree to submit any employment controversy, including discrimination disputes, to arbitration panels composed of neutral third parties. In recent years, the number of discrimination cases filed by registered representatives for arbitration at the New York Stock Exchange (NYSE) and the National Association of Securities Dealers (NASD) has remained low and relatively constant. Six discrimination cases were filed for arbitration with NYSE in 1990 and 14 in both 1991 and 1992. Between August 1990 and December 1992, NASD's New York Office and NYSE decided 18 discrimination cases. In 4 of the 10 cases involving financial awards, the monetary compensation was directly linked to discriminatory practices. Sex and age discrimination were cited most often in such cases. Some NYSE and NASD procedures for selecting arbiters need improvement. For example, NASD lacks written criteria for excluding potential arbiters with a history of disciplinary actions or regulatory infractions while working in the securities industry. In addition, NYSE and NASD differ in their requirements for arbiter disclosure of criminal convictions. The Securities and Exchange Commission's (SEC) oversight of arbitration programs focuses on customer-firm disputes rather than on employee-employer disputes. Because SEC does not review discrimination cases during its inspection of arbitration programs, it does not know the extent to which discrimination cases are filed and whether the industry has fairly and impartially resolved them. In addition, SEC has not established a formal inspection cycle—a set time for conducting inspections of securities' arbitration programs—to ensure that all programs are inspected regularly. SEC also does not know whether the securities industry corrects problems flagged by its inspections.

HEALTH ISSUES

Blue Cross and Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight (GAO/HEHS–94–71, Apr. 14, 1994)

The 1990 failure of Blue Cross and Blue Shield of West Virginia left thousands of people and many health care providers with millions of dollars in unpaid claims. More recently, congressional investigators uncovered serious financial problems as well as mismanagement at three other "Blues" plans and raised questions about the oversight of these plans by their boards of directors and State regulators. GAO found that 53 of 64 Blues plans are rated in fair to excellent condition by Weiss Research, Inc.—the only insurance rating agency doing such evaluations of Blues plans. The remaining 11 plans, which insure about one-quarter of all Blues subscribers, are rated as weak to very weak financially. Some plans were slow to respond to changing market conditions or made poor investment decisions, while others were put at a competitive disadvantage by rate-setting constraints and coverage requirements applicable only to Blues plans. In addition, weaknesses in oversight by plan boards of directors and State regulators allowed plans' financial problems to persist. The Blue Cross and Blue Shield Association, individual plans, and States have tried to remedy the problems of financially troubled plans, but it is too soon to tell how successful these efforts will be. Under health care reform, the role of State insurance regulators in monitoring the financial solvency of Blues plans and protecting subscribers' and providers' interest will become increasingly important and challenging. It is essential that State insurance regulators have the tools necessary to enforce new requirements on Blues plans and other health insurers. -Subformat:

Cancer Survival: an International Comparison of Outcomes (GAO/PEMD–94–5, Mar. 7, 1994)

In comparing United States and Canadian survival rates for lung cancer, colon cancer, Hodgkin's disease, and breast cancer, GAO found that breast cancer patients

lived longer after diagnosis in the United States than in Canada. The outcomes were mixed for the other types of cancer studied. Nine to 10 years after cancer was detected, the survival rates for U.S. patients were indistinguishable from (in the cases of colon cancer and Hodgkin's disease) or lower (in the case of lung cancer) than survival rates in Canada. One possible interpretation of these findings is that quality of care for breast cancer patients is better in the United States than in Canada and that for the three other cancers it is about the same. Other interpretations focus on differences in detection.

Early Retiree Health: Health Security Act Would Shift Billions in Costs to Federal Government (GAO/HEHS–94–203FS, July 21, 1994)

The President's proposed Health Security Act would relieve private industry of much of the financial burden of providing health insurance to early retirees. This would shift billions of dollars in costs each year to the Federal Government. Today, about 9 million private-sector retirees and one-third of all private-sector workers are in company health plans with coverage for health care between retirement and age 65—when Medicare kicks in. If the Health Security Act is enacted, the Federal Government, beginning in 1998, would not only pick up the tab for early retirees' share of their health costs but would also pay the major portion of company costs. The Federal Government's share would be $6 billion in the first year, growing to nearly three times that amount 3 years later. At the same time, companies would save $11 billion in the first 3 years and would ultimately save over $130 billion after 10 years.

Health Care in Hawaii: Implications for National Reform (GAO/HEHS–94–68, Feb. 11, 1994)

For nearly 20 years, Hawaii has been a leader in the effort to achieve universal access to health insurance. It is the only State that requires employers to provide a minimum level of health insurance benefits to employees, and its public programs cover many residents lacking employment-based insurance. GAO makes several points. First, Hawaii's employer mandate did not have a harmful effect on small businesses. Second, although Hawaii's system of near-universal access has lowered health premiums, its per capita health care costs have risen at a rate similar to the national average. Third, Hawaii's experience suggests that an employer mandate by itself will not necessarily result in universal access to health care. GAO summarized this report in testimony before the Congress; see Health Care in Hawaii: Implications for National Reform, by Mark V. Nadel, Associate Director for National and Public Health Issues, before the House Committee on Small Business (GAO/T–HEHS–94–123, Mar. 16, 1994).

Health Care Reform: "Report Cards" Are Useful but Significant Issues Need to Be Addressed (GAO/HEHS–94–219, Sept. 29, 1994)

As part of the debate over health care reform, the Congress is considering requiring health plans to provide prospective purchasers with information on the quality of care they furnish. Presumably, purchasers will use such "report cards" to compare health plans and choose one that provides the desired level of quality and price. Although report cards that compare the performance of competing health care plans could be a positive step in preserving quality and lowering costs, experts disagree about the type and amount of information to be published because such data may not be reliable or valid. Some experts believe that usable report cards can be produced within 2 to 5 years if the indicators are limited to those known to be valid and reliable. Others believe that it will be as long as 15 years before highly reliable and valid measures are developed. Several States and groups such as United HealthCare Corporation and Kaiser Permanente Northern California Region have already issued report cards on the care they furnish, but no studies have been done on the cards' validity or reliability. To overcome obstacles to using report cards, most experts recommend that (1) the Federal Government standardize indicators and the formulas for calculating results and (2) an independent third party verify data before they are published.

Health Care Reform: Proposals Have Potential to Reduce Administrative Costs (GAO/HEHS–94–158, May 31, 1994)

Americans today receive health insurance from a multitude of sources, including more than 1,200 commercial insurers; 550 health maintenance organizations, 69 Blue Cross and Blue Shield plans; thousands of self-insured plans run by private employers; and government programs, such as Medicaid and Medicare. Many believe that the complexity of this insurance system contributes to the Nation's high per capita health care costs. One of the aims of health care reform is to enhance administrative efficiency. To the extent that reform simplifies insurance administra-

tion, it may be able to cut costs. Any savings in administrative expenses could be applied to other valuable ends, such as expanding access and improving quality. This report examines the administrative cost implications of alternative reform proposals, including a single-payer plan and three managed competition plans, and compares their administrative cost savings potential.

Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People (GAO/HEHS–94–176, July 11, 1994)

To obtain basic health care, more than 30 million people depended on Medicare in fiscal year 1992. Federal and State governments spent nearly $120 billion to provide services to these people. However, millions of people with income below the poverty line are not now covered by Medicaid. Many of these who are potentially eligible do not apply, and many who apply are denied enrollment and remain uninsured. Because health care reform may expand coverage to many of the uninsured, some form of means testing may be required to determine eligibility. This report identifies the (1) reasons why people who may be potentially eligible for Medicaid are not being enrolled, (2) incentives hospitals have to facilitate enrollment of their patients in Medicaid, and (3) implications for eligibility determinations if health care reform is enacted.

Health Care: Antitrust Enforcement Under Maryland's Hospital All-Payer System (GAO/HEHS–94–81, Apr. 27, 1994)

One issue being raised in the debate over health care reform is how antitrust law should be applied to health care providers. Federal and State antitrust law seeks to prevent price fixing and predatory pricing and to ensure access to and quality of goods and services for consumers. Since 1974, Maryland has operated a rate-setting program that sets how much hospitals can charge for their services. Also, health care facilities operating in Maryland must obtain a certificate of need if they wish to change the type of services they provide or to make major capital expenditures. Because Maryland regulates hospital prices similar to the way in which public utilities are regulated, State antitrust concerns about hospital pricing are not an issue, and Planning Commission-approved mergers and joint actions by hospitals are exempt from the State's antitrust law. Also, to the extent that the State actively regulates hospitals, Federal antitrust enforcement concerning such regulated activities may not be relevant under the Supreme Court's State action immunity doctrine. Other concerns about anticompetitive conduct and its possible harmful effect on the public may still be relevant and covered by Federal or State antitrust law.

Health Care: Federal and State Antitrust Actions Concerning the Health Care Industry (GAO/HEHS–94–220, Aug. 5, 1994)

In response to a request to review antitrust enforcement actions involving hospitals by the Department of Justice and the Federal Trade Commission (FTC), GAO found that of 397 acute care hospital mergers reviewed by Justice and the FTC in the 13-year period of fiscal year 1981 through fiscal year 1993, less than 4 percent were challenged. For an additional 13 percent of these mergers, Justice or the FTC conducted a preliminary investigation and then allowed the mergers to go forward. The remaining 83 percent of cases involved no more than the required initial filing of notice of proposed merger. Neither Justice nor the FTC has ever challenged a hospital joint venture. GAO also found that the hospital industry has actively sought enactment of State laws that would confer antitrust immunity to collaborative actions by hospitals, such as mergers, joint ventures, and sharing of patients and equipment. Since 1992, 18 States have enacted regulatory programs of State approval of hospital activities that can fall under antitrust statutes. Such State laws are sought because under the State action immunity doctrine established by the Supreme Court, certain anticompetitive conduct regulated by the States may be immune from Federal antitrust enforcement action.

Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (GAO/HRD–94–40, Nov. 22, 1993)

As part of the ongoing debate over health care reform, policymakers have been weighing the pros and cons of alternative ways to purchase care. The administration's health care reform package and other recent reform proposals call for purchasing cooperatives to manage competition among health care plans. One frequently cited example of a successful purchasing cooperative is the California Public Employees' Retirement System (CalPERS), which negotiates health premiums for many public employees in California. This report analyzes CalPERS' effectiveness in controlling health care costs for its members. GAO (1) examines CalPERS' cost-containment record, (2) identifies factors that have contributed to the trend in its premium rates, (3) assesses the impact of CalPERS' cost-containment efforts on its members'

benefits, and (4) discusses the applicability of its Health Benefits Program as a model of managed competition—a system under which large purchasing cooperatives contract with a variety of competing health plans on behalf of employers and individuals.

Health Professions Education: Role of Title VII/VIII Programs in Improving Access to Care Is Unclear (GAO/HEHS–94–164, July 8, 1994)

During the past decade, the supply of nearly all health professionals has increased faster than has the population. For most health professions, however, data are unavailable to show whether this increased supply has meant more access to care in rural and underserved areas. For the two professions with the most data available—primary care physicians and general dentists—supply has increased in many rural areas but not in those urban and rural areas with the greatest shortages. GAO's findings are similar for minority recruitment: Although the number of minorities in the health professions is increasing, data are inconclusive about whether further increases will improve access to health care for underserved populations. Although nearly $2 billion has been provided to 30 Title VII and VIII programs during the last 10 years, evaluations have not shown that these programs have had a significant effect on changes in the supply, distribution, and minority representation of health professionals.

Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS–94–167, Aug. 11, 1994)

Because nearly one-third of the Nation's Medicaid expenditures are now spent on long-term care ($42 billion in 1993), GAO was asked to review the experience of States in expanding government-funded home and community-based services. GAO's review focused on Oregon, Washington, and Wisconsin. These three States have expanded home and community-based long-term care in part as a strategy to help control rapidly increasing Medicaid expenditures for institutional care. As they expanded home and community-based care, the three States restricted how large most of the programs can grow. Some restrictions were mandated by the Federal Government which approves capacity limits on programs operated under Medicaid waivers. Other restrictions result from constrained State budgets. Despite these deliberate limits on program size, one impact of the shift to home and community-based care is that the three States have been able to provide services to more people with the dollars available, primarily because home and community-based care is less expensive per person than institutional care.

Medicaid: Changes in Best Price for Outpatient Drugs Purchased by HMOs and Hospitals (GAO/HEHS–94–194FS, Aug. 5, 1994)

The Congress has tried to reduce Medicaid prescription drug costs by requiring drug manufacturers to give State Medicaid programs rebates for outpatient drugs. The rebates were based on the lowest or "best" prices that drug manufacturers charged other purchasers, such as health maintenance organizations (HMO) and hospitals. Concerns have been raised in the Congress that drug manufacturers might try to minimize the rebates to State Medicaid programs by increasing best prices and cutting best price discounts for drugs purchased by HMOs and others. This fact sheet (1) determines the changes in the best prices for the drugs bought by the HMOs and group purchasing organizations GAO studied; (2) determines the changes in the difference between the drugs' best prices and their average prices, known as the "best price discount;" and (3) compares the changes in the best prices with the changes in prices paid by the HMOs and the group purchasing organizations.

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS–94–133, Aug. 1, 1994)

Medicaid, which provides health insurance for qualified low-income persons, is jointly funded by the Federal Government and the states. Because of soaring health care costs during the past decade, States have been searching for new ways to help finance the $125 billion Medicaid program. Some States are now using dubious financial arrangements to collect Federal funds without committing their own matching amounts, thus increasing the share of Medicaid costs borne by the Federal Government. This report (1) examines the financial arrangements used by states to inflate the Federal share of Medicaid program expenditures, (2) describes the various techniques that States use to obtain Federal funds for their basic Medicaid and disproportionate share hospital programs, and (3) looks into whether States are using their Federal matching funds to provide medical services to Medicaid patients.

Medical Malpractice: Maine's Use of Practice Guidelines to Reduce Cost (GAO/HRD–94–8, Oct. 25, 1994)

As part of a larger goal of reducing health care costs and improving medical care, Maine is testing an innovative medical malpractice reform initiative. Maine has incorporated into State law 20 practice guidelines for four specialties; anesthesiology, emergency medicine, obstetrics and gynecology, and radiology. This effort seeks to resolve malpractice claims by eliminating the need to litigate to establish the standard of care. Maine officials expect that the practice guidelines will decrease doctors' motivation to do medically unnecessary tests and will lower health care costs. Maine was able to incorporate the practice guidelines into law by (1) gaining broad involvement of those affected by the guidelines, (2) ensuring that those developing and choosing the guidelines were accountable to the public, and (3) protecting the physicians who use the guidelines in their practice. Specifically, the project was developed and is overseen by health care providers, payers, and consumers. To persuade Maine's doctors to participate in the project once it was developed, the project provides physicians complying with the guidelines a defense in future malpractice lawsuits. With these components, the majority of eligible doctors opted to participate in the project.

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/HEHS–94–147, May 6, 1994)

The Department of Health and Human Services has been directed to establish a data bank, beginning in February 1995, that would contain information on all workers, spouses, and dependents who are covered by employer-provided health insurance. The goal is to save millions by strengthening processes to (1) identify the approximately 7 million Medicare and Medicaid beneficiaries who have other health insurance coverage that should pay medical bills before Medicare and Medicaid kicks in and (2) ensure that this insurance is appropriately applied to reduce Medicare and Medicaid costs. In GAO's view, however, the data bank will end up costing millions and likely achieve little savings. GAO believes that changes and improvements to existing activities would be a much easier, less costly, and thus preferable alternative to the data bank. This is largely because the data bank will result in an enormous amount of added paperwork for both the Health Care Financing Administration (HCFA) and the Nation's employers. GAO summarized this report in testimony before the Congress; see Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers, by Leslie G. Aronovitz, Associate Director for Health Financing Issues, before the Senate Committee on Governmental Affairs (GAO/T–HEHS–94–162, May 6, 1994).

Medicare: Graduate Medical Education Payment Policy Needs to Be Reexamined (GAO/HEHS–94–33, May 5, 1994)

It is widely held that the United States is not training enough primary care physicians relative to types of physicians. In 1961, about half of all doctors were in primary care practice; if current trends continue, that number could drop to about 26 percent by 2020. At the same time, if health care reform establishes a delivery system that incorporates managed care, the need for primary care physicians will increase. The Medicare program is the primary vehicle through which the Federal Government helps finance physician training and education. Although data are limited, some researchers argue that hospitals are using Medicare funds to disproportionately underwrite the training of nonprimary care physicians at a time when more primary care physicians are needed. This report (1) describes how Medicare compensates hospitals for the costs of graduate medical education and (2) determines the extent of Medicare support for the graduate medical education of primary and nonprimary care physicians.

Medicare: Technology Assessment and Medical Coverage Decisions (GAO/HEHS–94–195FS, July 20, 1994)

Thousands of medical procedures, devices, and drugs are available for patient care in this country. Each year, public and private health care insurers make coverage decisions for these medical technologies. To make these decisions, insurers increasingly rely on formal technology assessments, which evaluate a technology's safety and effectiveness. In this fact sheet, GAO provides general information about the technology assessment resources and activities of the Public Health Service's (PHS) Agency for Health Care Policy and Research, HCFA's resources and processes for making Medicare coverage decisions, and HCFA's process for making hospital payments that account for the use of new technologies.

Prescription Drugs: Companies Typically Charge More in the United States Than in the United Kingdom (GAO/HEHS–94–29, Jan. 12, 1994)

Drug manufacturers charge 60 percent more for 77 commonly prescribed, brand-name drugs in the United States than for the same medications in the United Kingdom. A total of 66 of the drugs were priced higher in the United States than in the United Kingdom; 47 of these were priced more than twice as high. Most of the differences in prescription drug prices between countries cannot be attributed to differences in manufacturers' costs. Instead, U.S.-U.K. drug price differences are mainly due to the lack of regulatory constraints in the United States. In the United Kingdom, the government health system—virtually the sole payer for prescription drugs—has an agreement with drug manufacturers that limits the profits that drug companies can earn on sales in the British Isles. Other factors may also work to lower drug prices in the United Kingdom. Pharmaceutical information is more widely available in the United Kingdom than in the United States, possibly enhancing price competition among drug manufacturers in the United Kingdom. U.K. doctors receive information on their own prescribing patterns and on the comparative prices and efficacy of drugs. The government can remove drugs from its list of reimbursable products if the manufacturers' prices for those drugs are considered excessive. Wholesalers and retailers can import brand-name drugs into the United Kingdom from elsewhere in Europe where drugs are cheaper.

Public Health Services: Agencies Use Different Approaches to Protect Public Against Disease and Injury (GAO/HEHS–94–85BR, Apr. 29, 1994)

The PHS conducts or supports national programs of health services delivery, disease prevention, health promotion, and biomedical research through eight agencies. Because agencies' programs often address the same diseases or conditions, the potential exists for duplication of effort. Congressional concerns have also been raised about the expansion of funding for the Centers for Disease Control and Prevention (CDC), which rose from $587 million to about $1.5 billion between fiscal years 1987 and 1992. Concerns have likewise been raised that the scope of CDC's programs and activities today extends well beyond the agency's early focus on communicable disease. GAO found that no PHS agency was duplicating another agency's public health activities in the programs GAO reviewed. Also, CDC's programs were appropriate considering the agency's legislative authority and its history of prevention and control efforts regarding chronic diseases and other health conditions. Public health experts GAO consulted support CDC's activities.

HOUSING ISSUES

Efforts to Assist the Homeless in San Antonio (GAO/RCED–94–238R, July 11, 1994)

Pursuant to a congressional request, GAO reviewed the role of McKinney Act programs in assisting the homeless in San Antonio. GAO noted that (1) although the homeless have had access to a range of low-income assistance programs since 1970, most of these programs were not targeted specifically toward the homeless; (2) before McKinney Act programs became available, emergency shelters were established by charitable organizations and health care was available through county facilities; (3) McKinney program funding has played a small but important role in San Antonio's homeless assistance efforts since 1987; (4) McKinney programs have improved existing emergency food and shelter programs, funded transitional housing, expanded health care services, helped link adult education programs with shelters, established mobile outreach services for the mentally ill and employment assistance for veterans, and improved coordination between local organizations and providers; (5) local service providers believe that their current resources are not sufficient to meet the special needs of the homeless; (6) service providers believe that San Antonio needs to increase the amount of transitional housing, employment training, literacy education, prenatal care for youths, substance abuse treatment, homeless prevention efforts, affordable housing for low-income persons, and high-paying jobs; and (7) San Antonio should seek new and creative ways to provide low-income housing, since affordable housing shortages contribute to homelessness in San Antonio.

Efforts to Assist the Homeless in Seattle (GAO/RCED–94–237R, July 11, 1994)

Pursuant to a congressional request, GAO reviewed the role of McKinney Act programs in assisting the homeless in Seattle. GAO noted that (1) homeless social service programs and emergency services have been available in Seattle for many years and are funded by local and state governments and private sources; (2) McKinney program funding has played an important role in Seattle's homeless assistance efforts since 1987; (3) McKinney programs have supplemented existing food and emergency shelter services, expanded employment and education programs, and funded

transitional housing, health care services shelters, and mentally ill outreach programs; (4) although McKinney funds are provided to cities for food, shelter, health care, education, and employment programs targeted to the homeless, the current resources available are not meeting service demands; (5) service providers believe that without McKinney program funds, health care outreach services, transitional housing, and education programs would be greatly reduced or discontinued; (6) local service providers believe that Seattle needs to increase the amount of affordable housing for low-income persons, funds for substance abuse programs, services targeted to youths, and its employment training, education, and homeless prevention efforts; and (7) Seattle should seek new and creative ways to provide low-income housing, since affordable housing shortages contribute to homelessness in Seattle.

Efforts to Assist the Homeless in Baltimore. (GAO/RCED–94–239R, July 11, 1994)

Pursuant to a congressional request, GAO reviewed the role of McKinney Act programs in assisting the homeless in Baltimore, GAO noted that (1) homeless emergency services have been available in Baltimore since the 19th century; (2) before McKinney Act programs became available, churches, missions, and private groups provided food and shelter services for the homeless; (3) since 1987, McKinney program funding has played an important role in Baltimore's efforts to assist the homeless; (4) McKinney programs have supplemented existing emergency food and shelter services, funded transitional housing and education programs for adults and children, expanded health care services, and established mobile outreach services for the mentally ill and a research demonstration project for homeless people with chronic mental illnesses and substance abuse problems; (5) service providers believe that without McKinney program funds, case management and health care outreach services, transitional housing, and adult education programs would be greatly reduced or discontinued; (6) local service providers believe that their current resources are not sufficient to meet the special needs of the homeless and that Baltimore needs to increase the amount of affordable housing, funds for substance abuse programs, and its homeless education and prevention efforts; and (7) Baltimore should seek new and creative ways to provide low-income housing, since affordable housing shortages contribute to homelessness in Baltimore.

Homelessness: McKinney Act Programs Provide Assistance but Are Not Designed to Be the Solution (GAO/RCED–94–37, May 31, 1994)

The Stewart B. McKinney Homeless Assistance Act of 1987 established emergency food and shelter programs; programs providing longer term housing and supportive services; and programs designed to demonstrate effective approaches for providing the homeless with other services, such as physical and mental health, education, and job training. GAO evaluated the act's impact in Baltimore, Maryland; San Antonio, Texas; Seattle, Washington; and St. Louis, Missouri. This report discusses (1) what difference the McKinney Act programs have made in these cities' efforts to help the homeless, (2) what problems the cities have experienced with McKinney Act programs, and (3) what directions the cities' programs for the homeless are taking and what gaps the McKinney Act programs may fill.

Homelessness: McKinney Act Programs and Funding Through Fiscal Year 1993 (GAO/RCED–94–107, June 29, 1994)

GAO is required to report annually to the Congress on the status of programs authorized under the McKinney Act. This report provides updated program and funding information for fiscal years 1992 and 1993. It also provides information on the third reauthorization of the Act. GAO discusses the legislative history of the act; describes each McKinney Act program, and identifies the funding provided under each program by State. GAO also briefly describes newly authorized assistance programs for the homeless and significant changes to existing McKinney Act programs that occurred during these two fiscal years.

Rental Housing: Use of Smaller Market Areas to Set Rent Subsidy Levels Has Drawbacks (GAO/RCED–94–112, June 24, 1994)

To ensure that needy families can live in adequate housing, the Department of Housing and Urban Development (HUD) provides rent subsidies to low-income households. This program, known as the Section 8 program, served more than 1 million households at a cost of about $7 billion in 1992. The amount of rental assistance that a household receives varies depending on the household's market area. The size and nature of a market area can vary greatly: Entire States, large metropolitan areas, and medium-sized cities can all be considered market areas. In response to congressional concerns that these market areas are too broadly defined to permit rental assistance payments that reflect true market rents, this report determines (1) the effects of basing rent subsidy payments on smaller market areas,

including any effects that doing so would have on recipient households' access to education and employment and (2) the extent to which payments made under the current program have an inflationary effect on the rental rates in surrounding areas. GAO also provides information on where Section 8 recipients lived and their proximity to key services and businesses. GAO based its analysis on the following four market areas: Oklahoma City, Oklahoma; Seattle, Washington; Washington, D.C.; and Wilmington, Delaware.

Section 8 Rental Housing: Merging Assistance Programs Has Benefits but Raises Implementation Issues (GAO/RCED–94–95, May 27, 1994)

HUD runs two similar rental housing subsidy programs for low-income households—the section 8 certificate and voucher programs. These two programs, which local and State housing agencies operate for HUD, enable 1.3 million poor families to live in decent, affordable, privately owned housing. Although these programs are in many ways similar, several statutory and administrative differences can affect the housing subsidy that households receive. Over the past several years, GAO, the Vice President's National Performance Review, and others have urged that the two programs be combined; legislation now before the Congress would accomplish that goal. This report examines (1) the benefits of a merger, (2) the major program differences that would need to be reconciled, (3) the effect of a merger on HUD's budgeting and financial management, and (4) the effort needed to merger the two programs.

INCOME SECURITY ISSUES

Social Security Disability: SSA Quality Assurance Improvements Can Produce More Accurate Payments (GAO/HEHS–94–107, June 3, 1994)

In 1993, the Social Security Administration's (SSA) Disability insurance program provided nearly $35 million to 5.3 million disabled workers and their dependents and the Supplemental Security Income (SSI) program provided about $24 billion to 6 million recipients. Although SSA runs these programs, State agencies determine whether claimants are disabled according to program rules. In recent years, disability benefit claims have soared, and the two programs have been unable to keep up with the high rate of claims submitted. In response to congressional concerns about the increasing workload pressures on the quality of disability determinations, this report evaluates (1) the reliability of SSA's reported accuracy rates and (2) how well SSA's quality assurance mechanism ensures the accuracy and consistency of State agencies' disability determinations and minimizes erroneous payments.

Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive (GAO/HEHS–94–34, Feb. 8, 1994)

More people are applying for and being awarded Social Security disability benefits than ever before, and these beneficiaries are remaining on the disability rolls for longer periods of time. As a result, disability payments have burgeoned. Changes in beneficiary characteristics have accompanied this growth: the average age of new beneficiaries is now below 50, mental impairment awards to younger workers have risen substantially, and more and more new beneficiaries receive such low disability insurance (DI) benefits that they get additional income from SSI. These low benefit levels suggest that the new beneficiaries had limited work histories. Higher unemployment probably contributes to increasing applications, and policy changes have produced changes in the numbers and types of beneficiaries. Quantitative data on the impact of these factors are lacking, however, and important questions remain. The upshot is that SSA's ability to predict future growth and change in the rolls is limited. Better information would also help SSA to determine whether improvements in program management are needed.

Social Security: Increasing Number of Disability Claims and Deteriorating Service (GAO/HRD–94–11, Nov. 10, 1993)

The administration SSA's disability programs has reached a crisis stage; service is poor and billions of dollars in payments will end up going to ineligible persons unless mandated continuing disability reviews are resumed. Claim backlogs and processing times for SSA's DI and SSI programs hit an all-time high in fiscal year 1992. The two programs have been unable to keep up with the high rate of claims for benefits, a trend that has continued into fiscal year 1993. Processing times have increased nearly 50 percent in recent years, and some States take more than 5 months to process claims. SSA has undertaken many short-term initiatives to keep up with claims—most significantly, the funding of overtime for disability determination services. According to administrators, staff are overworked and overtime is at record levels. SSA has also diverted staff from doing continuing disability reviews

to program benefits at a cost of at least $1.4 billion. These short-term initiatives have only slightly reduced pending claims and processing times. SSA also has several long-term initiatives under way to improve its disability programs; exactly how, when, and to what extent these initiatives will improve service is unknown at this point, however.

Social Security: Major Changes Needed for Disability Benefits for Addicts (GAO/HEHS–94–128, May 13, 1994)

The number of addicts receiving disability benefits has grown substantially during the last 5 years—from fewer than 100,000 to about 250,000 today. The annual cost of providing benefits to addicts is about $1.4 billion. The vast majority of addicts receiving disability benefits are either not in treatment of their treatment status is unknown. About 100,000 addicts have not been assigned a third-party or representative payee to manage their benefits. Consequently, SSA has no guarantee that these persons are not using their benefit checks to buy drugs or alcohol. Even in cases when payees have been assigned, their control over benefit payments is questionable; most of these payees are friends or relatives. Because addicts may abuse, threaten, and pressure their payees, GAO believes that organizations would make better payees for addicts than friends or relatives. SSA needs to ensure that all disability benefit recipients are in treatment and that all addicts have a third-party or representative payee. Also, the Congress needs to consider expanding the treatment requirement to all addicts and restructuring the program to improve the payoff from treatment. GAO summarized this report in testimony before the Congress, Social Security: Disability Benefits for Drug Addicts and Alcoholics Are Out of Control, by Jane L. Ross, Director of Income Security Issues (GAO/T–HEHS–94–101, Feb. 10, 1994).

Social Security: Most Social Security Death Information Accurate but Improvements Possible (GAO/HEHS–94–211, Aug. 29, 1994)

Nearly all the information based on reports of death that the SSA shares with other Federal agencies is accurate. The accuracy of this information, which is provided to such agencies as the Departments of Defense, Veterans Affairs, and Labor, is essential to prevent or identify millions of dollars in overpayments by Federal agencies to deceased persons and to avoid the erroneous termination of benefits. Fewer than 1 percent of the nearly 350,000 recorded deaths GAO reviewed were inaccurate. SSA can make its information more useful by taking action in four areas: the handling of cases erroneously terminated, processing of rejected death reports, providing information on nonbeneficiaries, and using feedback based on agency investigations of deaths.

Social Security: New Continuing Disability Review Process Could Be Enhanced (GAO/HEHS–94–118, June 27, 1994)

SSA's new process for conducting continuing disability reviews relies on computer profiling and beneficiary self-reported data. Beneficiary self-reported data, when used with other key information SSA has, appear reliable for making decisions about when to do full medical examinations of beneficiaries scheduled for reviews. SSA has also taken steps to further assess the reliability of the self-reported data and plans to continually refine its use of computerized beneficiary data to better predict medical improvements and likely benefit terminations. The mailer process appears to be a significant step by SSA to make the review process more efficient and cost-effective. SSA needs to send out more mailers and conduct more full medical reviews of program beneficiaries. As SSA gains more experience with the mailer process and improves its ability to accurately identify beneficiaries with the greatest potential for medical improvement, it should do more full medical reviews of those persons to achieve the most effective use of agency resources. By focusing on beneficiaries with the greatest likelihood of improvement, SSA can save taxpayers millions of dollars each year and help preserve the programs' integrity by removing ineligible persons from the rolls.

SOCIAL SERVICES ISSUES

Americans With Disabilities Act: Challenges Faced by Transit Agencies in Complying With the Act's Requirements (GAO/RCED–94–58, Mar. 11, 1994)

The Americans With Disabilities Act prohibits discrimination on the basis of disability. The law requires transit systems to gradually make their buses and rail systems accessible to the disabled, including wheelchair users, and provide alternative transportation to those unable to use the transit systems' fixed-route service. Alternative transportation, called paratransit or door-to-door service, is generally provided by vans, minibuses, or taxis. This report (1) reviews the early experiences of

transit agencies in phasing in the act's paratransit requirements and notes challenges to successful implementation, (2) provides information on transit agencies' projections of costs and time periods to implement the act's paratransit requirements, and (3) identifies variables affecting the reliability of projections and the magnitude of potential costs.

VETERANS ISSUES

Disabled Veterans Programs: U.S. Eligibility and Benefit Types Compared With Five Other Countries (GAO/HRD–94–6, Nov. 24, 1993)

The United States offers benefits specifically for disabled veterans and their survivors in more program areas than any of the five other nations GAO studied—Australia, Canada, Finland, Germany, and the United Kingdom. Major differences exist, however, in the kinds of benefits offered, the eligibility requirements for benefits, and the methods used to compute benefits. Countries without special programs for disabled veterans often help these men and women through programs that serve the general population. In fact, Germany and the United Kingdom run most of their special veterans programs through general social service agencies rather than a separate veterans agency as in the United States, Australia, Canada, and Finland. Countries differ in the extent to which a veteran's disability must be service connected for the veteran to receive benefits. Most foreign countries require that a disability be closely related to the performance of military duty to qualify for disability benefits; no such link is required in the United States. The upshot is that the United States provides benefits for some disabilities that other countries do not. In a July 1989 report (GAO/HRD–89–60), GAO recommended that the Congress consider tightening the U.S. criteria.

Health Security Act: Analysis of Veterans' Health Care Provisions (GAO/HEHS–94–205FS, July 15, 1994)

Reform of the Nation's health care system to reduce the number of Americans who lack coverage of basic acute health care services could significantly reduce demand for such services in facilities administered by the Department of Veterans Affairs (VA). GAO reported in 1992 that if changes were not made in the VA health care system as part of health reform, VA hospitals could lose about 50 percent of their acute hospital workload and 44 percent of their outpatient workload. To assist the congressional Veterans' Affairs Committees, which will be considering legislation to fundamentally reform the VA health care system and veterans' health benefits, GAO prepared this fact sheet, which analyzes the veterans affairs provisions of the administration's proposed Health Security Act.

Homelessness: Demand for Services to Homeless Veterans Exceeds VA Program Capacity (GAO/HEHS–94–98, Feb. 23, 1994)

Veterans are generally believed to be about one-third of the homeless population in the United States; on any given night, up to 250,000 of an estimated 600,000 homeless persons living on the streets or in shelters may be veterans. Virtually all of these veterans are men, many of whom suffer from mental illness or drug and alcohol problems. The capacity of VA programs to serve these homeless veterans, however, falls far short of the demand of such services. Further VA services for homeless veterans are nonexistent in many areas of the country. Every VA medical center is required to assess the needs of homeless veterans, determine the availability of VA and other services in its area, and establish plans to meet those needs in coordination with public and private providers. VA has not done these assessments and has yet to set specific targets dates. If VA is to address the medical and social needs to homeless veterans nationwide, existing substance abuse, mental health, and housing programs will need to be substantially expanded and enhanced. VA may need to open new beds, hire more staff, contract with private providers of health care/housing, and either renovate buildings or allow private homeless groups to do so to provide temporary housing. In an era of tight Federal budgets, however, increasing services for the homeless could force cutbacks in services to other veterans.

VA and the Health Security Act (GAO/HEHS–94–159R, May 9, 1994)

Pursuant to a congressional request, GAO reviewed the proposed Health Security Act, focusing on (1) the provisions that pertain directly to VA; (2) other provisions of the Health Security Act that pertains to veterans' health care; and (3) a comparison of the health care services that would be covered under the Health Security Act with the health care services currently available to veterans. GAO noted that (1) the comprehensive benefits package under the proposed Health Security Act and the scope of care currently available to veterans are very extensive; (2) current VA bene-

fits of mental health care, substance abuse treatment, dental treatment of children, and optometric treatment for children are more generous than those benefits proposed under the comprehensive benefits package; (3) VA currently provides for respite care and domiciliary care while the proposed Health Security Act does not; (4) the board array of VA benefits is affected by complicated VA edibility criteria; and (5) the proposed Health Security Act is more generous in regard to the broad category of outpatient services since it includes no limitations on outpatient care.

VA Health Care: A Profile of Veterans Using VA Medical Facilities in 1991 (GAO/HEHS–94–113FS, Mar. 29, 1994)

In 1993, the President proposed a major overhaul of the Nation's health care system that would guarantee universal coverage to all Americans. For many veterans, this reform would allow them, for the first time, to choose between VA medical centers and other health care providers. Employment status and income levels are expected to be major factors affecting veterans' decisions. This fact sheet profiles veterans who, during 1991, used VA medical centers. It describes veterans' income, age, marital status, usage rates, disability status, employment, family size, and other characteristics. GAO collected this information using VA patient records and Internal Revenue Service tax records.

VA Health Care: Delays in Awarding Major Construction Contracts (GAO/HEMS–94–170, June 17, 1994).

For major construction projects costing $3 million or more, the VA is required to award (1) construction document contracts by September 30 of the fiscal year in which funds are appropriated and (2) construction contracts by September 30 of the following fiscal year. VA is required to report to the Congress and to GAO on the projects that did not meet these time limits. VA's January 1994 letter to the Congress and GAO correctly identifies 15 projects that were required to but did not have construction document contracts or construction contracts awarded by September 30, 1993. GAO believes that the contracting delays for these projects do not constitute impoundments of budget authority under the Impoundment Control Act. In GAO's view, VA has shown no intent to refrain from using the funds appropriated. Information VA provided to GAO indicates that programmatic considerations caused the contracting delays. The reason cited most often for delays was changes in project scope or design. VA expects to award 13 of the 17 required contracts for these 15 projects by September 30, 1994.

VA Health Care: Labor Management and Quality-of-Care Issues at the Salem VA Medical Center (GAO/HRD–93–108 Sept. 23, 1994)

In April 1993, the bodies of two patients were found on the grounds of the VA Medical Center in Salem, Virginia, and allegations were made about poor quality patient care due to nursing shortages, employees' stress, and poor staff morale, GAO found that the center's new medical director is restoring both staff and public confidence in the facility's management and has started to deal with quality-of-care issues. He has addressed many of the labor-management issues confronting the facility and is trying to overcome nurse staffing shortages that have harmed the quality of care being provided. But more needs to be done. Nurse staffing shortages continue, medical records are incomplete, some psychiatrists are not seeing their patients regularly, and some psychiatrists and nurses are shirking essential duties, such as taking patient histories upon admission, assessing patient needs, and providing discharge planning before a patient is released. In addition, the center's quality assurance program could stand improvement. Management should ensure that this program objectively and systematically monitors and continuously improves the quality and appropriateness of services delivered.

VA Health Care: Medical Care Cost Recovery Activities Improperly Funded (GAO/HRD–94–2, Oct. 12, 1993)

Before 1990, the 158 medical centers run by the VA used medical care appropriations to finance the recovery of health care costs from veterans or third parties. In November 1990, the Congress established a Medical-Care Cost Recovery Fund to finance all recovery expenses related to collecting the cost of medical care and services provided by VA. This report examines whether medical centers were using only the fund to underwrite cost recovery activities. GAO also reviews VA efforts to improve the efficiency of its recovery activities.

VA Health Care: Restructuring Ambulatory Care System Would Improve Services to Veterans (GAO/HRD–94–4, Oct. 15, 1994)

Veterans are experiencing lengthy delays when receiving medical care at the approximately 200 outpatient facilities run by the VA. Veterans often wait up to 3

hours before being examined by a doctor in VA's emergency/screening clinics. In addition, veterans wait an average of 8 to 9 weeks for an appointment in specialty clinics, such as those for cardiology or orthopedics. Inefficient operating procedures are the main cause of these delays. President Clinton has called for VA to compete with other providers in meeting the health care needs of veterans. To be a viable competitor, VA needs to quickly restructure its outpatient care delivery system to provide more timely ambulatory services. The establishment of telephone assistance networks and appointment scheduling systems, for example, would help in the case of veterans with nonurgent conditions. GAO summarized this report in testimony before the Congress; see Veterans Affairs: Service Delays at VA Outpatient Facilities, by David P. Baine, Director of Federal Health Care Delivery Issues, before the Subcommittee on Oversight and Investigations, House Committee on Veterans Affairs (GAO/T–HRD–94–5, Oct. 27, 1993).

VA Health Care: Tuberculosis Controls Receiving Greater Emphasis at VA Medical Centers (GAO/HRD–94–5, Nov. 9, 1993)

Lax infection-control practices and inadequate isolation rooms were behind the tuberculosis outbreak at the VA medical center in East Orange, New Jersey. Medical center staff did not consistently use appropriate procedures for isolating suspected or known tuberculosis patients. The center lacked a comprehensive employee-testing program to monitor the staff's exposure to active tuberculosis. Isolation rooms did not have proper airflow, and air exhausted from these rooms may have contaminated other areas in the medical center. Since the outbreak, the center has made major improvements in its infection-control practices, and VA plans to construct 19 isolation rooms at the center. VA has also tried to beef up tuberculosis controls at its other medical centers and is giving greater scrutiny to centers' tuberculosis-control programs and practices. According to a December 1992 VA survey, 10 medical centers each had more than 20 cases of tuberculosis; 6 of the 10 also had the highest numbers of AIDS cases.

VA Health Care: VA Medical Centers Need to Improve Monitoring of High-Risk Patients (GAO/HRD–94–27, Dec. 10, 1993)

After two patients were found dead on the grounds of a VA medical center, GAO investigated and found that "high-risk" patients—those unable to care for themselves—who wander away are a significant problem at 39 of 158 VA medical centers. In a recent 2-year period, more than 100 searches were conducted for high-risk patients at 20 VA medical centers. Patients leave their treatment settings without staff knowledge primarily when medical center staff (1) underestimate the potential for these patients to wander off without authorization or (2) fail to closely watch all high-risk patients while they are in the facility or on its grounds. During the same 2-year period, about 7,000 searches were conducted throughout the VA system for high-risk patients who were reported missing. About 99 percent of these patients were ultimately found unharmed; 34 were found dead and 19 injured. VA is working to develop search procedures for these high-risk patients who disappear without staff knowledge and approval. The goal is to find these persons before they leave the medical center grounds. But VA also needs to do a better job of monitoring high-risk patients to prevent unauthorized departures in the first place. Further, VA can do more to locate unaccounted for patients.

Veterans Benefits: Redirected Modernization Shows Promise (GAO/AIMD–94–26, Dec. 9, 1993)

In December 1992, the VA awarded the first of its planned three-stage modernization procurements. This 8-year contract was awarded to Federal Data Corporation with a maximum value of $300 million. In response to congressional concerns about the benefits expected from this contract, this report discusses (1) the status of VA's business process redesign and its service improvement goals, (2) the validity of VA's cost estimates for the modernization, and (3) VA's contention that existing computer equipment failures were frequent and caused severe benefit service problems. In June 1993, VA and the Office of Management and Budget (OMB) agreed to redirect VA's modernization effort. This report also comments on the VA-OMB agreement.

Veterans' Benefits: Lack of Timeliness, Poor Communication Cause Customer Dissatisfaction (GAO/HEHS–94–179, Sept. 20, 1994)

In fiscal year 1993, the VA provided nearly $19 billion in nonmedical benefits to veterans and their families. In 1993, GAO surveyed 1,400 recent applicants for VA nonmedical benefits nationwide. Although most applicants were satisfied with VA's services, more than one-third were unhappy with VA's handling of their claims. The time it takes VA to process claims was by far the greatest source of applicants' dissatisfaction. Communication with VA was another major concern for applicants.

Many customers said that they were dissatisfied, whether the communications were by mail, by phone, or in person. For example, 40 percent of those who visited a VA office said that they did not get the information they needed. The need to resubmit documents to VA also inconvenienced applicants. GAO's study pointed out two other factors that may hold significant implications for VA's efforts to improve customer satisfaction. First, applicants whose claims were denied represented a significant portion—36 percent—of VA's customers. VA knows very little about who those applicants are, why their claims were denied, or what it could do to help these people. Second, 60 percent of VA customers received service from sources over which VA has no authority, such as State and county veterans offices and veterans service organizations.

Veterans' Benefits: Status of Claims Processing Initiative in VA's New York Regional Office (GAO/HEHS–94–183BR June 17, 1994)

The VA recognizes slow claims processing and poor customer service as critical concerns. Claims processing time is increasing as are claims backlogs. In 1993, more than 500,000 claims were pending in VA regional offices nationwide. One of the most highly publicized initiatives to reduce claims processing time and improve service to veterans and their families is the restructuring of the claims processing system in VA's New York Regional Office. In May 1993, the regional office began processing a quarter of its claims in a prototype unit. This new unit differs substantially from the traditional "assembly line" organization used by the rest of the New York office and most other VA regional offices. This briefing report determines (1) how the operation of the prototype unit differs from the traditional operation in New York, (2) how VA is assessing the effectiveness of the prototype and how the prototype's performance compares to the rest of the New York office's, and (3) what plans New York has for expanding the use of the prototype.

Veterans' Health Care: A Profile of Married Veterans Using VA Medical Centers in 1991 (GAO/HEHS–94–223FS, Aug. 26, 1994)

In a March 1994 report (GAO/HEHS–94–113FS), GAO profiled veterans who used medical centers run by the VA. That report focused on veterans' family incomes and showed how family income varied in relation to a range of characteristics, including employment status. This fact sheet examines married veterans, analyzing the percentage of family income attributable to veterans and spouses and comparing married veterans' incomes with those of single veterans. In addition, this fact sheet further refines veterans' employment status to differentiate between veterans receiving employee compensation and those with self-employment income.

Veterans' Health Care: Implications of Other Countries' Reforms for the United States (GAO/HEHS–94–210BR, Sept. 27, 1994)

Reform of the Nation's health care system would have a major impact on the VA health care system, one of the Nation's largest direct delivery systems. Health care reform would give many uninsured and poor veterans the freedom to choose between VA and other health care providers. This would likely cause many veterans to leave the system unless it changes or VA benefits change to encourage those now in the system to stay or those outside the system to start using VA facilities. Without such changes, VA would likely lose nearly 50 percent of its acute hospital workload. This report studies changes in veterans health care systems and benefits in other countries that implemented universal health care systems. GAO limited its review to four countries—Australia, Canada, Finland, and the United Kingdom—that ran separate direct delivery systems for veterans when they instituted universal health care.

Veterans' Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS–94–104BR, Apr. 25, 1994)

When the VA health care system was established in 1930, neither public nor private health insurance programs were available to American veterans. With the subsequent growth of public and private health insurance programs, most veterans today have alternatives to VA health care. National health care reform could further reduce the number of veterans lacking health insurance. This briefing report determines (1) how many veterans are receiving services under other federal health programs and the cost of providing those services and (2) how many veterans using VA services are eligible to receive care under other Federal programs.

OTHER ISSUES

Americans With Disabilities Act: Effects of the Law on Access to Goods and Services (GAO/PEMD–94–14, June 21, 1994)

This report looks at the extent to which the Americans With Disabilities Act has improved the access for persons with disabilities to goods and services provided by businesses and State and local governments. Overall, GAO found steady improvement in both accessibility and awareness during the initial 15 months that the act was in effect. However, enough areas of concern remain to suggest a need for continuing educational outreach and technical assistance to business and Government agencies covered by the act, as well as continued monitoring by the Congress.

Budget Policy: Issues in Capping Mandatory Spending (GAO/AIMD–94–155, July 18, 1994)

GAO examined whether implementation of a budgetary cap on mandatory entitlement spending is a practical way to control growth in mandatory programs. Although a spending cap on mandatory spending for Federal entitlement programs would yield savings, a cap would have little, if any, effect on the long-term growth of these programs until the issues of eligibility and benefits, which drive up spending, are addressed.

FDA User Fee: Current Measures Not Sufficient for Evaluating Effect on Public Health (GAO/PEMD–94–26, July 22, 1994)

The Congress passed legislation in 1992 requiring the Food and Drug Administration (FDA) to charge fees for reviewing new drug applications to determine whether the drugs can be marketed in the United States. The fees collected are to be used to augment FDA resources devoted to reviewing new drug applications. This increase in resources, in turn, is intended to speed drug review and approval. GAO reviewed whether the data mandated by the law will be sufficient to evaluate how well the law has achieved its goal of getting drugs to patients sooner. GAO found that the existing reporting requirements of the user fee act, if satisfied, will provide detailed information on one aspect of the drug review and approval process—the timeliness of FDA performance. However, because FDA performance is not the sole determinant of how long the process takes, these data alone will not be enough to evaluate how long it takes for drugs to become publicly available, and more data are needed.

Federal Aid: Revising Poverty Statistics Affects Fairness of Allocation Formulas (GAO/HEHS–94–165, May 20, 1994)

Concerns have been raised in the Congress that revising counts of people in poverty by adjusting the official poverty line for geographic differences in the cost of living could significantly alter the allocation of Federal aid to State and local governments. This report presents GAO's views on how such a revision could affect the fairness of the distribution of Federal formula grants if such an adjustment were made. GAO concludes that adjusting poverty counts to reflect differences in the cost of living, if proven feasible, would bolster the Federal Government's ability to target Federal aid to places with the greatest needs. GAO also believes that such a change should not be implemented in Federal allocation formulas without first assessing the impact of the change on the fairness with which Federal funding is allocated to States and localities. In a formula lacking an indicator of States' own funding capabilities, such a change by itself could increase inequities. In formulas that already adequately reflect States' funding capabilities, such a change would improve fairness.

Health, Education, Employment, Social Security, Welfare, and Veterans Reports (GAO/HEHS–94–233W, Sept. 1994)

This booklet lists GAO documents issued on government programs related to health, education, employment, Social Security, welfare,and veterans issues, which are primarily run by the Departments of Health and Human Services, Labor, Education, and Veterans Affairs. One section identifies reports and testimonies issued in the 2 months prior to September 1994 and summarizes key products. Another section lists all documents published during the past 2 years, organized chronologically by subject. Order forms are included.

Status of Open Recommendations: Improving Operations of Federal Departments and Agencies (GAO/OP–94–1, Jan. 14, 1994)

In fiscal year 1993, GAO made more than 1,600 recommendations. This yearly report highlights the impact of GAO's work on everything from health care to transportation to international affairs. It also summarizes the key recommendations that

have yet to be fully acted upon. For the first time, computer disks are being automatically included with the printed report. This hypertext software, which provides greater detail on all open recommendations, contains menu options that allow users to locate information easily.

APPENDIX III—FISCAL YEAR 1994 TESTIMONIES RELATING TO ISSUES AFFECTING OLDER AMERICANS

GAO testified 28 times before congressional committees during fiscal year 1994 on issues relating to older Americans. Of the testimonies, 13 were on health, 1 on housing, 8 on income security, 5 on veterans, and 1 on other issues.

HEALTH ISSUES

Health Care in Hawaii: Implications for National Reform (GAO/T–HEHS–94–123, Mar. 16, 1994)

For nearly 20 years, Hawaii has been a leader in the effort to achieve universal access to health insurance. It is the only State that requires employers to provide a minimum level of health insurance benefits to employees, and its public programs cover many residents lacking employment-based insurance. GAO makes several points. First, Hawaii's employer mandate did not have a harmful effect on small businesses. Second, although Hawaii's system of near-universal access has lowered health premiums, its per capita health care costs have risen at a rate similar to the national average. Third, Hawaii's experience suggests that an employer mandate by itself will not necessarily result in universal access to health care.

Health Care Reform: Supplemental and Long-Term Care Insurance (GAO/T–HRD–94–58, Nov. 9, 1993)

Provisions of the Clinton administration's Health Security Act that deal with private long-term care insurance and supplemental health insurance address many of the problems that GAO has pointed out in the past. The act has detailed sections governing the content and marketing of such insurance, including disclosure standards that protect consumers from deceptive marketing practices, grievance procedures that allow policyholders to contest insurance company decisions, and sales commission standards that discourage questionable sales practices. In general, GAO believes that the administration's proposal contains the kinds of consumer protections that GAO has long advocated. Some problems, however, are not addressed. Specifically, the act will not protect consumers from the sale of duplicate policies or high-pressure sales techniques. It also does not address other kinds of supplemental insurance that cover specific diseases or conditions requiring hospitalization. Because of their limited, narrow coverage, such insurance may be unnecessary for many consumers.

Health Care Reform: Implications of Geographic Boundaries for Proposed Alliances (GAO/T–HEHS–94–108, Feb. 24, 1994)

A common feature of many health reform bills is the creation of public or private health alliances that would seek to broaden coverage, pool risks, give consumers a choice of health care plans, and disseminate information on the costs and quality of plans. All the bills leave the establishment of alliance boundaries to the States. This testimony discusses (1) the provisions of major health reform bills concerning the configuration of alliance boundaries; (2) experiences of two States that have established entities similar to alliances; (3) features and procedures for creating a Metropolitan Statistical Area; and (4) issues relating to the potential effects of alliance boundaries on existing health markets, access to health care, and distribution of health care costs within a State. Concerns about the boundary provisions of the health reform proposals include the potential for gerrymandering, changing the provision and receipt of health care, segmenting high-risk groups, and isolating underserved areas.

Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T–HEHS–94–124, Mar. 17, 1994)

Weaknesses within the current health insurance system allow unscrupulous health care providers to cheat insurance companies and programs out of billions of dollars annually. Fraud and abuse flourish in a health care system that collects little information on provider practices, encourages high profits at the expense of cost-effective care, and has ineffective laws and enforcement mechanisms to punish and recover money from those abusing the system. This testimony makes several recommendations aimed at overcoming these problems. Recent legislative proposals to

reform the health care system, including the administration's proposal, address each of these elements to some extent.

Long-Term Care Reform: Program Eligibility, States' Service Capacity, and Federal Role in Reform Need More Consideration (GAO/T–HEHS–94–144, Apr. 14, 1994)

Passage of any long-term care reform legislation is merely the first step in a long journey toward meeting the Nation's long-term care needs. Knowledge about determining long-term care needs and services, derived largely from the experience of innovative States suggests that State flexibility is the best way to meet the diverse needs of individuals and communities. This flexibility requires a new, different Federal role, largely one of partnership with the States in the design and management of programs. The administration's proposal would give states $38 billion in Federal funding each year for a new Federal-State program of home and community-based services, to be phased in from 1996 to 2003. States will be given wide latitude to design and run programs to serve persons of all income ranges. The proposal would also liberalize Medicaid nursing home eligibility, provide tax credits to defray the costs of personal assistance for working persons with disabilities, and encourage and regulate private long-term care insurance. If the administration's proposal is to be the blueprint for long-term care reform, the new Federal role should be spelled out more clearly. More thought should also be given to developing State guidance on determining eligibility and to helping States with less capacity to use program funds wisely.

Long-Term Care: Demography, Dollars, and Dissatisfaction Drive Reform (GAO/T–HEHS–94–140, Apr. 12, 1994)

The long-term care system has evolved in a patchwork fashion and today comprises multiple programs that individuals find hard to access. Despite millions of dollars in outlays, the system often fails to meet the diverse needs of the disabled, and many believe that access to services could be improved with the same level of funding. This testimony focuses on three trends underlying the quest for reform. First, demographic changes make rising demand for long-term care inevitable across all ages, not just for the elderly. Second, spending will escalate sharply across all ages, not just for the elderly. Third, despite high costs, disabled persons are increasingly unhappy with available services and their ability to obtain them.

Long-Term Care: The Need for Geriatric Assessment in Publicly Funded Home and Community-Based Programs (GAO/T-PEMD–94–20, Apr. 14, 1994)

Because of advances in medicine and public health, Americans are living longer than ever before. Nearly one in every eight Americans was 65 years of age or older in 1990; by 2020, this ratio is expected to rise to one in five. To maintain their independence, many elderly people need daily help with routine activities, such as bathing, dressing, shopping, and meal preparation. Home and community-based long-term care for the elderly is today financed and run through a host of Federal and State programs. This fragmentation can result in elderly persons being reevaluated every time they apply for a new program or pass a particular milestone, such as being discharged from a hospital. Despite this potential for redundancy, geriatric assessment is a potentially useful part of any program with frail elderly clients seeking community and home-based long-term care. This testimony discusses (1) what geriatric evaluation is and how it is used, (2) the extent to which it is available in public programs, (3) the professional requirements for persons who administer it, and (4) the pros and cons of standardizing the evaluation process.

Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/T–HEHS–94–91, Feb. 2, 1994)

Although some "managed care" plans have the potential for delivering health care at lower cost, little empirical evidence exists showing that the use of these plans has contained employers' overall health care costs. Managed care refers to insurance plans that limit patients to a specific network of doctors and hospitals, control the use of services, and negotiate reimbursement with providers. Under this definition, about half of all insured workers are covered by managed care plans. GAO reviewed employers' experience with managed care and found that some managed care plans, by negotiating physician and hospital payments and controlling the use of services, can potentially hold down costs. Lower costs for these plans, however, may not translate into lower health care spending for employers due to enrollee differences and pricing policies. GAO also discovered that employees like many features of managed care plans but would rather not be limited in their choice of physicians.

Medicaid: A Program Highly Vulnerable to Fraud (GAO/T–HEHS–94–106, Feb. 25, 1994)

The Medicaid program cost State and local governments more than $150 billion in 1993 for health services and supplies. It is highly vulnerable to fraud because of its size, structure, target population, and coverage. The ensuring drain on program funds is hard to gauge, but State Medicaid officials believe it may be as high as 10 percent of program expenditures. Prescription drugs are a very appealing target. Schemes include pharmacists routinely adding medications to customers' orders and clinics inappropriately giving Medicaid recipients completed prescription forms, or scrips, that can be sold on the street to the highest bidder. Some pills costing 50 cents at the pharmacy have been resold for as much as $85. Although States have been tackling Medicaid fraud with some success, the problem persists. Officials in many States say that most leads to unpursued, cases take too long to resolve, and penalties are light even for those convicted. Most say that a lack of resources hinders oversight, investigations, and prosecutions. GAO suggests that the Health Care Financing Administration (HCFA) take the lead and develop an overall strategy to guide States in their struggle against Medicaid fraud.

Medicare Part B: Inconsistent Denial Rates for Medical Necessity Across Six Carriers (GAO/T–PEMD–94–17, Mar. 29, 1994)

GAO discovered large disparities in a probe of how many Medicare claims are being rejected for medical reasons in different parts of the country. The study looked at six carriers: California Blue Shield, California-Occidental, Illinois Blue Shield, Wisconsin Physician Services, North Carolina-Connecticut General, and South Carolina Blue Shield. In Southern California, for example, the insurance carrier handling Medicare claims rejects as medically unnecessary 54 of every 1,000 claims for mammograms. In contrast, in Northern California, only 3 claims in 10,000 for the same procedure are turned down. GAO discovered (1) sizable differences among the carriers with respect to denial rates for the services screened for medical necessity; (2) that the number of services that carriers screened for medical necessity varied markedly; and (3) that the overall denial rate for medical necessity also differed among the six carriers reviewed. At one extreme, one carrier denied as few as 1 service per 1,00 allowed, while at the other extreme, another carrier denied 23 services per 1,000 allowed. Medicare is a national program under which beneficiaries in different geographic areas should be receiving similar benefits. Although it may be essential for Medicare to allow for local determination of medical policy, GAO concludes that this allowance, left to itself, results in inconsistent treatment of beneficiaries and providers.

Medicare/Medicaid: Data Bank Unlikely to Increase Collections From Other Insurers (GAO/T–HEHS–94–162, May 6, 1994)

The Department of Health and Human Services has been directed to establish a data bank, beginning in February 1995, that would contain information on all workers, spouses, and dependents who are covered by employer-provided health insurance. The goal is to save millions by strengthening processes to (1) identify the approximately 7 million Medicare and Medicaid beneficiaries who have other health insurance coverage that should pay medical bills before Medicare and Medicaid kicks in and (2) ensure that this insurance is appropriately applied to reduce Medicare and Medicaid costs. In GAO's view, however, the data bank will end up costing millions and likely achieve little in the way of savings. GAO believes that changes and improvements to existing activities would be a much easier, less costly, and thus preferable alternative to the data bank. This is largely because the data bank will result in an enormous amount of added paperwork for both HCFA and the Nation's employers.

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (GAO/T–HRD–94–59, Nov. 12, 1993)

Soaring expenditures for health care underscore the need for the government to fund and manage Medicare judiciously, but budget constraints have resulted in underfunding key program safeguards that control billions of dollars in benefit payments. In fiscal year 1993, Medicare cost $146 billion, covered about 35 million beneficiaries, and processed nearly 700 million claims. Medicare has delegated much of the responsibility for program safeguards to a national network of some 80 claims processing and payment contractors. GAO testified that, given shortcomings in these safeguards, any cuts in Medicare's administration budgets should take into account their likely effect on benefit payments. During the past 5 years, Medicare's program safeguards budget, on a per claim basis, has declined dramatically. The upshot is that opportunities to curb unnecessary Medicare expenditures are being lost. Strong

evidence exists that with an adequately funded and managed safeguard program, Medicare could avoid millions of dollars in unnecessary expenditures. GAO believes that the Congress should continue to pursue modifying budget procedures so that Medicare's safeguard funding could be boosted without cutting spending elsewhere. GAO also believes that HCFA needs to develop an effective strategy to manage contractors' payment safeguard activities.

1993 German Health Reforms: Initiatives Tighten Cost Controls (GAO/T–HRD–94–2, Oct. 13, 1993)

Expensive new technologies, an aging population, administrative waste, structural inefficiencies, and unnecessary medical procedures have all fueled soaring health care costs in most industrialized nations. In 1993, Germany, concerned about sharp rises in health insurance premiums, began tightening its existing cost-control measures. The United States may find the German experience instructive because that Nation provides coverage of nearly all its residents, guarantees a generous benefit package, and, like the U.S. system, relies mainly on employment-based financing. This testimony, which draws on a July 1993 GAO report (GAO/HRD–93–103), provides an overview of the German health care system, discusses problems leading up to the 1993 reforms, and presents some early results of these changes.

HOUSING ISSUES

Federally Assisted Housing: Condition of Some Properties Receiving Section 8 Project-Based Assistance Is Below Housing Quality Standards (GAO/T–RCED–94–273, July 26, 1994)

Physical conditions in the Section 8 assisted properties GAO visited ranged from very good to very poor. The properties in good physical condition show that the Section 8 program can work. Conditions in some properties, however, clearly violate the Department of Housing and Urban Development's (HUD) housing quality standards. In the distressed properties, families lived in units with leaking toilets and sinks, exposed electrical wiring, holes in walls and ceilings, broken air conditioners and smoke detectors, damaged and missing kitchen cabinets, and roach and rat infestation. Moreover, the landlords for some of these distressed properties collected rents that were higher than those for well-maintained apartments nearby. Although HUD has various enforcement tools to ensure that properties comply with this housing quality standards, including barring or suspending landlords from further participation in Section 8 programs and terminating housing assistance contracts, HUD has used these tools sparingly and inconsistently.

INCOME SECURITY ISSUES

D.C. Pensions: Plans Consuming Growing Share of District Budget (GAO/T–HEHS–94–192, June 14, 1994)

The District of Columbia's overall financial status is being affected by the increasing demand on city revenues from its underfunded pension plans for police and fire fighters, teachers, and judges. In 1991 the District's contribution to these plans was about 8 percent of revenues, and unless remedial action is taken, the contribution could rise to about 15 percent of revenues by 2005. Pension costs are now running more than 50 percent of payroll and will grow to 70 percent after 2004. This testimony provides a brief historical overview of the unfunded liability in the District's Pension plans; outlines the plans' current funding provisions; and discusses the effects of H.R. 3728, the District of Columbia Pension Liability Funding Reform Act of 1994, which seeks to eliminate the District's financial liability for these plans, as well as the responsibilities of the Federal Government, the District, and the plans' participants.

Social Security Administration: Many Letters Difficult to Understand (GAO/T–HEHS–94–126, Mar. 22, 1994)

The Social Security Administration (SSA) each year sends letters to more than 44 million people. To accommodate this extremely high volume, virtually the entire process is automated, SSA relies on these letters to officially notify individuals about their eligibility for benefits or adjustments SSA is making to their benefits. SSA has had long-standing problems communicating clearly in its letters. Although SSA's recently revised communication standards appear to be a positive step, they do not address problems such as illogically ordered information or missing details. GAO staff trained in accounting and the Social Security program examined a representative sample of 500 letters and found them hard to understand. GAO concludes that SSA needs to establish overall communication objectives, including iden-

tifying this customers' preferences and measuring progress toward achieving such objectives.

Social Security Administration Major: Changes in SSA's Business Processes Are Imperative (GAO/T–AIMD–94–106, Apr. 14, 1994)

SSA's current disability determination process is extremely stressed, burdened with increasing workloads and enormous backlog. SSA has turned to automation to improve operations, but these efforts have had only a minimal impact because they focused on automating existing processes that are inefficient, SSA's April 1994 proposal for redesigning the disability process is a credible proposal that would make the basic changes needed to realistically cope with disability determination workloads. The proposal, which combines top management leadership with the necessary staff and money, documents the existing disability determination problems and recommends a solution to dramatically change the process. As with any major reform, however, many implementation issues still need to be addressed, including new staffing and training demands, developing necessary automation requirements, and confronting the entrenched cultural barriers to changes.

Social Security: Continuing Disability Review Process Improved, but More Targeted Reviews Needed (GAO/T–HEHS–94–121, Mar. 10, 1994)

GAO is encouraged SSA's efforts to make the continuing disability review process more efficient and cost-effective through the use of computer profiling and beneficiary self-reported data. GAO is concerned, however, that SSA continues to do too few continuing disability reviews, particularly for beneficiaries with the greater likelihood of being removed from the disability rolls. In GAO's view, finding ways to provide SSA with more money to do the reviews is worthwhile.

Social Security: Disability Benefits for Drug Addicts and Alcoholics Are Out of Control (GAO/T–HEHS–94–101, Feb. 10, 1994)

The number of drug addicts receiving Social Security disability benefits has soared in recent years; about 250,000 addicts now receive disability benefits at an annual cost of $1.4 billion. Despite the fact that half of them qualify for benefits on the basis of their addiction alone, most addicts are not required to be in treatment. Finding qualified representative payees to manage addicts' benefits have been a long-standing problem for the SSA. Most payees are either friends or relatives. In the absence of tight controls, addicts are free to buy drugs and alcohol to maintain their addictions. GAO believes that organizational payees would be in a better position to provide the strict controls needed over benefit payments to addicts.

Social Security: GAO's Analysis of the Notice Issue (GAO/T–HEHS–94–236, Sept. 16, 1994)

GAO has been studying the "notch" issue for more than 8 years and has testified before the Congress many times. This testimony briefing covers the critical matters that GAO believes the Commission on the Social Security Notch Issue must deal with in addressing the notch issue in 1994. In summary, GAO concludes that retirees in the notch group who claim an inequity are comparing themselves to a group of retirees who received benefits based on an overgenerous formula. If the Congress chooses to pursue legislation, it should consider several factors, particularly the cost of financing any legislation.

Underfunded Pension Plans: Federal Government's Growing Exposure Indicates Need for Stronger Funding Rules (GAO/T–HEHS–94–149, Apr. 19, 1994)

Sponsors of underfunded pensions are required by law to make additional contributions to their funds, but no evidence exists that the problem of underfunding has abated. The total underfunding in single-employer plans insured by the Pension Benefit Guaranty Corporation (PBGC) rose from $31 billion in 1990 to more than $50 billion 1992. In a random sample of plans paying PBGC's variable rate premium, GAO discovered that only 40 percent of the plan sponsors subject to the law were making additional contributions in 1990, and the amount of additional contributions was less than 3 percent of the plans's underfunding. GAO found that the amounts sponsors were allowed to use to reduce their additional contributions were much larger than the unreduced additional contributions for some plans, suggesting that the design of the offset is flawed and needed to be changed. H.R. 3396 contains provisions to improve funding in underfunded plans, including a measure to correct the design flaw in the offset. Although it believes that the bill is a step in the right direction, GAO believes that the provisions of H.R. 3396 should be strengthened to ensure that sponsors of a greater percentage of underfunded plans make additional contributions.

Underfunded Pension Plans: Stronger Funding Rules Needed to Reduce Federal Government's Growing Exposure (GAO/T–HEHS–94–191, June 15, 1994)

Although the majority of pension plans insured by the PBGC are well funded, a significant minority are underfunded, and the level of underfunding in these plans has been growing in recent years. This growth increases PBGC's exposure, which refers to the size of its potential claims. This testimony makes three main points. First, current rules designed to ensure that sponsors of underfunded plans make additional contributions to better fund their plans are not working well. Second, provisions in the administration's proposed pension reform bill—S. 1780, the Retirement Protection Act of 1993—especially the revised offset design, should increase both the number of sponsors of underfunded plans that make additional contributions and the amount of those contributions. Third, GAO believes that the proposed funding provisions should be strengthened further to ensure that an even greater percentage of underfunded plan sponsors make additional contributions.

VETERAN'S ISSUES

VA Health Care for Women: In Need of Continued VA Attention (GAO/T–HEHS–94–114, Mar. 9, 1994)

This testimony discusses the Department of Veterans Affairs' (VA) long-standing problems in meeting the health care needs of women veterans and the implications for VA's role in a reformed national health care system. VA has repeatedly stressed the need for delivering better service to women veterans and has issued guidance to its medical centers that responds to problems identified in a January 1992 GAO report. VA's greatest success has been in improving privacy for women veterans. VA has not, however, effectively monitored field facilities to ensure that they have actually improved service for women veterans. For example, even when medical centers submitted inadequate plans for improving breast cancer screenings, VA did not notify the medical centers of its findings. Under VA's health reform proposal, each veteran would be assigned a primary care physician. This step should improve the thoroughness of cancer screenings for women veterans. But real progress in improving service for women veterans depends on the leadership of individual VA medical center directors.

VA Health Care Reform: Financial Implications of the Proposed Health Security Act (GAO/T–HEHS–94–148, May 5, 1994)

This testimony discusses the financial and policy implications of the veterans' health care provisions in the administration's proposed Health Security Act. GAO focuses on (1) veterans health coverage under VA and other Federal programs; (2) factors that will likely affect the potential population of enrollees in VA health plans; (3) the potential costs associated with the expanded entitlement and supplemental benefits provisions of the Health Security Act; and (4) VA's ability to set realistic premiums and the implications of inaccurate premiums for cost, quality, and access to care for VA clients.

Veterans Affairs: Service Delays at VA Outpatient Facilities (GAO/T–HRD–94–5, Oct. 27, 1993)

Veterans are experiencing lengthy delays when receiving medical care at the approximately 200 outpatient facilities run by the VA. Veterans often wait up to 3 hours before being examined by a doctor in VA's emergency/screening clinics. In addition, veterans wait an average of 8 to 9 weeks for an appointment in specialty clinics, such as those for cardiology or orthopedics. Inefficient operating procedures are the main cause of these delays. President Clinton has called for VA to compete with other providers in meeting the health care needs of veterans. To be a viable competitor, VA needs to quickly restructure its outpatient care delivery system to provide more timely ambulatory services. The establishment of telephone assistance networks and appointment scheduling systems, for example, would help in the case of veterans with nonurgent conditions.

Veterans' Health Care: Veterans' Perceptions of VA Services and Its Role in Health Care Reform (GAO/T–HEHS–94–150, Apr. 20, 1994)

GAO conducted a series of focus group meetings with veterans to explore their views on the current veterans health care system and the future role of the VA under health care reform. Among the topics discussed were the reasons and extent to which the veterans used VA health care services; their overall satisfaction with the care VA provides; the need to maintain a separate VA health care system; whether the VA health care system should be expanded to cover dependents; whether VA should set up managed care plans to compete with private-sector plans, and

the potential competitiveness of VA plans; the factors they would consider in deciding whether to select a VA health plan; and improvements that would make VA a more competitive provider. The veterans expressed a wide range of opinions on these topics. Although their views may not be representative of the Nation's 27 million veterans, many of the concerns expressed—such as the excessive waiting times and poor customer service—have been the focus of earlier GAO reports and congressional hearings.

Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T–HEHS–94–197, June 29, 1994)

GAO is undertaking several studies of the potential effects of health care reform on the VA health care system and options for restructuring veterans' health benefits. This testimony draws on the preliminary work of one of those studies and discusses (1) legal and structural barriers that could limit VA's ability to restructure its health care facilities into managed care plans and compete with private-sector health plans, (2) the extent to which the Health Security Act would overcome these barriers, and (3) the potential risks associated with efforts to make VA competitive with private-sector managed care plans competitive with private-sector managed care plans.

OTHER ISSUES

Human Experimentation: An Overview on Cold War Era Programs (GAO/T–NSIAD–94–266, June 29, 1994)

During World War II and the Cold War, the Defense Department (DOD) and other national security agencies conducted extensive radiological, chemical, and biological research programs. Precise information on the number of tests, experiments, and participants is unavailable and the exact numbers may never be known. However, GAO has identified hundreds of experiments in which hundreds of thousands of people were used as test subjects. These experiments often involved hazardous substances, such as radiation, blister and nerve agents, biological agents, and lysergic acid (LSD). In some cases, basic safeguards to protect people were either not in place or were not followed. Some tests and experiments were done in secret, and others involved the use of people without their knowledge or consent or their full knowledge of the risks involved. The effects of the experiments are hard to determine. Although some participants suffered immediate injuries, and some died, in other instances health problems did not surface until 20 or 30 years later. It has proven difficult for participants in Government experiments between 1940 and 1974 to pursue claims because little centralized information is available to provide participation or determine whether health problems resulted from the testing. Government experiments with human subjects continue today. For example, the Army uses volunteers to test new vaccines for malaria, hepatitis, and other exotic diseases. Since 1974, however, Federal regulations have required (1) the formation of institutional review boards and procedures and (2) researchers to obtain informed consent from human subjects and ensure that their participation is voluntary and based on knowledge of the potential risks and benefits.

APPENDIX IV—ONGOING GAO WORK AS OF SEPTEMBER 30, 1994, RELATING TO ISSUES AFFECTING OLDER AMERICANS

At the end of fiscal year 1994, GAO had 55 ongoing assignments that affected older Americans. Of these, 26 were on health, 8 were on income security, and 21 were on veterans issues.

HEALTH ISSUES

A Survey of Assessment Instruments in Medicaid Waiver Programs for Home and Community Based Long-Term Care
Adult Immunization Under Medicare
Assessing the Accuracy of Cholesterol Measurement
Cost and Quality of Hospital Care
Development of Formula and Program Alternatives to the Current Long-Term Care Component of Medicaid
Disabled Medicare Beneficiaries' Ability to Obtain Durable Medical Equipment
HCFA Management of Medicare Medical Policies
Implementation of the "Patient Self-Determination" Provisions of OBRA '90
Inappropriate Prescription Drug Use Among the Elderly
Investigation of Inappropriate Medicare Billings for Rehabilitation Services to Nursing Home Residents

Long-Term Care Financing
Long-Term Care Populations
Long-Term Care Services
Loss Ratio Experience for MediGap Insurance in 1992
Medicare Claim Denials and Appeals Across Six Carriers
Medicare High Risk Report Follow-Up
Medicare's Use of Data to Monitor Performance of HMO's
Nursing Home Billing Abuses
Quality Assurance in Home Care
Recent Growth of Medicare Home Health Care
Review of Billing and Payment Procedures for Medical Supplies
Review of HUD's Hospital and Nursing Home Insurance Programs
Safeguards Against Inappropriate Use of Drugs in Nursing Homes
Study of Mergers and Alliances Between Pharmaceutical Manufacturers and Pharmacy Benefit Management Companies
Supportive Services and Long-Term Care
Time Charges to Medicare for Anesthesia Services

INCOME SECURITY ISSUES

Characteristics of 401(k) Plans and Their Participants
Federal Options for Funding DC Pension Plans for Fire, Police, and Teachers
HRA4: 1995 Update of Pension Benefit Guaranty Corporation High Risk Report
Public Pension Public Fund
Reasons for Caseload Growth in Supplemental Security Income
Social Security Administration: SSA's Transition to Independence
Social Security Administration: Office of Hearings and Appeals
Social Security Administration: SSA Services Provided to Employees

VETERANS ISSUES

Adequacy of VA's Planning for the Reuse of the Orlando Naval Hospital
Availability of VA Health Care in Community-Based Settings
Evaluation of VA Direct Cost Comparison Studies
Evaluation of VA Medical Centers' Discharge Planning
Evaluation of VA Programs to Treat Veterans' Drug and Alcohol Dependency
How Well Is the Current VA Structure Meeting Health Care Needs of Veterans?
Nonveterans Use of VA Medical Centers
Preventing Needle-Stick and Sharp Injuries in VA
Prevention of Compensation and Pension Overpayments to Veterans and Their Survivors
Quality of Care: Factors Influencing Consumers' Decisions
Relationship Between Distance to VA Medical Centers and Use of VA Services
Review of the Quality of Care Provided in VA Hospital Based Nursing Homes
Review of VA's Selection of a Nursing Home Site in the Chesapeake Region
Study of VA Survivor's Benefits Program
Survey of Veterans Benefit Administration Interface with Other Entities
Types of Services Used by Medicare-Eligible Veterans
VA Albuquerque Medical Center's Lithotripsy Contracting Practices
VA Process for Evaluating Physicians Performance
Veterans' Compensation and Pension Claims Take Far Too Long to Process
Veteran's Perceptions Under Health Care Reform
What Barriers Could Affect VA's Plans to Implement a Managed Care Program?

APPENDIX V—MAJOR CONTRIBUTORS TO THIS REPORT

Cynthia A. Bascetta, Assistant Director, (202) 512–7207
James C. Musslewhite, Assignment Manager
Benjamin C. Ross, Evaluator-in-Charge
Stephen F. Palincsar, Network Librarian

ITEM 22. LEGAL SERVICES CORPORATION

SERVICE TO THE AGING

In 1993, LSC funded programs served 153,955 Americans over the age of 60, with an additional 19,771 being served through private attorney pro bono referrals. Roughly one-third of these cases involved Social Security benefit or Medicare. The other cases fell into the categories indicated above.

Also in 1993, LSC provided a one-time grant to Legal Counsel for the Elderly, in Washington, DC, to hold a National Conference on Utilizing Senior Volunteer Attorneys. The conference was attended by representatives from 20 LSC programs and was hailed as a great success. In fact, three of the programs involved are set to begin their own Senior Volunteer Attorney programs.

For more information on activities taken on behalf of older Americans by the legal services community, I would suggest talking to the two individuals listed below.

Wayne Moore, Executive Director, Legal Counsel for the Elderly, 601 E Street, NW, 4th Floor, Washington, DC 20049, (202) 434–2120.

Burton D. Fretz, Executive Director, National Senior Citizens Law Center, 1815 H Street, NW, Suite 700, Washington, DC 20006, (202) 887–5280.

Both should be able to provide you with more specific programmatic information than I.

NATIONAL SENIOR CITIZENS LAW CENTER

Main Office: 1052 West 6th Street—Suite 700, Los Angeles, California 90017, (213) 482–3550.

Branch Office: 1815 H Street, Northwest—Suite 700, Washington, DC 20006, (202) 887–5280.

The National Senior Citizens Law Center (NSCLC), a national support center, was awarded a $658,919 LSC grant in fiscal year 1992. Under the terms of its grant, the NSCLC provides a variety of services to LSC-funded field programs, including legislative and administrative representation on behalf of the elderly poor. The Center also provides training for attorneys and paralegals, on such topics as age discrimination, Medicaid, Medicare, long-term disability, the Older Americans Act, pensions, Social Security/SSI, and disability. In addition to producing and distributing the *Washington Weekly* and the *Nursing Home Law Letter,* the Center processed approximately 1,824 requests for assistance regarding elderly issues in calendar year 1991. The Center's Executive Director, Burton D. Fretz, can be contacted for further information at the DC office.

LEGAL COUNSEL FOR THE ELDERLY

601 E Street, Northwest Building "A", 4th Floor, Washington, DC 20049, (202) 434–2120.

Legal Counsel for the Elderly (LCE) was awarded a $119,533 LSC supplemental field grant in fiscal year 1992. During calendar year 1991, LCE processed over 339 requests for assistance from elderly clients, in such general areas as public benefits protection, protective services, consumer and probate. In addition, LCE, in conjunction with the American Association for Retired Persons (AARP), provides specific outreach to the homebound and the Hispanic communities of Washington, DC. The Program's Executive Director, Wayne Moore, can be contacted for further information.

LEGAL SERVICES FOR NEW YORK CITY

Main Office: 350 Broadway, Sixth Floor, New York, New York 10013–9990, (212) 431–7200.

Branch Office: Legal Services for the Elderly, 130 West 42nd Street, 17th Floor, New York, New York 10036–7803, (212) 391–0120.

For fiscal year 1992, Legal Services for New York City (LSNYC) was awarded a $13,753,672 basic field grant and a $127,081 State support grant. A portion of the States support grant was given to an LSNYC branch office, Legal Services for the Elderly (LSE), which provides legal assistance exclusively to the elderly on such issues as pensions, age discrimination, Social Security and SSI.

In calendar year 1991, LSE processed approximately 320 requests for legal assistance to the elderly. LSE's Director, Jonathan Weiss, can be contacted for further information.

It is important to note, though, that while not all LSC programs have a special, elderly law unit, they all potentially provide services to the elderly. Most LSC programs are in the yellow pages of any given locale, usually listed under "Legal Aid,"

or "Legal Services." I don't know if that is something you want to include in your listings, but I thought I would let you know.

ITEM 23. NATIONAL ENDOWMENT FOR THE ARTS

NATIONAL ENDOWMENT FOR THE ARTS SUMMARY OF ACTIVITIES RELATING TO OLDER AMERICANS—FISCAL YEAR 1994

THE ENDOWMENT'S GOALS AND VISION

The National Endowment for the Arts is actively engaged in making the arts more accessible in the firm belief that the arts enhance the quality of life for everyone and serve as catalysts in bringing people of all ages closer together. This contact between generations contributes to the revitalization of communities. The arts offer exciting opportunities for self expression, and contribute to their vitality and well being of everyone. The expansion of people's longevity and time has led to a shift away from the over-emphasis on aging as a social problem and toward the recognition that later life contains positive potential for growth and enrichment.

The Arts Endowment holds as one of its guiding principles that the arts belong to everyone. As we look to the future of the arts in America, this belief must be ever present in our vision. Americans deserve and should receive a life of learning through the arts from grade school through adulthood and into their later years. In its plans for the future, the Endowment seeks to promote three key elements to the arts in America, Excellence, Diversity, and Vitality. These goals are being achieved through a number of strategies, many of which should improve the quality of life for older citizens. They include:

Addressing health concerns of artists, disseminating information to the field, and supporting President Clinton's goal of health coverage for all Americans.

Funding and promoting inter-generational programs that include the passing down of traditional arts to younger generations.

Supporting initiatives across the country to involve the arts in non-traditional venues such as community centers, nursing homes, substance abuse treatment centers, hospitals, and correctional facilities. It is in these settings that the arts can become a powerful tool to educate, rehabilitate, and heal.

Advocating for the concept of Universal Design, a design process that makes structures, spaces, products, and programs accessible to people of all abilities, throughout their lifespan.

Encouraging and supporting Lifelong Learning through our neighborhood centers, senior homes, hospitals, libraries, theaters, and local cultural events.

Ensuring that the Endowment's funding strategies serve an aesthetically, economically, culturally, and racially diverse field.

Advocating the use of state-of-the-art technologies to make cultural facilities and programming fully accessible to people with disabilities. Innovative access tools like Audio Description, Closed Captioning, and Universal Design will assist our grantees in becoming full accessible.

Working with other Federal, State, and local agencies to develop innovative arts programming in areas previously not involved in the arts. Already the Endowment is working with Department of Housing and Urban Development and the Department of Justice to create programs that utilize the arts as a tool to prevent crime and improve public housing.

ART–21: ART REACHES INTO THE 21ST CENTURY

On April 14–17, 1994, the Arts Endowment convened the first government sponsored national arts conference, "ART–21: Art Reaches Into the 21st Century", in Chicago. Over 1,100 artists, arts administrators, educators, foundation leaders and government policy makers at the Federal, State and local levels from across the country came together to discuss major trends, priorities, and new ideas in the arts as changes in resources, demographics, and technologies shape new directions for America.

The nationwide forum featured breakout sessions on a variety of topics, all centered around moving the arts into the 21st century. One such session was entitled "Reaching Special Constituencies" and featured Rev. Sally S. Bailey, Director of Arts, at the Connecticut Hospice. Rev. Bailey discussed the Hospice's 20 year history of integrating the arts into the lives of people who are terminally ill. She gave examples of patients whose lives were transformed by music, poetry, and the visual arts, stressing the proposition that lifelong learning must encompass people with life threatening illnesses as well.

Artist Eleanor Schrader, who works with Elders Share the Arts (ESTAR) in Brooklyn, New York, presented the wide variety of programs offered by her organization: "Pearls of Wisdom", a senior theater project; "Discoveries", a visual arts program that displays the work of older artists in museums and senior centers; and "Living History", a training series in living history theater techniques.

Among the major themes that emerged for the conference sessions was "Access to the Arts" that encompassed: the need to appreciate the cost and availability of the arts as America enters the high tech era; to fully integrate the arts in all aspects of the society; and to assure the availability of the arts to all segments of the community.

This highly successful meeting was well received, and participants overwhelmingly registered the value of networking, exchanging ideas, sharing experiences, and envisioning the 21st Century.

OFFICE FOR SPECIAL CONSTITUENCIES

Since 1976, the Special Constituencies Office has served as the technical assistance and advocacy arm of the Arts Endowment for people who are older, disabled, or living in institutions such as nursing homes. This office works with Endowment staff and grantees, State and local arts organizations, other Federal agencies, and organizations that represent older and disabled persons to educate and advocate quality arts programming for these underserved segments of our population. The focus is inclusion, opening up existing programs, and outreach, taking the arts to people who would not otherwise have such opportunities.

Older adults are currently participating in a vast array of Endowment supported programs across the country as artists, audiences, students, teachers, volunteers, supporters, and arts administrators. In addition, the Arts Endowment supports projects that target older adults. Many of these efforts are developed through our Special Constituencies Office.

DESIGN FOR ACCESSIBILITY: AN ARTS ADMINISTRATORS GUIDE

The Arts Endowment produced the most comprehensive arts access guide to date, "Design for Accessibility: An Arts Administrators Guide," in partnership with the National Assembly of State Arts Agencies (NASAA) to assist Endowment grantees in making their programs and facilities fully accessible to older adults and people with disabilities.

We developed this first-time publication using a method that the Arts Endowment and NASAA recommend to our constituents: that is to provide for broad constituent involvement and to seek advice from older adults and people with disabilities. We worked with a 17 member Arts Access Task Force to compose the Guide as well as 18 additional artists, arts administrators, and accessibility experts who served as reviewers. The 700 page Guide contains a wide variety of information and resource materials that may be copied from its looseleaf format for even wider dissemination: for example: a checklist specifically designed for cultural groups; guidance on how to write and speak about people with disabilities and older adults; information on how to make historic properties accessible; and guidance on accommodations for people who are hard of hearing. Section IV of the Guide is for each organization's access documentation that may be designed to fit its particular needs.

The book was premiered at a reception on July 28, 1994 in celebration of its release and the fourth anniversary of the Americans with Disabilities Act. This gala event was held at Arena Stage in Washington, DC, which is a model of accessibility in terms of opening its programs to older and disabled people. In my remarks, I said:

> We must widen the circle and welcome everyone into our organizations, our institutions, our creative enterprise. It may be that we must change our attitude, just as society has had to overcome prejudice on the basis of race, creed, or religion. There are financial barriers, programmatic barriers, architectural and logistical barriers. According to surveys, participation in the arts declines with age, so there may be other hidden obstacles to overcome.
>
> Our focus is on inclusion—integration into the arts mainstream for full and equal participation. I emphatically reject the notion that special or different arts programs be developed for older and disabled persons; rather, existing programs of the highest quality should be opened to everyone. It's the only way we know of to avoid creating double standards, to avoid ghettoizing older and disabled persons.

The Arts Endowment and NASAA are disseminating 3,500 free copies of the Guide to grantees through the 56 State arts agencies and territories, and it will be marketed to the public through NASAA.

ACCESS TO THE ARTS: BEYOND COMPLIANCE

The Arts Endowment worked with the Mid-America Arts Alliance to convene this six-State region's first access conference, "Access to the Arts: Beyond Compliance," on July 25–27, 1994 at the Johnson County Community College in Overland Park, Kansas. Over 200 artists and arts administrators attended workshops that focused on design, performing and visual arts, new technology that make the media more accessible, outreach to people living in institutions including nursing homes, and public policy that affects older and disabled people. Kristine Gebbie, White House National AIDS Policy Coordinator, was one of the keynote speakers whose presentation included the impact that AIDS is having on older people in America.

In the workshop concerned with outreach initiatives, Dr. William Guilford, Director of Oklahoma Arts and Older Adults Project, discussed his organization's extensive work to involve older people in a wide variety of arts forms. The Project is a joint effort between the Oklahoma Arts Council and the University of Oklahoma in Norman. Dr. Guilford highlighted: professional artists' work in a wide variety of settings including nursing homes with Alzheimer's patients; older students' artwork that is exhibited at the state capitol and other settings; and intergenerational arts programs in Day Care Centers where artists, children, and older adults create murals as well as life history stories and poetry. These successful programs involve artists of many disciplines—musicians, painters, storytellers, dancers, and theatre artists—and serve over 1,000 of Oklahoma's older citizens each year.

The Director of the Mid-America Arts Alliance, Henry Moran, described the symposium as a landmark that has substantially assisted arts groups in the region to open up their programs in ways that promote dignity and independence. This effort represents the third in a series of regional conferences sponsored by the Arts Endowment.

AIDS AND OLDER ADULTS

The definition of a disabled person in both the Endowment's Section 504 Regulations and the 1990 Americans with Disabilities Act includes people with life threatening illnesses, such as cancer and AIDS.

This year, studies from the National Institutes of Health, the Centers for Disease Control, and the National Institutes on Aging reported dramatic increases in the number of older Americans testing positive for HIV, the virus that causes AIDS. While the number of new infections in citizens under the age of 30 dropped 3 percent last year, the number of newly infected people over the age of 65 leapt 17 percent. Today, 1 in every 10 that reported cases of AIDS is an individual over the age of 50. As the virus continues to move beyond its original boundaries, older adults are being affected more and more. Arts programs such as Visual AIDS and Day Without Art can be highly effective tools in educating people of all ages to the dangers of the AIDS pandemic in our society.

Further, the Endowment worked in partnership with the Dayton-Hudson Foundation to convene a forum on Health Insurance and the Arts on September 20, 1994. This all-day meeting was organized by the Endowment's AIDS Working Group, which consists of staff members from across the Endowment. The purpose of the meeting was to address the problem of Health Insurance coverage for artists who are living with catastrophic diseases such as AIDS. Over 30 prominent artists, arts administrators, private sector, and government officials took part in this landmark meeting, leading to the formation of strategies to help artists and arts organizations deal with the complexities of health care coverage in today's market. Proposed action steps include providing a source for information dissemination to artists in all 50 States. To that end, funds are being sought from private sources to conduct research and provide information on insurance options for artists.

WHITE HOUSE CONFERENCE ON AGING

The Endowment feels that it is important that the White House Conference on Aging (WHCoA) address how the arts enrich the lives of older Americans, and assign a high priority to the involvement of older adults in the arts. As first steps to address the arts in the White House Conference, the Endowment worked with Robert B. Blancato, Director of the WHCoA, to send information to hundreds of arts groups across the country encouraging them to highlight the importance and value of older adults' participation in and contributions to the arts.

LIFELONG LEARNING IN THE ARTS

The Arts Endowment is undertaking an extensive effort to extend the reach and resources of the arts to all Americans by working with other Federal agencies to:

identify mutual interests and concerns; ensure that they employ the arts to achieve their goals; and create continuing connections, partnerships, and collaborations. To this end, the Endowment has organized a series of team efforts including the Lifelong Learning Team that is composed of nine Endowment staff and chaired by the Coordinator of our Special Constituencies Office. Staff are contacting the Administration on Aging, the Department of Educator's Rehabilitation Services Administration, the National Endowment for the Humanities and other Federal agencies to explore and identify ways in which the Endowment may work in partnership with them to achieve our common goals through the arts.

ARTS ENDOWMENT FUNDING

Endowment supported programs are aimed at benefiting all Americans including people of all ages. In addition, many of these projects specifically address older adults. For example:

The Grass Roots Art and Community Effort (GRACE) located in West Glover, Vermont discovers, develops, and promotes visual art produced primarily by older self-taught artists in rural Vermont. Since 1975, GRACE has involved older adults in arts programs, many of whom are in nursing homes and other residential centers. Each week, GRACE holds eight art sessions across the State. Participants have the choice of working in small groups or individually and workshops are held in comfortable supportive atmospheres. Many of GRACE's artists sell their work and their art is displayed in galleries.

Another exemplary organization is Elders Share the Arts (ESTAR) in Brooklyn, NY that produces a wide variety of arts programs for older adults including on-going living history arts workshops. These sessions involve older citizens in oral history interviewing, writing, sharing life stories, and learning creative arts skills. The workshop series culminates with a group arts project that often tours elementary schools. One of the most popular touring groups is the "Pearls of Wisdom", a group of older adult storytellers who spin original tales from their personal experiences. Other programs include inter-generational workshops where participants discuss common interests with members of younger generations. For example, one group of older Puerto Rican women chose to look at games from their childhood and share them with children in grammar school. Each generation showed their version of the same game. One older citizen from Flushing, NY said "I am glad I got to know the children. We are both learning a new language, English, at the same time.

CHALLENGE AND ADVANCEMENT

Dell'arte, Inc. in Blue Lake, CA is a theater organization that provides a full-time, 2 year training program which includes traditional theater forms of mime, mask, comedy, and physical styles from around the world. The grant helped to support remodeling and renovation of their theater in compliance with the 1990 Americans with Disabilities Act so that people with limited mobility may comfortably use the theater as audience members and as artists.

DANCE

Theatre Development Fund, Inc. in New York, NY encourages older people to take advantage of the performing arts in New York City by providing discounted tickets and working with theaters for increased access through its Theater Access Project. Efforts include maintaining a mailing list of older citizens on fixed incomes to notify them of discounted tickets to arts events, scheduling sign-interpreted performances each month, and offering assistive listening systems.

Very Special Arts New Mexico in Albuquerque features the Buen Viaje Dancers, a modern dance troupe of all ages with multiple disabilities, which, since its founding in 1984, has performed original works and offered participatory workshops throughout the nation. This year they received a grant to produce, market, and distribute a videotape on working with individuals with disabilities in dance. This video will demonstrate improvisational dance technique and choreographic approaches for people with disabilities. Their goal is to encourage similar programs that stimulate creative growth and expression.

Fellowships

The Dance Program awarded seven Choreographer fellowships and three Master Teacher Awards to older artists.

EXPANSION ARTS

National Institute of Art and Disabilities (NIAD) in Richmond, CA provides an ongoing, 40-hour week art program for adults with developmental disabilities, many of whom are older and are developing careers as visual artists. Participants' work is facilitated by Master artist teachers who are all practicing artists with MFA degrees or equivalent body of work and exhibition history. NIAD is currently developing a new gallery at San Francisco's Ghiradelli Square to display the work of their artists.

City Lore, Inc. located in New York, NY selects activities that bring elementary students in contact with older individuals at senior centers on field trips. Through the Arts Partners Program, participants from different generations discuss their memories and experiences and work on arts projects together. For example, one project involved creating a "Tradition Tree," a potted branch with crafted objects representing family traditions.

Jamaica Center for the Performing and Visual Arts, Inc. (JAC) in Jamaica, NY is conducting several programs that target older Americans. Their Community workshop series features courses such as painting and drawing, which are scheduled during weekday mornings to specifically attract older adults from the community. People who are older receive a 50% discount for JAC workshops, performances and memberships. Further, JAC presents a yearly series of traditional jazz and other live music at senior centers throughout Queens, NY.

Senior Arts, Inc. Albuquerque, NM is in its eleventh year of sponsoring a unique program of art activities for older people that take place throughout the city. The program consists of performances and workshops in music, dance, theater, literature, and visual arts. Workshops include Spanish Tinworking, Polish Paper Cutting, and Pueblo Ceramic Sculpture. Local artists, representing traditional New Mexican folk arts (Hispanic and Native American) and contemporary forms, are employed to share their skills and artistic vision. Senior Arts brings its programs, free of charge, to all six of Albuquerque's major senior centers as well as 18 satellite and residential sites. Gwen Forrester, a participant in the classes remarked, "Thanks to Senior Arts, I am learning the crafts of my Native-American ancestors." At the close of last year, Senior Arts mounted an exhibit displaying the artwork of older citizens and their instructors in a gallery at the South Broadway Cultural Center.

Appalshop in Whitesburg, KY provides programs that seek to break down cultural stereotypes of the Appalachian people to acknowledge them as a community with a full and wonderful heritage in the arts. Appalshop has several programs that target older citizens, allowing them to share their Appalachian culture with others. For example: the Roadside Theater program draws together diverse groups to examine local heritage, identify community concerns, and bridge age barriers; school children and older citizens are brought together to share stories and pass on cultural traditions; and their community radio program features programs such as "Deep in Tradition", an old-time mountain music show very popular with older Appalachians.

Lola Montes and Her Spanish Dancers in Hollywood, CA perform a program entitled "California Heritage" in senior centers across the state. Through the medium of dance, music and story telling, and with authentic costuming, the dancers explore Hispanic contributions to California.

Center on Deafness in Northbrook, IL is dedicated to enhancing individual growth within the community of deaf and hard of hearing people of all ages. This year they received a grant to provide fully accessible theater experiences to people with disabilities including deaf and hard of hearing audiences. Their efforts include involving actors, directors, and stage crew who are deaf in their work, and working to preserve the cultural differences involved in sign language and deaf art including literature. The company utilizes "reverse shadow interpretation" where deaf actors use sign language, and the hearing cast (dressed in black and placed in the background) voice interpret for hearing audience members. This creates a blended experience that is carefully choreographed and well received by audiences.

Fairmount theatre of the Deaf in Cleveland, OH is one of the few professional theater companies in the United States that produces shows using both deaf and hearing actors, and in July 1990. FTD conducts outreach programming as well as performing three local mainstage productions each year. This year's performances include: Neil Simon's "I Ought To Be In Pictures", "Children of a Lesser God" and "Counterfeits", a world premiere work by FTD's artistic director Shanny Mow.

Theater by the Blind Corporation in New York, NY recruits and trains actors and writers of all ages who are blind. The group conducts workshops to develop the talents of blind artists, and outreach to cultivate audiences for their work. They will present two fully staged productions which explore a production style unique to them.

FOLK ARTS

Appalshop in Whitesburg, KY will present performances that offer an opportunity for artists to pass along their skills and receive recognition for their art. This cultural center is dedicated to celebrating the artistic and cultural heritage of the Appalachian region, and reaches many local residents through programs that present traditional Appalachian artistry to the community. Appalshop believes in utilizing the artistic mastery of many of the region's older citizens, who serve as guides to a cultural legacy for younger generations. Their older artists are featured in Appalshop events such as the annual Seedtime and the Cumberland Festival.

Fellowships

The Folk Arts Program awarded five National Heritage fellowships to older folk artists.

LITERATURE

Elders Share the Arts in Brooklyn, NY received a grant to introduce a writing project to older adults in New York's inner-city community centers. Three African-American, Chinese, and Jewish writers conduct readings and discussions of their own work. In subsequent workshops, they teach older adults how to develop their own narratives through writing and taping which helps them to better understand the richness of their own heritage.

Howard County Poetry and Literature Society, Inc. in Columbia, MD will sponsor a tour that brings poetry to underserved communities in their region, including people in retirement communities as well as non-resident senior centers. This fall they conducted five readings with a diverse group of poets and plan to hold four more in the Spring. Their goal is to reach at least 1,000 people through poetry this year.

Fellowships

The Literature Program awarded one Creative Writing fellowship and two Translator fellowships to older adults.

MEDIA ARTS

International Museum of Photography at George Eastman House in Rochester, NY presents matinees of restored films from its archives that target older people in the Greater Rochester area. They include American and foreign classics, independents and silent films with full orchestral accompaniment.

The Washington, DC International Film Festival presents free films in their "Cinema for Seniors" program. In addition, international guest filmmakers participate in workshops, panels, and seminars with audience members. This festival brings classic films to the city which attracts hundreds of older residents.

Ilene Segalove of Venice, CA received a grant to support the production of Handshake, a half-hour experimental radio drama using monologue, dramatic reenactment, and original music to explore the psychological and physiological aspects of aging in America.

MUSIC

Nevada Symphony Orchestra in Las Vegas, NV will sponsor the Saturday Morning Series consisting of six concerts, which provides convenient orchestral performances for older Americans. The concerts are performed in an informal setting and include commentary from the musical director or conductor. Special attention is given to Las Vegas' extensive retiree population through the sale of group tickets and by providing transportation.

Queens Symphony Orchestra in Long Island City, NY presents musical repertoire and guest artists of international acclaim. In addition, they offer pre-concert talks, open rehearsals, family day, discounted tickets, and a transportation program, all related to their Masterworks series which reaches out to older people.

The Saint Paul Chamber Orchestra in Saint Paul, MN provides "The Morning Coffee Series". This program, geared toward older people, is comprised of eight morning Baroque concerts opening with informative concert previews.

Fredric R. Mann Music Center in Philadelphia, PA has an outreach program that provides free concert tickets to many older Philadelphians on fixed and low incomes. Blocks of tickets are set aside for regional nonprofit groups serving people who are disabled, on fixed or low incomes, or older.

The Louisville Orchestra located in Louisville, KY offers the Cumberland Coffee Concerts, a nine-concert, morning series of classical programs. This program was specifically created to make symphonic music more accessible to older citizens.

Other music groups that conduct audience development in the form of daytime concerts, discounted tickets, free concerts, attendance of final rehearsals, and/or concerts in healthcare facilities are:

Bronx Arts Ensemble Inc., Bronx, NY.
Caramoor Center for Music and the Arts, Inc., Katonah, NY.
Chicago Symphony Chorus, Chicago, IL.
The Columbus Symphony Orchestra, Columbus, OH.
Fort Wayne Philharmonic Orchestra, Inc., Fort Wayne, IN.
Eastern Connecticut Symphony, Inc., New London, CT.
Evansville Philharmonic Orchestra Corp., Evansville, IN.
Grand Rapids Symphony Society, Grand Rapids, MI.
Lexington Philharmonic Orchestra, Lexington, KY.
Los Angeles Chamber Orchestra Society, Los Angeles, CA.
Memphis Orchestra Society, Memphis, TN.
Mississippi Symphony Orchestra Association, Jackson, MS.
Missouri Symphony Society, Columbia, MO.
New York Chamber Ensemble, Inc., New York, NY.
Northeastern Pennsylvania Philharmonic, Avoca, PA.
Rockford Symphony Orchestra, Rockford, IL.
South Carolina Orchestra Association, Columbia, SC.

Fellowships

The Music Program awarded three American Jazz Masters Fellowships and one Special Projects Fellowship to older adults.

PRESENTING AND COMMISSIONING

Onion River Arts Council in Montpelier, VT invites artists from many different cultures, including French-Canadian, Scottish, Irish, Italian, African, Hispanic, and Asian to participate in programs with older people where they discuss their work. In addition, they provide subsidized tickets to performances and present at least one program a year that involves performers with disabilities.

Artswatch in Louisville, KY exposes older Kentuckians to the arts through its arts presenting programs that are held at senior centers, Kentucky School for the Blind, and AIDS support centers.

THEATER

Deaf West Theatre Company, Inc. in Los Angeles, CA will produce "Medea" with traditional fifth century Greek costumes. This unique theater serving the deaf community produces all of its plays with deaf actors of all ages. The company uses a unique infrared listening system, which allows hearing audience members to listen to the play via headsets. Last year their production of Marsha Norman's "Night Mother" opened to rave reviews.

National Theatre of the Deaf in Chester, CT is a professional ensemble of deaf and hearing actors of all ages. This season's production of Eugene Labiche's "An Italian Straw Hat," will be performed with a new translation from the French and an original percussion score.

Fellowships

One fellowship was granted to an older writer in the category of Solo Theater Artist.

LOCAL ARTS AGENCIES

North Carolina Arts Council in Raleigh, NC provided three 1-day workshops on accessibility to the arts for people with disabilities and older adults. These workshops offered an opportunity for board, staff, and volunteers to learn first hand about the 1990 Americans with Disabilities Act and how compliance affects an organization's facilities and programs. The program included a keynote speaker and panelists who provided specific steps toward compliance with the ADA and included outreach strategies for including more older Americans in the arts.

STATE AND REGIONAL

Vermont Council on the Arts Inc. in Montpelier, VT brings individuals with specific knowledge about accessible facilities and programming to Vermont's cultural organizations. These groups, funded through the Council's general operating support program, will welcome site visits and receive direct technical assistance to help develop increased access to their programs and facilities.

University of Massachusetts at Boston in Boston, MA presents a reading series sponsored by the Joiner Center for the Study of War and Social Consequences and the University's Creative Writing Program. During 3-day residencies, four poets give public readings and conduct workshops specifically geared toward veterans and other older Americans who lived through periods of war.

INTERNATIONAL

Axis Dance Troupe in Oakland, CA received a grant to support a collaborative residency program in Siberia with the Novosibirsk Regional Disabled Sports Club. Axis introduced disability culture to the people of Siberia and established dance as a vital part of that culture. The troupe performed, taught, and shared their technique and philosophy with members of local Siberian dance companies and disabled members of local civic organizations, which includes older adults.

Kansas Arts Commission in Topeka, KS provides grants through its Grassroots Cultural Development Program. Some of the projects they fund include a visual artists working in a group home of Alzheimers's patients. The patients' difficulty with organized thinking and actions has been addressed by the artist in her nonthreatening and encouraging approach. Also, they have developed annual juried exhibitions of two and three dimensional artworks by retirement and home care residents that are shown at the Kansas Museum of History, and a poetry festival during which the literary works by older citizens were recognized.

VISUAL ARTS

Visual AIDS in New York, NY presents several national programs to increase AIDS awareness in all generations. Programs include "Day Without Art" and "Night Without Light" and are supported by the organizations Red Ribbon program, which employs older adults to construct the thousands of ribbons needed each year.

Fellowships

One Visual Arts fellowship in Photography was awarded to an older adult.

ITEM 24. NATIONAL ENDOWMENT FOR THE HUMANITIES

NATIONAL ENDOWMENT FOR THE HUMANITIES REPORT ON ACTIVITIES AFFECTING OLDER AMERICANS IN 1994

Although the Endowment does not have programs specifically directed at aging, NEH actively supports books, lectures, exhibitions, programs for radio and television, and adult educational courses which help bring the humanities to seniors. In addition, each year a number of scholars, age 65 or older, receive NEH funding to conduct research in the humanities, while others assist the Endowment by serving on grant review panels or as expert evaluators.

Older scholars compete for Endowment support on the same basis as all other similarly qualified applicants. No information regarding age is requested from applicants. Applications for funding are evaluated by peer panels and specialist reviewers, Endowment staff, the National Council for the Humanities, and the NEH Chairman. Only applicants whose proposals are judged likely to result in work of exemplary quality and central significance to the humanities receive support. However, anyone may apply for an NEH grant, and no one is barred from consideration by reason of age. In addition, each year numerous projects are funded that involve older persons as primary investigators, project personnel, or consultants.

The Jefferson Lecture in the Humanities is the highest official award the Federal Government bestows for distinguished intellectual achievement in the humanities. Since its establishment in 1972, the lecture has provided an opportunity for 22 of the Nation's most highly regarded scholars to explore matters of broad concern in the humanities. Not coincidentally, many of the scholars so honored have been among the most senior members of their profession. Poet Gwendolyn Brooks, who delivered the 1994 Jefferson Lecture, historian and poet Robert Conquest, classicist Bernard Knox, historians Gertrude Himmelfarb and Bernard Lewis, and sociologist Robert Nisbet are among the recent Jefferson Lecturers who, though still active scholars, were beyond the traditional retirement age at the time they received this honor.

The Endowment's Charles Frankel Prize, first awarded in 1989, honors distinguished individuals who have enriched our national life by sharing their understanding and appreciation of history, literature, philosophy, and other aspects of the humanities. Many of the interpreters and patrons of the humanities who have received a Frankel Prize have been 65 years of age or older, including in 1994 historian and bibliographer Dorothy Porter Wesley. In prior years the Endowment's

Frankel Scholars have included such distinguished senior Americans as Puerto Rican historian, anthropologist, and folklorist Ricardo Alegria; historian John Hope Franklin; novelist Eudora Welty; Civil War historian and novelist Shelby Foote; University of Dallas English professor emeritus and co-founder of the Dallas Institute of Humanities and Culture Louise Cowan; author and folklorist Americo Paredes; philosopher, author, and originator of the Great Books Program Mortimer Adler; classicist and 1992 Jefferson Lecturer Bernard Knox; and, originator of Brooklyn College's highly regarded core curriculum, Ethyle Wolfe.

Older scholars are particularly evident in several types of research and teaching projects supported by the Endowment's Fellowships and Seminars division and Research Programs division. Of course, this is a reflection of the depth and breadth of knowledge that many senior scholars bring to their work in the humanities. In a number of cases, older scholars are receiving NEH support to continue long-term, collaborative research projects that they have directed and sustained for many years.

Older Americans also participated in NEH programs by serving as grant review panelists and specialist reviewers. In some cases, older Americans have contributed to Endowment-sponsored projects by providing invaluable information. For example, in 1994 an NEH sponsored collaborative research project directed by William Chafe of Duke University, "Behind the Veil: Documenting African Life in the Jim Crow South," aims primarily at recording and analyzing the recollections of people, obviously seniors, who were eyewitnesses and participants in Southern society prior to the Civil Rights movement. Also in 1994 the Endowment supported a project to prepare a five-volume edition of the correspondence of Irish playwright Samuel Beckett (1906–89). Essential to the project are interviews conducted by the editors with Beckett's correspondents, most of them very elderly, in the United States, England, France, and Ireland. The recollections and reflections of these contemporaries of the writer are an invaluable source of information not only on the writer himself but also on early twentieth century culture in general.

The Endowment achieves its greatest impact among older Americans when they read books, attend public programs, view television productions, or listen to radio broadcasts made possible by an NEH grant. Many humanities programs for the general public supported by the Endowment through our Division of Public Programs reach large numbers of older persons.

Humanities Projects in Media

Television productions supported by the Endowment are ideal for older people who cannot or prefer not to leave their homes. Widely acclaimed programs such as the 18-hour historical documentary series, *Baseball;* the series of dramatic literary adaptations, *American Short Story and Life on the Mississippi;* the biographical documentary, *Huey Long;* and *Voices and Visions;* a 13-part series chronicling the achievements of American's outstanding contemporary poets, have been viewed by millions throughout the country. NEH-funded programs have included *The Donner Party,* an award-winning documentary film that chronicles the ordeal of a group of settlers stranded in the Sierra Nevada during the winter of 1846; *D.W. Griffith,* an examination of the life and work of the controversial film pioneer; several episodes of *Dancing,* an eight-part, multi-disciplinary exploration of world-wide dance tradition; and *George Marshall and the American Century,* a 90-minute biographical documentary that places the general and statesman during the first half of the twentieth century.

Elderly persons who have visual handicaps may find that Endowment-sponsored radio programs best suit their needs. The NEH-supported *Craven Street: Franklin in London 1770–75* was broadcast for the first time on National Public Radio. The 5-hour dramatic radio series portrays the role of Benjamin Franklin as colonial representative in London in the years just preceding the American Revolution.

Information about NEH-sponsored media programs is routinely provided to organizations working for special groups, including the elderly. For many elderly people confronting problems such as impaired vision, reduced mobility, and isolation, Endowment-funded media programs not only provide individual access to the humanities but can also provide the context for stimulating group activities and discussions.

Humanities Projects in Museums and Historical Organizations

In this program, the Endowment encourages museums or historical organizations receiving federal funding to waive entrance fees for the general public on certain days, an effort that helps make cultural programming more accessible to retired persons living on a fixed income. In recent years, a number of the institutions that

have received NEH support for interpretive exhibitions have begun to establish a continuing relationship with local senior centers.

HUMANITIES PROJECTS IN LIBRARIES AND ARCHIVES

By sponsoring reading and discussion programs for adults in public libraries, this Endowment program is helping to make intellectually stimulating activities available to senior citizens in their local communities. Recently the Endowment has awarded $2.8 million for programs throughout the country that will offer adults, including persons over 65, opportunities to read and talk about important books and issues under the direction of a humanities scholar from a nearby college or university, and a great many more reading and discussion programs—more than 1,600—were supported by the State humanities councils. Additionally, these reading and discussion programs for seniors make available large print books and audio tapes.

EXAMPLES OF NEH GRANTS SPECIFICALLY FOR OR ABOUT OLDER AMERICANS

Since FY 1976, the Endowment has awarded approximately $5 million to the National Council on the Aging for its reading programs in senior centers and libraries. Throughout a network of over 1,500 senior centers and other sites participating in the NCOA's "Discovery Through the Humanities" program, volunteer leaders guide small groups of senior citizens through active, in depth discussions of the work of prose writers, poets, artists, philosophers, scholars and critics. Project staff prepare and distribute thematically organized anthologies and ancillary instructional materials and provide training and technical assistance to discussion leaders. Anthologies currently in use include: "A Family Album, The American Family in Literature," "Image of Aging," "Americans and the Land," "The Remembered Past, 1914–1945," "Work and Life," "The Search for Meaning," and "Roll on, River: Rivers in the Lives of the American People." Each anthology is designed to stimulate the group participants to relate what they read to their own experience and to universal human issues. Ranging between 100 and 300 pages in length printed in large print-type, and attractively illustrated with paintings, sculpture, and photographs, each anthologizes material from history, philosophy, and literature.

NEH grants to the National Council on the Aging have also supported several large-scale reading and discussion programs led by scholars rather than by nonacademic volunteers. For example, recently NCOA received $244,977 to conduct 60 8-week programs on the topic "Remembering World War II." The programs will be held in senior centers, nursing homes, veteran's hospitals, libraries, and other community centers throughout the country. The discussions at each site will be lead by a scholar, who will provide historical perspective to complement the participants' real life experiences. Specifically prepared anthologizes of readings—available in large-print format—will cover a variety of topics related to the war and the home front and will include relevant documents such as letters, photographs, and memorabilia.

The Federal/State Partnership of the Endowment makes grants to humanities councils based in the 50 States, Puerto Rico, Marianas, and Guam. These councils, in turn, competitively award grants for humanities projects to institutions and organizations within each State. State humanities councils have been authorized to support any type of project that is eligible for support from the Endowment, including educational and research projects and conferences. The special emphasis in State programs, however, is to make focused and coherent humanities education possible in places and by methods that are appropriate to adults.

Example of projects for older Americans or about aging-related topics that received State council support during 1993 and 1994 are presented below.

Alaska

The Alaska Humanities Forum awarded a grant to the Tanana Yukon Historical Society, Fairbanks, in support of their project, "Faces of Alaska, Book III,'" to conduct interviews with 15 older Alaskans of diverse backgrounds. A glimpse of history will be gained through paintings, photographs, and oral histories provided by older residents of the State. The future publication, "Faces of Alaska III" will complete the series.

Florida

The Florida Humanities Council awarded a grant to the Women's Studies Program at the University of Florida in conjunction with the Harn Museum of Art titled: "Creativity! a Symposium on Gender and Age," to sponsor a symposium to celebrate the resiliency of older women through the creative merging of scholarly theory about women's role in society and topics ranging from aesthetics to social policy and

health. The symposium will also examine stereotypes of age and gender in literature, film, the arts, in order to evaluate their implications in the lives of all women.

Illinois

The Illinois Humanities Council awarded a grant to the Westside Health Authority in conjunction with the Austin Academy, Northwestern University, titled: "History for the Present," to develop an intergenerational history project, which aims to record, interpret, and share the life histories and struggles of Westside residents. Through this project, the Westside Health Authority will create a forum for sharing life histories to help create a community from which young and old people can draw strength and models of struggle. The project will involve senior citizens and high school humanities students who will conduct group and individual interviews to collect the life stories of participants, covering a broad range of community residents. These stories will be interpreted and assembled to produce a humanities newsletter as a supplement to the humanities curriculum at Austin Academy; and the material will also be shared with other schools and community groups.

Maryland

The Maryland Humanities Council supported "The Annapolis I Remember," conducted by the Arundel Senior Assistance Project. Oral history interviews with 73 senior Annapolis citizens were recorded and over 800 historic photographs were collected to provide documentation for a six-character stage performance depicting an Eastport waterman, a Greek immigrant, and African-American businessmen, among other residents of the city during the period 1900–65.

Minnesota Humanities Commission

The Minnesota Humanities Commission awarded a grant to the College of St. Scholastica-Emeritus College program in conjunction with the Virginia Public Library titled: "Emeritus College," for 15 humanities courses for older adults in Duluth, Two Harbors, Virginia, and Grant Marais. Emeritus College has received grant funds from the Minnesota Humanities Commission since 1982; this ongoing support has enabled the program to increase the number of communities and persons served. Topics in the 1994 program series include natural history, international studies, and literary studies.

New York Council For The Humanities

The New York Council for the Humanities awarded the LaGuardia Community College of Long Island City a grant to sponsor Speakers in the Humanities lectures. One such lecture by Susan Miller was titled: "Drama of Aging in Contemporary Theatre and Films." Another award was given to the Rockland Community College Senior Citizens Club of Suffern for a lecture given by Dr. Finnegan Alford-Cooper on the subject "Aging in Non-Western Societies: What Does It Mean for Us?

Ohio

The Ohio Humanities Council, with a special grant from the Ohio Department of Aging, began planning humanities programs for rural senior centers. A pilot project will bring one-act plays by Harden Foote about small-town Texas life to the centers and allow senior citizens to participate in follow-up discussions with the actors and with participating scholars.

South Carolina

The South Carolina Humanities Council sponsored a number of programs for seniors on public policy issues such as "the value of the individual life" and "the need to understand the common humanities of older adults." Using a reader developed especially for this project, the participants read and discussed thematically related selections from writers ranging from Cicero to Hemingway.

Arizona

The Arizona Humanities Council with additional funding from the Marshall Fund of Arizona, planned a series of town hall meetings and reading and discussion program on the issue of elderly suicide.

Connecticut

The Connecticut Council for the Humanities supported a scholar-led discussions series for older adults on the history and cultural continuities of Native Americans, focusing especially on the role of elders and healers.

Georgia

The Georgia Humanities Council began a series of interviews with outstanding creative older adults including former President Jimmy Carter, about the philosophical and cultural significance of creativity and its relationship to continuing self-esteem. The interviews will form the basis for a planned series of radio and television programs.

ITEM 25. NATIONAL SCIENCE FOUNDATION

NATIONAL SCIENCE FOUNDATION REPORT FOR DEVELOPMENTS IN AGING

The National Science Foundation, an independent agency of the Executive Branch, was established in 1950 to promote scientific progress in the United States. The Foundation fulfills this responsibility primarily by supporting basic and applied scientific research in the mathematical, physical, environmental, biological, social, and engineering sciences, and by encouraging and supporting improvements in science and engineering education. The Foundation does not support projects in clinical medicine, the arts and humanities, business areas, or social work. The National Science Foundation does not conduct laboratory research or carry out educational projects itself; rather, it provides support or assistance to grantees, typically associated with colleges and universities, who are the primary performers of the research.

The National Science Foundation is organized generally along disciplinary lines. None of its programs has a principal focus on aging-related research; however, a substantial amount of research bearing a relationship to aging and the concerns of the elderly is supported across the broad spectrum of the Foundation's research programs. Virtually all of this work falls within the purview of the Directorate for Biological Sciences; the Directorate for Social, Behavioral, and Economic Sciences; and the Directorate for Engineering.

DIRECTORATE FOR BIOLOGICAL SCIENCES (BIO)

The research supported by the Directorate for Biological Sciences is devoted to understanding how living systems function. This includes studies on the structure, function, and interaction of biological molecules; processes by which organisms develop, grow, and function; and investigations on how organisms perceive their surroundings and interact with other organisms. Aging as a normal biological phenomenon is part of development and growth. Therefore, studying organisms during development and in response to environmental and physiological stresses is an aspect of aging studies. The research divisions comprising the Directorate for Biological Sciences in a sense all look at aging. The Division of Molecular and Cellular Biosciences looks at the genetic basis and regulation of life processes, the molecules that are synthesized, degraded, and altered quantitatively throughout life, as well as cellular processes associated with different stages of life. The Division of Integrative Biology and Neuroscience is concerned with how organisms develop, function, and interact. This includes studies of the nervous system which directs and regulates many of these processes. The Division of Environmental Biology looks at groups of organisms and how they exist within different environments and respond to changes therein.

DIRECTORATE FOR SOCIAL, BEHAVIORAL, AND ECONOMIC SCIENCES (SBE)

The Directorate for Social, Behavioral, and Economic Sciences supports research in a broad range of disciplines and interdisciplinary areas through its Division of Social, Behavioral, and Economic Research. For example, sociological research is being supported which examines how the labor force participation and earnings of older Americans have been affected by recent economic trends; how Americans in their 50's cope with the dual pressures of supporting aging parents and grown children; how income distribution differs between the "young old" and the "old old," and how the degree of political activism of older Americans has changed over time in the twentieth century. Projects within anthropology are being supported to examine how economic development affects patterns of caring for dependent elderly, and with cognitive psychology to examine the extent to which knowledge acquired in youth is retained in later life.

The SBE Directorate also supports several large-scale data gathering efforts which can be and have been used to study issues related to aging, although that is not their sole or even primary purpose. For example the Panel Study of Income Dynamics, which has been tracking a sample of more than 7,000 American families since 1968, provides information on changing household composition, labor force participation, income, assets, and consumption patterns as individual respondents

grow older. The General Social Survey, which has carried out sample surveys of the U.S. adult population more or less annually since 1972, contains several attitudinal items dealing with the status of, and care for, the elderly. These surveys enable researchers to examine how attitudes toward the elderly have changed over time and how age groups differ across a wide range of opinion areas. The National Election Survey, which has studied American elections since 1952, provides information on how attitudes regarding candidates and issues vary across age groups. The SBE Directorate is also supporting a project that will make available to researchers in a consistent and readily usable form public use microdata from the U.S. censuses from 1850 through 1990. When completed, this project will make it possible to examine how the status and family relationships of older Americans have changed over the course of a century and a half.

DIRECTORATE FOR ENGINEERING (ENG)

The National Science Foundation's Directorate for Engineering seeks to enhance long-term economic strength, security, and quality of life for the Nation by fostering innovation, creativity, and excellence in engineering education and research. This is done by supporting projects across the entire range of engineering disciplines and by identifying and supporting special areas where results are expected to have timely and topical applications, such as biotechnology and materials processing.

Aging-related research is primarily supported within the Directorate for Engineering through the Biomedical Engineering and Research to Aid Persons with Disabilities. Research funded in this program relates to issues of aging and the elderly due to the propensity for the elderly to develop physical disabilities. Projects recently supported by this program include the following studies:

Musculoskeletal investigations to understand the process of maintaining erect posture and stepping.

Investigating the development of an electromagnetic device for measuring bone condition.

Computer assisted design of orthopedic surgeries involving joint replacement, cementing techniques, and failure detection.

Cardiovascular systems studies involving tissue engineering for the replacement of arteries and veins.

Research directed toward correcting hearing loss through improved signal process techniques.

Studies concerned with drug infusion and control techniques.

Undergraduate projects by student engineers to construct custom designed devices and software for disabled individuals.

While these projects are not specifically directed toward problems of aging, all of these studies have potential for dealing with conditions prevalent among the elderly.

ITEM 26. PENSION BENEFIT GUARANTY CORPORATION

EXECUTIVE DIRECTOR'S REPORT

Twenty years ago, the enactment of the Employee Retirement Income Security Act opened a new era of pension security for American workers. Our Nation's working men and women acquired stronger rights to their hard-earned pensions, funding rules promised that their pensions would be paid, and PBGC was established to provide pension insurance. However, weaknesses in the law, and particularly the funding standards, undermined the promise of pension security. While the vast majority of single-employer pension plans are fully funded, underfunding in single-employer plans has been chronic, persistent, and growing, reaching $71 billion in the most recent report.

With enactment of the Retirement Protection Act, we can now begin to reverse the trend. This carefully designed package of pension reforms renews ERISA's promise of retirement security. Pensions will be better funded, the pension insurance program will be financially secure, and companies with underfunded pension plans will pay their fair share to support the retirement system. Workers and their employers can now have greater confidence in a stronger pension system and in PBGC. They can be assured they will receive their hard-earned benefits.

For PBGC and the working people it protects, 1994 was a year of great progress. Passage of the Administration's pension reforms, a landmark pension funding agreement with General Motors, and PBGC's first unqualified independent audit opinion on its financial statements stand out. The energy, ingenuity, and diligence of the people at PBGC led to a number of other important accomplishments.

BENEFIT PROTECTION

Through our early warning program, we are constantly on the lookout for corporate transactions or events that may be harmful to the pensions of workers or to PBGC. If circumstances warrant, we try to reach agreement with the plan sponsor before the transaction is consummated for additional protection that will strengthen the plan and keep it ongoing. During 1994, we negotiated 16 agreements totalling nearly $11 billion that provided increased protection for workers and retirees in underfunded plans and recoveries on losses from the underfunding.

Our negotiations yielded the largest contribution ever made to a PBGC-insured plan when, in May, we reached a landmark $10 billion pension funding agreement with General Motors Corporation. At the time, GM's plans were reported to be underfunded by more than $20 billion, most of which was in one plan covering some 600,000 GM workers and retirees. GM's contribution of cash and stock will assure this plan a level of funding it would not otherwise have reached for almost a decade.

In another noteworthy settlement, New Valley Corporation, once known as Western Union Corporation, had an ongoing pension plan for 16,000 Western Union workers and retirees that was under-funded by nearly $400 million. PBGC's immediate action seeking a district court order to terminate and protect the plan and preserve our claims against Western Union led to an agreement that has kept the plan ongoing and funded by a financially strong company. This prevented any loss of benefits for the participants in the plan and a significant loss for the pension insurance program. In the words of one grateful Western Union pensioner. "Without your presence and brilliant maneuvering . . . both the Taxpayers and Pensioners of Western Union would have gotten a raw deal."

CUSTOMER SERVICE

The payment of benefits and service to those receiving these benefits are the central work of the Corporation. PBGC established customer service standards for our principal customers, the workers and retirees to whom we owe benefits. These standards represent our commitment to provide the best possible service to our customers. We want PBGC to be a model customer-driven agency.

Over the years, PBGC has distinguished itself for its service to participants. It was most gratifying when Vice President Al Gore presented PBGC with a "Hammer Award" in recognition of our success in reinventing and expanding our participant locator program. This ongoing program enables PBGC to find workers and retirees owed benefits that cannot be paid for lack of a valid address. In 1994 alone, we were able to find addresses for 12,000 out of 15,000 missing people.

There is always room for improvement. To this end, we moved ahead to reorganize our insurance operations to institute more efficient team processing of plan terminations and participant benefits. We also made progress in our optical imaging effort, converting 1.2 million participant documents to computerized images. Optical imaging will make these records more accessible and enable our staff to answer participant inquiries more quickly and accurately than in the past.

We continued to upgrade our participant communications. We introduced a semiannual *Pension Newsletter* to keep retirees receiving pensions from PBGC informed about our services and important developments. We produced a new videotape entitled "Your Guaranteed Pension" to explain PBGC's guarantees to people in newly trusteed plans. In certain cases in which PBGC assumed pension plans, senior agency officials conducted townhall-type meetings to explain the PBGC program and protections.

Our pilot information campaign, "Know Your Pension," also proved successful. We initiated this effort as a way to inform workers and retirees with underfunded pension plans about their pensions and PBGC's guarantees. Targeted to parts of Ohio and Pennsylvania, the campaign's message was carried by radio stations and newspapers and over 100,000 people took pamphlets from supermarket racks. We will be expanding the campaign in 1995 to cover six States.

For its outreach efforts, PBGC received the Award of Excellence of the National Association of Government Communicators, which cited our raising public awareness about pensions and pension funding issues as "a prime example of the type of government communication NAGC strives to recognize."

MANAGEMENT

PBGC's extensive efforts to improve its financial management were rewarded in 1994 when the General Accounting Office issued the first unqualified opinion on PBGC's financial statements. GAO stated that it found PBGC's 1993 and 1992 statements of financial condition for both insurance programs "reliable in all mate-

rial respects." PBGC's significant progress in improving financial operations and reporting paved the way for last year's GAO opinion. We continued to sustain our high level of financial management in 1994 and we have again received an unqualified opinion from GAO on our 1994 financial statements.

This year, PBGC's deficit decreased. This is a positive development, but it must be viewed with caution. The change in the deficit reflects a convergence of several factors arising from a strong economy. We sustained no major terminations this year; our negotiations resulted in the continuation of a significantly underfunded Western Union plan once considered probable for termination, reducing our evaluation of probable future claims; and our improved collection efforts produced the largest premium revenues in our history. However, the most important factor affecting the deficit was the rise in interest rates, which reduced the value of PBGC's benefit obligations but can fall again, with the opposite effect, in the future. Lasting progress on the deficit will come from the newly enacted pension reforms, which will improve funding of pension plans at risk and increase PBGC's premium revenues to offset the deficit.

Although beneficial for PBGC's deficit, the rise in interest rates adversely affected investments. PBGC responded to changing market conditions by revising its investment policy to maximize long-term investment returns, with less risk to the agency, in order to reduce the deficit. We shortened the duration of fixed-income assets and increased investment in equities.

In other areas, we continued our efforts to improve our automated information systems. We are completing the development of our new premium accounting system. The new system will enhance collection efforts that have netted approximately $85 million in previously unpaid amounts, including about $20 million in 1994. At the same time, we are continuing to work on integrating our various information systems and improving our controls over our data.

We also instituted tighter controls on our contracts and contractors and expanded the number of audits we perform. For the year, we completed 21 contact audits and achieved savings of more than $3 million.

PBGC, 20 Years Later

In September we commemorated the 20th anniversary of ERISA's enactment, and we reflected on the intervening years. PBGC started with a small staff housed in temporary offices with borrowed equipment and no money. In those pioneering days, the agency faced an immediate backlog of plan terminations to be processed, and an almost immediate deficit. In contrast, we now collect almost $1 billion in premiums annually, a far cry from the $22 million collected the first year, and we are managing $8.7 billion in assets. We insure the benefits of more than 41 million Americans, with direct responsibility for the pensions of 372,000 people. We are paying nearly $65 million in benefits every month.

PBGC has accomplished much in the last 20 years, and yet more remains to be done. Our first priority is to implement the reforms. We must close the gap in pension funding and make sure that pensions and PBGC are truly safe. The reforms give us the tools to do so. With continued hard work, we will build a future as memorable as our past.

Martin Slate, *Executive Director.*

RETIREMENT PROTECTION REFORMS

On December 8, 1994, President Clinton signed into law the Retirement Protection Act of 1994 as part of the General Agreement on Tariffs and Trade legislation passed by the Congress. With enactment of the pension reforms, the Administration and the Congress have acted to close the gap of pension underfunding that has troubled the defined benefit pension system for more than a decade. For many workers and retirees, the Retirement Protection Act makes retirement security a reality.

During the year, the reforms were widely discussed and broadly supported. Secretary of Labor Robert Reich and PBGC Executive Director Martin Slate testified in support of the legislation during three Congressional hearings. Both the House Ways and Means Committee and the House Education and Labor Committee considered the legislation and unanimously reported it out for action by the full House. In addition, editorials supporting the pension reforms appeared in 85 newspapers across the country.

The heart of the reforms is strengthened and accelerated funding for single-employer pension plans that are less than 90 percent funded. The reforms also provide PBGC with additional enforcement tools, improve information for workers and retirees in underfunded plans, and increase pension insurance premiums for the plans

that pose the greatest risk. Companies with well-funded plans are not affected by these reforms.

PBGC expects that, over a 15-year period, the reforms will reduce underfunding by more than two-thirds and put the Corporation on a sound financial basis by eliminating the deficit within 10 years.

PENSION FUNDING REFORMS

For single-employer plans that are less than 90 percent funded, the reforms will strengthen funding by:

Accelerating the funding formula so that new benefits are funded over a shorter period, with the greatest effect being felt by plans that are less than 60 percent funded—most benefit increases for these plans will be funded over 5–7 years;

Removing a loophole in prior law that allowed employers to use certain credits or other offsets to lessen minimum funding payments;

Constraining the interest and mortality assumptions that may be used for calculating minimum funding contributions by specifying the appropriate mortality tables and gradually narrowing the range of permissible interest rates; and

Adding a new plan solvency rule to ensure plans have enough cash and marketable securities to pay current benefits.

Transition rules will ease the impact and enhance the affordability of the new requirements. The reforms also remove certain impediments to full funding by granting excise tax relief in some situations. They also eliminate requirements for quarterly contributions for fully funded plans.

COMPLIANCE REFORMS

The reforms enhance PBGC's compliance authority and early warning program by strengthening our ability to protect pensions through new reporting requirements that should assure PBGC will have adequate information with which to act. Employers with large pension underfunding are required to provide PBGC annually with detailed actuarial information on their plans and financial information on the sponsoring companies and their controlled group members. Privately held companies with plans that are, in the aggregate, less than 90 percent funded and underfunded by more than $50 million must provide PBGC with 30 days' advance notice of significant corporate transactions that might threaten the future funding of pensions. PBGC already is able to monitor the transactions of publicly held companies through publicly available sources.

PBGC is given express authority to enforce minimum funding requirements, and the reforms improve the agency's authority to file liens against employer assets for missed contributions. Finally, employers are prohibited from increasing benefits in underfunded plans during bankruptcy.

PARTICIPANT PROTECTION REFORMS

Workers and retirees need to know the financial condition of their pension plans, the consequences of underfunding on their promised benefits, the scope of PBGC's guarantees, and that they will receive their benefits even if they are unaware that their fully funded plan has terminated. The reforms broaden information requirements and provide other protection for workers and retirees. Employers whose plans are less than 90 percent funded must provide participants with an annual plain-language explanation of their plan's funding status and the limits on PBGC's guarantee. In addition, PBGC will serve as a clearinghouse for participants who cannot be located upon termination of a fully funded plan. The employer will have to either purchase an annuity contract covering such people or transfer sufficient assets to PBGC to pay the participants' benefits once the participants are found or they contact PBGC. Also, the reforms require employers, by the year 2000, to use uniform interest and mortality assumptions in calculating minimum lump-sum payments of benefits.

PREMIUM REFORMS

PBGC's annual insurance premium for single-employer plans includes a flat-rate charge of $19 per participant paid by all plans and an additional variable-rate charge of $9 per $1,000 of unfunded vested benefits paid only by underfunded plans. The variable-rate charge, however, had a maximum cap under prior law that limited premium obligations and weakened the funding incentive for the most seriously un-

derfunded plans. Although plans affected by the cap accounted for 80 percent of all the underfunding in single-employer plans, they paid only 25 percent of PBGC's total premium revenues. The reforms provide an incentive for funding pensions and bring balance to the premium structure by phasing out the current cap on the variable-rate charge over 3 years. With the premium reforms, PBGC expects the deficit to be eliminated within 10 years.

BANKRUPTCY REFORMS

The Congress also passed legislation during the year to amend the Bankruptcy Code. Signed into law by President Clinton on October 22, 1994, one provision of the Bankruptcy Amendments of 1994 allows PBGC to be a member of creditors' committees with full voting rights. Under prior law, PBGC was not allowed to be a member of these committees, despite frequently being the largest creditor because of pension underfunding. The change in the Bankruptcy Code will enable PBGC to participate in bankruptcy reorganizations, to have full access to essential information, and to expedite reorganization proceedings for the benefit of all parties concerned.

ENFORCEMENT

Vigilance and decisive action marked PBGC's enforcement activities during 1994. Through year-round monitoring of companies with substantially underfunded plans, combined with determined negotiations and litigation, PBGC achieved some of the biggest successes in its history.

EARLY WARNING PROGRAM

PBGC's early warning program played a vital role in the agency's efforts to prevent benefit losses for workers, retirees, and the insurance program. PBGC seeks to proactively identify and address concerns about large underfunded plans that will strengthen the plans and keep them ongoing. The Corporation tries to ensure that pensions are protected when companies restructure or otherwise engage in major transactions.

During the year, in-house financial analysts and actuaries closely monitored more than 300 companies with significantly underfunded plans that represented over 80 percent of the total underfunding in PBGC-insured single-employer plans. Through analysis of company financial statements, government reports, actuarial valuations, and public announcements of major transactions, the PBGC staff evaluated the risk of future plan terminations and identified transactions or events that could adversely affect a plan and its participants.

This information enabled PBGC to negotiate key settlements valued at nearly $11 billion with 16 plan sponsors. This includes a major pension funding agreement with General Motors Corporation, and other settlements that provided more than $800 million in increased protection for participants of underfunded plans.

General Motors Corporation. In May 1994, following months of negotiations, PBGC reached an agreement with GM for the company to contribute about $10 billion in cash and stock to its largest and most underfunded pension plan. At the time of the agreement, the total underfunding for all of GM's plans was reported to be approximately $20 billion, most of which was in the plan covered by the agreement. That plan covers more than 600,000 GM workers and retirees.

GM's contribution consists of $4 billion in cash and 177 million shares of GM Class E stock. The company agreed not to use the $10 billion contribution to offset its annual required contributions until 2003, except under certain circumstances. In return, PBGC agreed to release GM's information technology services subsidiary, Electronic Data Systems Corporation (EDS), from liability for GM's pensions, under certain circumstances, if EDS leaves the GM corporate group.

New Valley Corporation (formerly Western Union Corporation).—Throughout New Valley's bankruptcy proceedings, which began in November 1991, PBGC actively sought an agreement that would ensure that New Valley's ongoing pension plan—the tenth most underfunded plan in the country—was adequately protected under any reorganization proposal. That plan, which is underfunded by about $400 million, covers 16,000 Western Union workers and retirees.

On September 23, 1994, the bankruptcy court approved, over PBGC's objections, a bid for Western Union Financial Services, Inc., New Valley's major asset, that did not include assumption of the pension plan. On October 17, PBGC sought a district court order terminating the plan before the sale could be finalized. PBGC took this action to preserve its pension claims against Western Union while it was still a member of New Valley's controlled group. In response, on October 19, New Valley

and First Financial Management Corporation (FFMC), the prospective purchaser of Western Union, agreed that FFMC would assume responsibility for the pension plan as part of the sale of Western Union. The bankruptcy court subsequently confirmed New Valley's plan of reorganization, including the sale of Western Union. Because of this swift action, the plan will be kept ongoing and funded by a financially strong company, thus protecting the pensions of Western Union's workers and retirees and averting a potentially significant loss for the pension insurance program.

Pan Am Corporation. PBGC reached a $110 million cash settlement of the defunct airline's liability for three terminated Pan Am pension plans, which the bankruptcy court approved after the year ended. PBGC had asserted claims in Pan Am's bankruptcy for more than $900 million of unfunded benefits. Although little was left in the Pan Am estate, PBGC recovered about a third of what was available. In return, PBGC relinquished all other claims against Pan Am and ended all its litigation with the airline.

Armco, Inc.—In June 1994, PBGC and Armco reached a settlement worth $27.5 million that resolved Armco's liability for a terminated plan once sponsored by Armco's affiliate, Reserve Mining Company, and strengthened a separate ongoing Armco plan. The settlement ended a PBGC suit seeking to establish Armco's responsibility for the plan, which was underfunded by about $21 million when terminated in 1987. Under the agreement, Armco paid PBGC $10 million in cash to satisfy its liability for the plan's underfunding. Armco also contributed $17.5 million, in addition to its normal annual contributions, to its own ongoing plan for hourly employees. That plan, underfunded by nearly $300 million as of 1992, covers 20,000 workers and retirees. The $17.5 million contribution far exceeded the amounts Armco would have contributed to the plan over the next 2 years had the agreement not been reached.

Harvard Industries, Inc.—Harvard Industries, with eight pension plans that were underfunded by at least $25 million, planned a $100 million debt offering to retire existing bank and trade debt and a portion of its preferred stock. Concerned that collateralization of the new debt and other aspects of the transaction would increase PBGC's risk of long-run loss should the plans terminate in the future, PBGC reached an agreement with the company for advance funding of the plans. Under the agreement, Harvard Industries will contribute $24 million, over and above its required pension funding, to its underfunded plans over the next 3 years. The agreement includes additional protections for PBGC, including restrictions on preferred stock redemptions.

Great American Management and Investment, Inc., (GAMI).—Shortly after the year ended, PBGC reached an agreement with GAMI that protected the pensions of 11,000 workers and retirees of companies under GAMI's control. The pension plans of GAMI and its subsidiaries are underfunded by more than $30 million.

Most of GAMI's earnings are derived from an affiliated group of companies, the Falcon Group. Falcon was planning an initial public offering of stock that could have relieved the group of joint-and-several liability for the GAMI pensions. Under the agreement with PBGC, each company in the Falcon Group will remain liable for the underfunding of any GAMI-affiliated pension plan that terminates in the next 5 years.

Lone Star Industries, Inc.—Lone Star, which successfully emerged from bankruptcy in April 1994, has nine underfunded pension plans that will be better protected as a result of the company's settlement agreement with PBGC. The plans cover about 5,900 people and were underfunded, at the time, by about $73 million. Under the settlement, Lone Star agreed to keep the plans ongoing and to contribute about $12.3 million to them in addition to its required annual contributions. The company also gave PBGC a security interest in real property and a partnership with a value of at least $35 million as additional protection should the plans terminate in the future.

American Cyanamid Corporation (ACY).—ACY, which had a single pension plan with 37,000 participants, proposed to break up its controlled group by spinning off a subsidiary, Cytec Industries, Inc., to its shareholders. As part of this transaction, ACY proposed to spin off the portion of the ACY plan relating to Cytec's 4,500 active employees. The plan being spun off had underfunding of about $100 million. Because Cytec did not have the financial resources of ACY, PBGC sought protection from ACY for Cytec's pension obligations. ACY subsequently agreed to remain responsible for full termination liability should the Cytec plan terminate without enough money to pay all promised pension benefits.

LITIGATION

PBGC prefers to negotiate settlements of pension issues with the responsible employers, but the agency will not hesitate to take legal action when necessary to protect its interests or those of workers and retirees. Its successful record in Federal courts across the country is an important incentive for employers to seek resolution of pension issues through negotiated settlements rather than litigation.

At the end of the year, PBGC had 121 active cases in State and Federal courts and 638 bankruptcy cases.

East Dayton Tool and Die Company, Inc.—PBGC won a significant victory when an appellate court applied PBGC's definition of a group of commonly controlled companies in finding that the members of the Roscommon Group were jointly and severally liable for the terminated East Dayton pension plan. The court upheld PBGC's determination that, under Federal pension law, a corporate group's responsibility for an underfunded pension plan is based on stock ownership of the plan sponsor rather than on "actual" control of the company. The Roscommon Group owned all of East Dayton's stock but had lost control of the company after defaulting on the loan through which the group obtained East Dayton. The court found that actual control of East Dayton on the date the pension plan terminated was irrelevant.

CF&I Steel Corporation.—In a case with potentially broad ramifications for PBGC's recoveries in bankruptcies, PBGC continued to pursue its claims for a CF&I plan that was underfunded by about $220 million when terminated in March 1992. Under CF&I's consensual plan of reorganization, which was confirmed in 1993, PBGC is to receive a share of liquidation proceeds that will include a limited partnership interest in the business that was transferred to new owners by an asset sale, and may include cash and other consideration. PBGC estimates the total value of the potential recovery at about $33 million. PBGC may recover additional amounts depending on the outcome of pending litigation on its claims.

In a November 1994 ruling, a distinct court denied priority to most of PBGC's claims for minimum funding contributions owned CF&I's plan and for the plan's underfunding. The court also remanded the case to the bankruptcy court for reconsideration of the amount of PBGC's underfunding claim, ruling that the bankruptcy court erred in deferring to PBGC's interest rate assumption. PBGC is seeking leave to pursue an immediate appeal of this ruling.

White Consolidated Industries, Inc.—White continued to contest PBGC's claims for the estimated $120 million underfunding in several pension plans that White transferred in a 1985 transaction with Blaw Knox corporation. PBGC is alleging that a principal purpose of White in entering into the transaction was to evade the pension liabilities. Within the past 3 years, PBGC has had to terminate all six Blaw Knox plans, because they either ran out of money or lacked sufficient funds to pay all benefits when due. The case remained pending before a district court at yearend.

Collins v. *PBGC; Page* v. *PBGC.*—In these consolidated class-action suits, the plaintiffs—participants in plans that terminated before September 26, 1980, without having been amended to adopt ERISA's minimum vesting standards—sought a court ruling requiring PBGC to guarantee their benefits as if their plans had been amended. PBGC had determined at the time their plans terminated that only those benefits vested under the express terms of their plans were guaranteeable. PBGC and the plaintiffs continued to discuss a settlement throughout the year.

RULEMAKING

PBGC issued final rules shortly after the year ended that will strengthen the agency's debt collection powers. One set of rules has enabled PBGC to participate in the Internal Revenue Service's tax refund offset program and claim the tax refunds of companies to offset amounts owed to PBGC, particularly unpaid premiums. A separate program known as administrative offset will allow PBGC to claim money owed to its debtors by other Federal agencies. The offset programs will be triggered only when there is a failure to pay a legally enforceable debt already owed to PBGC.

CUSTOMER SERVICE

In 1994, PBGC expanded its efforts to reach out to people covered by plans taken over by the agency and to reassure them about their retirement security. Changes are in process that are enhancing PBGC's ability to process plan terminations and serve the workers and retirees in terminated plans.

BENEFIT PROCESSING

PBGC's responsibility for benefit payments begins immediately upon becoming trustee of a terminated plan. Top priority is given to maintaining uninterrupted benefit payments to existing retirees and commencing payments to new retirees without delay. Concurrently, PBGC staff also begin intensive efforts to obtain essential data and records on each individual participant, a difficult task frequently complicated by inadequate plan and employer records.

PBGC pays estimated benefits to retirees until it has confirmed all necessary participant data and valued plan assets and recoveries from the plan's sponsor. PBGC then calculates the actual benefit payable to each participant according to the specific terms of the participant's plan, statutory guarantee levels, and the funds available from plan assets and employer recoveries. These benefit calculations can be an intricate process since each trusteed plan is different and must be administered separately.

TRUSTEED PLANS

During 1994, PBGC became trustee of 105 single-employer plans, almost 40 percent more than in 1993. PBGC is in the process of trusteeing an additional 117 terminated single-employer plans, which, along with 10 multiemployer plans previously trusteed, will bring the cumulative number of trusteed plans to 1,971. This total also reflects the changed circumstances of one plan, which no longer required PBGC trusteeship.

BENEFIT PAYMENTS

About 372,000 participants from single-employer and multiemployer plans rely on PBGC for current and future pension benefits. These include 174,200 retirees receiving pensions and about 200,000 additional people who are entitled to receive benefits when they retire in the future. Another 71,000 participants are in plans that were considered likely to terminate but had not done so before the year ended. Benefit payments during 1994 totalled about $721 million.

WE PLEDGE

As customers of PBGC, you deserve our best efforts. Our first goal, of course, is getting you your benefit check on time each month. We are also committed to always showing you courtesy and respect when you contact us. For 1995, we pledge that:

> In all communications with you, we will acknowledge your inquiry within one week. If we cannot give you an immediate answer, we will tell you when to expect it and we will give you a specific point of contact at PBGC.
>
> If it will take us longer than expected to answer your question, we will give you a status report and tell you a new date when to expect an answer.
>
> If you are receiving a pension check, changes you request (such as address change, direct deposit, tax change) will be made within 30 days, if the request is received by the first of the month. It will take another month if the request is received after the first of the month.

CUSTOMER SERVICE STANDARDS

PBGC established Customer Service Standards to better serve our principal customers, the workers and retirees to whom we pay pension benefits. Publication of these standards as part of the National Performance Review report, "Putting Customers First, Standards for Serving the American People," culminated a cooperative effort that involved frontline PBGC employees who deal directly with the participants, representatives of participants, and PBGC management.

To implement the standards, PBGC is reviewing the processes that affect customer services to ensure they support this effort, providing customer service training to staff who deal directly with our customers, and identifying additional standards that may be needed. PBGC also will measure overall customer satisfaction through a periodic survey of the workers and retirees whose plans the agency has taken over.

PARTICIPANT OUTREACH

Overall communications with our customers took a major step forward as PBGC introduced the *Pension Newsletter* for retirees paid benefits by the agency. The semiannual newsletter, which has met with an enthusiastic response from the retirees, keeps them abreast of developments at the agency and communicates important in-

formation about PBGC's customer services and benefit payment procedures. In addition, PBGC produced and issued a videotape entitled "Your Guaranteed Pension" to explain PBGC's guarantees and reassure participants in newly trusteed plans. The video has proven particularly useful in meetings PBGC conducts with participants of large, newly trusteed plans to allay their concerns about their pensions. In 1994, PBGC held 10 such meetings in several locations across the country for plan terminations affecting about 15,000 people.

During the year, PBGC conducted a pilot "Know Your Pension" information campaign targeted to parts of Ohio and Pennsylvania. The campaign sought to educate participants in ongoing underfunded plans about their pensions and PBGC's guarantees through newspaper articles, radio messages, posters, and readily accessible pamphlets. The results of the campaign far exceeded expectations. The radio messages were carried on about 40 stations reaching almost 2 million homes. The newspaper columns were carried by nearly 70 newspapers with more than 6 million readers. More than 100,000 pamphlets were taken, generating over 32,000 requests for additional publications. The program will be expanded in 1995 to cover six States where there are 4,700 underfunded plans covering more than 2.4 million people.

PBGC's missing participant program, through which PBGC tries to find workers and retirees who may be unaware they are entitled to benefits, generated successful results during the year. A *Wall Street Journal* article headlined "Agency Reunites People and Their Pensions" began: "They're from the government, and they're here to help you. Really."[1] The project enabled PBGC to locate addresses for 12,000 out of 15,000 missing people, for which Vice President Gore presented PBGC with the National Performance Review's "Hammer Award."

SERVICE IMPROVEMENTS

PBGC moved ahead with plans to reorganize its longstanding "assembly line" method for processing plan terminations and participant benefits in order to streamline and strengthen the process. In place of the agency's previous sequential handling of the procedural steps, PBGC has put in place interdisciplinary teams combining the various actuarial, financial, and benefit processing skills needed to simultaneously complete these tasks. The teams will assure faster, more efficient, and more accurate results than are possible through the current procedures. Participants will receive individualized and direct service.

PBGC has a range of actions underway to improve customer service. One project to expedite the calculation and communication of participant benefits resulted in the issuance of more than 25,500 individual benefit determinations, nearly 25 percent more than were issued in 1993. In addition, PBGC established "800" telephone numbers at all 18 of its field benefit locations, assuring direct, toll-free services for the people paid through these local pension administration offices, and will soon establish this service at its headquarters location in Washington, D.C.

The past year also saw significant progress in PBGC's optical imaging of plan and participant documents, a program initiated in 1993. Optical imaging provides enhanced computer-based document storage and retrieval capabilities through conversion of documents to computerized images. Optical imaging is critical to PBGC's ability to provide faster, better service to participants. During 1994, the agency imaged 1.2 million separate participant documents. PBGC expects to complete imaging of all its plan and participant records during 1995.

APPEALS OF BENEFIT DETERMINATIONS

PBGC established its Appeals Board in 1979 to resolve appeals of certain initial PBGC determinations. Almost all of the appeals PBGC receives are from participants disputing PBGC's determination of their benefits. Approximately 2 percent of all determinations issued are actually appealed.

Most appeals are closed without Appeals Board action because the appeals department and other PBGC staff are able to resolve the issue informally or the appellant simply needs a better explanation of PBGC's determination. In 1994, 63 of the 156 appeals decided by the Board required changes in participants' benefits, and those changes usually were due to new facts presented by the appellant or a different interpretation of plan provisions.

PBGC's single-employer plan insurance program posted a significant financial gain for the year largely through the effect of rising interest rates on the program's benefit obligations, the low impact of plan terminations, including deterrence of the termination of a major underfunded plan, and stepped-up collection efforts. As a re-

[1] Excerpted from *The Wall Street Journal,* February 17, 1994, ® Dow Jones & Company, Inc.

sult, the program's deficit fell sharply by yearend. The separate insurance program for multiemployer plans, while still carrying a considerable surplus, recorded its first financial loss in 11 years.

SINGLE-EMPLOYER PROGRAM

The number of American workers and retirees with pensions insured under the single-employer program grew slightly, to nearly 33 million people, despite a continuing decline in the number of single-employer pension plans covered by PBGC. There are about 56,000 single-employer plans, based on the most recent data available, which is for 1992 when there were about 8,000 terminations of fully funded plans. The number of terminations each year has dropped considerably since then.

PROGRAM FINANCES

A healthy economy buttressed the pension system. With no major plan terminations and rising interest rates, PBGC reported a $249 million reduction in its accumulated losses from actual and probable plan terminations. This reduction of losses contributed to PBGC's significantly increased underwriting income.

As a result of stepped-up collection efforts and the continued growth in underfunding, PBGC's premium revenues increased by $65 million to $955 million. Despite investment losses, PBGC also reported more than $400 million in financial income primarily due to actuarial credits reflecting the change in interest rates. The net result for the year was that the single-employer program's liabilities dropped to about $9.5 billion. Assets increased slightly to nearly $8.3 billion. By yearend, the single-employer program's deficit had fallen to about $1.2 billion.

STANDARD TERMINATIONS

An employer may end a fully funded plan in a standard termination by annuitizing or paying lump sums to participants. Standard terminations are subject to legal requirements governing notifications to participants and PBGC and payment of the participants' benefits. PBGC may disallow any standard termination that does not comply with the requirements.

There were considerably fewer standard terminations in 1994, continuing a decline from the historically high levels reported during the late 1980's. In 1994, PBGC received about 3,950 notices of standard terminations, about 25 percent fewer than were received in 1993 and one-third the number received annually in the years 1987–90. Including plans for which PBGC received notices before 1994, the Corporation permitted completion of about 4,060 standard terminations and returned or disallowed another 1,560 cases that were incomplete or failed to meet legal requirements. The agency processes its applications for standard terminations well within the 60-day statutory time period.

PBGC audits a statistically significant number of completed terminations to confirm compliance with the law and proper payment of participants' benefits. These audits generally have found few and relatively small errors in benefit payments, which plan administrators are required to correct. Under prior law, certain situations involving distribution of assets could be corrected only by cancellation of the termination, which could prove harmful to plan participants. The new law allows PBGC to exercise other remedies, such as the imposition of a penalty, if the agency determines that cancelling a termination would be inconsistent with the interests of the plan's participants and beneficiaries.

DISTRESS AND INVOLUNTARY TERMINATIONS

Defined benefit plans that are not able to pay all promised benefits may be terminated either by the employer responsible for the plan or by PBGC. An employer wishing to terminate an underfunded plan generally may do so only if the employer is being liquidated or if the termination is necessary for the company's survival. The employer must first prove to PBGC, or to a bankruptcy court if appropriate, that it and each of its affiliated companies meets one of the financial distress criteria set by law.

An underfunded plan also may be terminated involuntarily by PBGC when necessary to protect the interests of the participants or of the insurance program. PBGC must terminate any plan that has insufficient assets to pay current benefits.

The number of underfunded plans requiring distress or involuntary termination increased in 1994. Terminations during the year included plans from Schwinn Bicycle Company; Avtex Fibers, a Virginia textile company; Washington Industries, a Tennessee clothing manufacturer; Heintz Corporation, a Philadelphia aeronautical parts manufacturer; Blaw Knox Corporation; and Sharon Steel, a Pennsylvania steel

company. By yearend, PBGC had approved the termination of 114 underfunded plans, in contrast to the 88 plans in 1993. The actual termination date for many of these plans occurred in earlier years.

Although more underfunded single-employer plans terminated in 1994 than in the previous year, losses from underfunded plans dropped substantially. PBGC's annual losses from underfunded single-employer plans have been variable throughout its history, with net losses generally increasing since 1982.

SINGLE-EMPLOYER PROGRAM EXPOSURE

The majority of single-employer plans insured by PBGC are fully funded. However, total underfunding in single-employer plans increased to $71 billion as of December 31, 1993, from the $53 billion reported for the end of 1992. These underfunded plans, which covered about 8 million workers and retirees, had total assets of $316 billion and total liabilities for vested benefits of $387 billion.

LOSS EXPERIENCE FROM SINGLE-EMPLOYER PLANS[1]

[Dollars in millions]

Year of termination	Number of plans	Benefit liability	Trust plan assets	Recoveries from employers	Net losses	Average net loss per terminated plan
1975–1981	824	$742	$295	$129	$317	$0.4
1982–1988	781	3,058	922	203	1,932	2.5
1989–1994	356	4,690	2,043	390	2,257	6.3
Subtotal	1,961	8,489	3,260	723	4,506	.....
Probable	39	2,699	1,201	333	1,166	.....
Total	2,000	11,188	4,461	1,055	5,672	.....

Note: Numbers may not add up to totals due to rounding.

[1] Stated amounts are subject to change until PBGC finalizes values for liabilities, assets, and recoveries of terminated plans. Amounts in this table are valued as of the date of each plan's termination and differ from amounts reported in the Financial Statements and elsewhere in the Annual Report, which are valued as of the end of the stated fiscal year.

This underfunding remains concentrated in a relatively small number of companies and industries. More than half of the underfunding is in large pension plans, primarily in the automobile, steel, industrial and commercial machinery, airline, and tire and rubber industries.

Underfunding increased in 1993 primarily due to the historically low interest rates, but a hard core of underfunding has persisted since enactment of ERISA in 1974. Even if interest rates remained constant, there still would have been no significant improvement in underfunding, which has grown over the past decade.

In order to measure how much of the current underfunding may result in future claims, PBGC categorizes underfunding into three loss contingency classifications that follow generally accepted accounting principles and are based on the financial condition of plan sponsors. The classifications are: probable, reasonably possible, and remote.

Probable claims are those that are likely to occur. PBGC estimates and records them as liabilities as they are determined, as required by financial accounting standards.

Approximately one-fourth of the $71 billion underfunding (about $18 billion based on public information obtained from corporate annual reports) is in plans maintained by companies that had below-investment-grade bond ratings as of September 30, 1994, and present a risk to the insurance program and to participants with nonguaranteed benefits. These plans are included in PBGC's reasonably possible claims.

About three-fourths of the underfunding is in plans sponsored by financially sound firms. These are categorized as remote claims. Pension underfunding in these plans is not presently a risk to participants or PBGC.

PBGC's estimate of underfunding in single-employer plans does not reflect increases in underfunding that typically occur in plans of troubled companies as they minimize their pension contributions and pay costly early retirement benefits that result from increased layoffs and plant shutdowns. In certain cases, the underfunding that PBGC is obligated to make up will have increased substantially by the time an underfunded plan is terminated.

FINANCIAL FORECASTS

ERISA requires that PBGC annually provide an actuarial evaluation of its expected operations and financial status over the next 5 years. PBGC historically has extended these forecasts to cover 10 years. As a result of passage of the Retirement Protection Act of 1994, the forecasts for PBGC's future have improved markedly.

PBGC's forecasts are subject to significant uncertainty since the amount of PBGC's future claims depends on many factors, including current underfunding among insured plans, future changes in funding levels, bankruptcies among plan sponsors, and recoveries from these bankrupt sponsors. These factors are influenced by future economic conditions, investment results, and the legal environment that the Congress and the courts create for PBGC's insurance program. Over the longer term, PBGC also will be affected by labor force trends, global trade, and employers' preferences among the variety of pension plans available.

PBGC's current methodology for the 10-year forecasts relies on an extrapolation of the agency's claims experience and the economic conditions for the past two decades. As a result, the forecasts do not reflect a full range of economic conditions and do not measure the high degree of uncertainty surrounding PBGC's future claims. To address the limitations of the forecast methodology, PBGC is developing a simulation model, called the Pension Insurance Management System (PIMS), to examine its financial condition under a full range of economic scenarios. Until PIMS is complete, PBGC is continuing to rely on its current methodology.

TEN-YEAR FORECASTS

PBGC has prepared three 10-year forecasts of its single-employer program (A, B, and C) using its current methodology to give a long-term view of the expected status under different loss scenarios. PBGC expects its history of significant annual variations in losses to continue. These forecasts include the significant improvement in PBGC's financial condition expected as a result of the December 1994 enactment of the Retirement Protection Act.

Forecast A is based on the average annual net claims over PBGC's entire history ($382 million per year) and assumes the lowest level of future losses. Forecast A projects steady net income resulting in gradual elimination of PBGC's deficit and a surplus of $5.1 billion at the end of 2004.

Forecast B, which assumes the mid-level of future losses, is based upon the average annual net claims over the most recent 13 fiscal years ($516 million per year). PBGC began incurring significantly larger claims in 1982. Forecast B projects lower net income levels than Forecast A that still lead to gradual elimination of PBGC's deficit and a surplus of $2.8 billion at the end of 2004.

Forecast C is highly pessimistic and reflects the potential for heavy losses from the largest underfunded plans by assuming that the plans that represent reasonably possible losses will terminate uniformly over the next 10 years in addition to a modest number of lesser terminations each year. (Reasonably possible losses are discussed in Note 8 to the financial statements.) This forecast assumes $1.15 billion of net claims each year, resulting in steady growth of PBGCs deficit throughout the 10-year period of $7.8 billion.

The methodology used to produce Forecast C was revised for this year to reflect the impact of the sharp increase in interest rates that has occurred since December 31, 1993. The value of assets and liabilities of plans that represent reasonably possible losses has been re-estimated consistent with the September 30, 1994, interest rate, mortality, and administrative expense assumptions used in Forecasts A and B. If Forecast C had been prepared consistent with the prior year's methodology, on the basis of the December 31, 1993, 5.65 percent interest rate assumption at which reasonably possible losses were initially valued, the forecasts would have reflected $1.72 billion of net claims each year and projected rapid growth of PBGC's deficit throughout the 10-year period to $17.2 billion.

The 1994 forecasts share several assumptions. Projected claims are in 1994 dollars. The present value of future benefits is valued using actuarial assumptions consistent with assumptions used to value the present value of future benefits in the financial statements as of September 30, 1994. Assets are projected to grow at 7.81 percent annually. Benefits for plans terminating in the future are assumed to grow at 5.93 percent annually until termination. Plan funding ratios are assumed to increase at 1.5 percent per year from historical averages and recoveries from plan sponsors are assumed to be constant at 10 percent of plan underfunding. The number of participants in insured single-employer plans is assumed to remain constant. The flat-rate portion of the single-employer premium is assumed to remain constant at $19 per participant. Receipts from the variable-rate portion of the premium are projected on the basis of a constant 30-year U.S. Treasury bond rate of 7.75 percent.

Assumed administrative expenses through 1996 are consistent with PBGC's 1996 President's Budget submission and are projected to grow 5.93 percent each year thereafter.

MULTIEMPLOYER PROGRAM

The multiemployer program, which covers about 8.7 million participants in about 2,000 insured plans, is funded and administered separately from the single-employer program and differs from the single-employer program in several significant ways. The multiemployer program covers only collectively bargained plans involving more than one unrelated employer. For such plans, the event triggering PBGC's guarantee is the inability of a covered plan to pay benefits when due at the guaranteed level, rather than plan termination as required under the single-employer program. PBGC provides financial assistance through loans to insolvent plans to enable them to pay guaranteed benefits.

The significant reforms enacted in 1980 created several safeguards for the program, including a requirement that employers that withdraw from a plan pay a proportional share of the plan's unfunded vested benefits. These safeguards have permitted PBGC to maintain multiemployer premiums at a constant, reasonably low level.

The program continues in sound financial condition with assets of $378 million, liabilities totalling $181 million for future benefits and nonrecoverable future assistance, and a net surplus of $197 million. During 1994, the program's assets, which are invested primarily in U.S. Government securities, declined in value for the first time since passage of the 1980 reforms because of the effect of rising interest rates on the securities. The combination of reduced assets and an increased allowance for nonrecoverable future assistance due to a new probable liability produced the first decline in the multiemployer program's financial condition in 11 years.

PLAN UNDERFUNDING

Based on data as of the beginning of 1992—the most recent information available—multiemployer plans had total assets of $189.3 billion and liabilities of $177.5 billion. PBGC has determined that, of these plans, a small number were underfunded by a total of about $12 billion.

FINANCIAL ASSISTANCE

The multiemployer program has received relatively few requests for financial assistance. Since enactment of the reforms in 1980, PBGC has provided approximately $24 million in total assistance, net of repaid amounts, to only 13 of the 2,000 insured plans. Of this amount, about $4 million went to 8 plans in 1994. PBGC estimates that about $164 million, at present value, will be required to make all nonrecoverable future payments to the 8 plans currently receiving assistance and to other plans expected to require assistance in the near future.

IMPROVED ADMINISTRATION

During 1994, the Corporation established a Multiemployer Working Group to coordinate all multiemployer program activities within PBGC. The working group identifies and monitors underfunded multiemployer plans to assure better administration of the multiemployer program and to minimize losses for plan participants and the program.

PBGC also took steps to enhance its evaluation of the multiemployer program's exposure to losses for nonrecoverable financial assistance. The agency established a new automated multiemployer plan financial database with historical data that can be used to assess multiemployer plan financial trends. This database, in combination with better and more timely information on the universe of insured multiemployer plans and improved valuation procedures, enabled a more complete and reliable assessment of the program's exposure.

CORPORATE MANAGEMENT

The efforts to address longstanding problems in the agency's financial operations and reporting resulted in the General Accounting Office issuing its first clean opinion on PBGC's 1993 financial statements, confirming the validity of the reported financial condition of both of PBGC's insurance programs. PBGC is developing and implementing a new automated premium accounting system. A revised investment strategy, designed to maximize long-term investment performance, reduced PBGC's investment losses in a bad year for the capital markets.

SYSTEMS INITIATIVES

Modernization and integration of PBGC's information systems, many of which are more than 10 years old, remained a priority for the Corporation during 1994. At yearend, PBGC was well on the way to replacing several of its most critical systems. A state-of-the-art premium accounting system—one of the more advanced systems in government service—is being developed and will soon be operational. This new system will integrate the latest electronic processing capabilities, including optical scanning and computer imaging of documents, with PBGC's cash receipt and premium receivable systems. These features should reduce data entry cost by half while making much more accurate data available more quickly than in the past.

PBGC also began developing the systems architecture that will link PBGC's various information systems and assure that systems and programs adopted in the future are consistent with existing systems. Systems integration will improve the quality of, and controls over, corporate data and permit more efficient delivery of information to corporate staff.

FINANCIAL MANAGEMENT

PBGC's improved financial management enabled GAO to issue its first unqualified opinion on the financial condition of both the single-employer and multiemployer programs. In its May 1994 report, GAO stated that it found PBGC's statements of financial condition for both 1993 and 1992 "reliable in all material respects." PBGC has also received an unqualified opinion from GAO on the 1994 financial statements. GAO further recognized PBGC's progress by removing the pension insurance program from its high-risk list.

GAO's ability to reach its conclusions rested largely on PBGC's progress in strengthening its financial operations and reporting functions. PBGC continues to take corrective actions in specific financial and management information systems to remedy internal control weaknesses. Actions in 1994 included concentrating oversight of financial policies, procedures, and internal controls in one unit and centralizing the audit function to monitor and test all financial operations and supporting information systems; developing the new premium accounting system; and developing a systems integration strategy. PBGC's "1994 Management Report on Internal Controls" is included as part of GAO's audit report on PBGC's 1994 financial statements (GAO/AIMD–95–83).

Another area of concern has been PBGC's assessment of the multiemployer program's liability for financial assistance. Measures targeted at the multiemployer program during the year included instituting an automated database on insured multiemployer plans and improved oversight of multiemployer plan cases.

PBGC also made progress in addressing concerns about its participant data. The agency is instituting database system enhancements that will automatically check participant data and improve the valuing of the Corporation's benefit liabilities. PBGC also is computer-imaging plan and participant records to preserve the records, facilitate responses to participant inquiries, and improve operational efficiency.

OTHER INITIATIVES

The agency made significant progress on a number of other initiatives. PBGC implemented contract planning and monitoring procedures, including a formal advance procurement planning process, and introduced "electronic commerce" technology, which uses nationwide electronic bulletin boards to increase competition and reduce costs for small procurements. The Corporation also continued developing and implementing agency program performance measurements, with the majority of the measures identified to date to be implemented by the end of 1995, well ahead of the schedule set by the Government Performance and Results Act for all Federal agencies. In addition, PBGC identified and initiated personnel reforms, including improved employee development programs and increased diversity of staff, and relocated the entire agency to a new building.

INVESTMENTS

The Corporation's approximately $8.2 billion of total assets available for investment consist of premium revenues held in the revolving funds and assets from terminated plans and their sponsors held in the trust funds. The revolving funds are required to be invested in Treasury securities and the trust funds are invested principally in high-quality stocks, with a small portion invested in real estate. PBGC

uses major investment management firms to invest these assets subject to PBGC's policy of investing for long-term reduction of its deficit.

INVESTMENT POLICY

With the approval of the Board of Directors, PBGC implemented a strategic change in its investment program to maximize long-term investment return within acceptable levels of risk. PBGC's new investment strategy emphasizes long-term asset growth in order to reduce PBGC's deficit. As interest rates began to climb, PBGC shortened the duration of its bond portfolio from 16.4 years to 5 years. PBGC reset the target duration to 10 years near the end of the fiscal year. PBGC further enhanced its ability to diversify the portfolio and improve investment performance by establishing a new equity ceiling of up to 50 percent of the overall portfolio value, in line with other pension funds.

Under the new strategy, PBGC increased its equity investment level from 17 percent at the beginning of the fiscal year to approximately 30 percent at fiscal yearend. Given the relative size of PBGC's trust fund compared to the larger revolving fund, which must be invested in Treasury securities, PBGC's current 30 percent allocation to equities represents the maximum level that could be achieved in 1994. This diversification in the overall portfolio protected PBGC's assets and reduced potential investment losses in 1994.

INVESTMENT PROFILE

As of September 30, 1994, the value of PBGC's total investments, including cash, was approximately $8.2 billion. The revolving fund value was $4.9 billion and the trust fund value was $3.3 billion.

Cash and fixed-income securities decreased from 79 percent of investable assets at the beginning of the fiscal year to 69 percent at fiscal yearend. This reduction was offset by an increase in equity investment from 17 percent at the beginning of the year to 30 percent at yearend. The balance of the invested portfolio remains in real estate and other financial instruments.

INVESTMENT PROFILE

	September 30,	
	1994	1993
Fixed-Income Assets:		
Average Quality	AAA	AAA
Average Maturity (years)	23.0	22.7
Duration (years)	9.9	16.2
Yield to Maturity (percent)	7.8	6.4
Equity Assets:		
Average Price/Earnings Ratio	18.3	20.3
Dividend Yield (percent)	2.8	2.7
Beta	1.07	1.04

INVESTMENT RESULTS

The past year proved difficult for capital market investments. The broad stock market, as measured by the Wilshire 5000 Index, returned just 2.5 percent over 1994 while PBGC's equity investments returned 4.5 percent. The segment of the bond market in which PBGC invested returned −11.2 percent. In comparison, the Lehman Brothers 20 Plus Treasury Index returned −11.6 percent and the Lehman Brothers Treasury Index returned −4.0 percent. Overall, the investment program, including fixed-income securities, equities, and real estate, returned −6.4 percent. For the year, PBGC reported $74 million in income from equity investments and a loss of $536 million from fixed-income investments. Other investments, including real estate, produced $36 million in income, for a total investment loss of $426 million.

INVESTMENT PERFORMANCE

[Annual rates of return in percent]

	September 30,		Five Years Ended September 30, 1994
	1994	1993	
Total Invested Funds	−6.4	27.7	9.7
Equities	4.5	13.3	8.1
Fixed-Income	−11.2	32.8	11.5
Trust Funds	1.6	15.7	8.3
Revolving Funds	−11.2	37.7	11.6
Indices:			
Wilshire 5000	2.5	17.3	9.1
S&P 500 Stock Index	3.7	13.0	9.1
Lehman Brothers Treasury Index	−4.0	11.1	8.2
Lehman Brothers 20+ Year Treasury Index	−11.6	21.5	8.6

The change in investment strategy helped to mitigate the negative impact of rising interest rates on PBGC's fixed-income investments. Although PBGC experienced investment losses in 1994 due to poor performing capital markets, PBGC's combination of a shorter duration bond portfolio and increased equity investments prevented approximately $395 million in losses that would have otherwise occurred. The losses that did occur, however, were more than offset by the decline in PBGC's benefit liabilities attributable to the rising interest rates, which resulted in a decrease in the agency's overall deficit.

ITEM 27. UNITED STATES POSTAL SERVICE

PROGRAMS AFFECTING OLDER AMERICANS

Carrier Alert Program

Carrier Alert is a voluntary community service provided by city and rural delivery letter carriers who watch participants' mailboxes for mail accumulations that might signal illness or injury. Accumulations of mail are reported by carriers to their supervisors, who then notify a sponsoring agency, through locally developed procedures, for follow-up action. The program completed its Twelfth year of operation in 1994 and continues to provide a lifeline to thousands of elderly citizens who live alone.

Delivery Service Policy

The Postal Service has a long-standing policy of granting case-by-case exceptions to delivery regulations based on hardship or special needs. This policy accommodates the special needs of the elderly, handicapped, or infirm customers who are unable to obtain mail from a receptacle located some distance from their home. Information on hardship exceptions to deliver receptacles can be obtained from local postmasters.

Services Available From Your Rural Carrier

Rural carriers continue to provide their customers with the retail services they have come to expect from the rural "post office on wheels." Some of the retail services provided by rural carriers are registered and certified mail, accepting parcels for mailing, taking applications for money orders, and providing their customers with receipts for these services.

Retail services are available to all customers served by rural carriers but are most beneficial to those individuals who are elderly or have a physical handicap which limits their ability to go to the post office for these important services. Rural carriers provide their customers with almost all retail services available from the post office 302 days per year.

Parcel Delivery Policies

For customers who are unavailable to receive uninsured parcels, but who are normally at home, we automatically redeliver the article on the following day. Additionally, if the mailer requests, parcels are left at customers' homes or businesses provided there is reasonable protection from the weather and theft. Both of these poli-

cies make it easier for customers to receive mail, and minimize the need for trips to the post office.

FEDERAL ACCESSIBILITY STANDARDS

The Postal Service is subject to the Architectural Barriers Act of 1968 which requires that most Federal buildings leased or constructed after 1968 meet applicable standards. In 1986, the Postal Service amended USPS Handbook RE4, *Standards for Facility Accessibility by the Physically Handicapped,* by adding a new section, "Accessible Buildings: Leasing of Space in Existing Buildings." These standards established accessibility requirements for existing buildings leased on or after January 1, 1977, and provided the Postal Service with guidelines for accomplishing its Architectural Barriers Compliance Program.

The scope of this program includes 26,000 facilities which were surveyed to identify deficiencies and possible solutions for those that were determined to be inaccessible. During FY 94, approximately 12,600 alteration projects were in progress. The success of the program is often heard at the local level from the elderly and physically disabled members of the community when accessibility alterations are completed. Our commitment to barrier-free facilities is apparent as over $130 million was funded to provide access in FY 94, including design for projects planned for FY 94. To date, the Postal Service has spent over $130 million on accessibility projects, including design for projects planned for FY 95. To date, the Postal Service has spent over $260 million on accessibility projects. The Postal Service has an aggressive Architectural Barriers Compliance Program and is committed to making its facilities accessible to all its customers. The Postal Service values its elderly customers and feel they will benefit from our efforts to make facilities accessible.

MAIL FRAUD AND MAIL THEFT INVESTIGATIONS

The Postal Inspection Service successfully collaborated with the American Association of Retired Persons (AARP) Bulletin and Publications Division on an article concerning telemarketing frauds against the elderly ("Tapes Reveal Cons Targeting Elderly," AARP Bulletin, March 1994). The circulation of the AARP Bulletin is approximately 23 million households. We also have provided other information of interest to the AARP on investigations conducted by postal inspectors with unusual or newsworthy aspects.

In October, the Postal Inspection Service was invited to participate in a news conference hosted by the AARP at the National Press Building on the subject of sweepstakes fraud. We hope to form a lasting working relationship with the AARP which will help us publicize the various fraudulent promotions which target the elderly with alarming success.

In an effort to alert the public to prevalent mail fraud schemes, the Postal Inspection Service has issued a variety of public service messages in the form of video news releases during the last 6 years. The releases have covered such topics as boiler room fraud, government look-a-like mail, 900 number frauds, medical quackery, and deceptive unclaimed tax refund notices, all of which target the elderly.

We often receive complaints from individuals who have discovered their elderly parents or relatives have lost tens, or in some instances hundreds of thousands of dollars to a variety of old fashioned con games that find their victims through the mail or by telephone. This year we produced a video news release entitled "Holiday Travelers: Scam-Proofing Your Older Relatives." The video and a corresponding press release were disseminated on December 21 with the target audience being individuals who would be visiting with their elderly relatives during the holidays.

Each year, during National Consumers Week, the Postal Inspection Service seeks to draw attention to some facet of consumer fraud. This year we issued a national news release through the wire services, national news syndicates and through each of our 30 division offices concerning investment frauds that impact the elderly. We offered a number of prevention tips that would help prospective targets avoid being victimized.

INJUNCTIONS AND OTHER CIVIL POWERS

In addition to the investigation of individuals or corporations for possible criminal violations, the Inspection Service can protect consumers from material misrepresentations through the use of several statutes. In less severe cases, operators of questionable promotions agree to a Voluntary Discontinuance. This is an informal promise to discontinue the operation of the promotion. Should the agreement be violated, formal action against the promoter could be initiated. In certain cases where a more formal action is better suited, a Consent Agreement is obtained. Generally, a pro-

moter signs a Consent Agreement to discontinue the false representations or lottery charged in a complaint. If this agreement is violated, the Postal Service may withhold the promoter's mail pending additional administrative proceedings.

The Postal Service (Judicial Officer) is empowered under 39 U.S.C. 3005(b)(2) to issue a Cease and Desist (C&D) Order which requires any person conducting a scheme in violation of Section 3005 to immediately discontinue. C&D orders are issued as part of a False Representation order and, as a matter of course, are agreed to as a part of a Consent Agreement. Violators of C&D orders may be subject to civil penalties under 39 U.S.C. 3012. When more immediate relief to protect the consumer is warranted, the Postal Service has a number of effective enforcement options available. Title 39 U.S.C. 3003 and 3004 enables the Postal Service, upon determining that an individual is using a factitious, false, or assumed name, title, or address in conducting or assisting activity in violation of 18 U.S.C. Sections 1302 (Lottery), 1341 or 1342 (Mail Fraud), to withhold mail until proper identification is provided and the person's right to receive mail is established.

In those instances where a more permanent action is necessary, 39 U.S.C. 3007 allows the Postal Service to seek a Temporary Restraining Order detaining mail. By withholding service to the suspected violator, the extent of victimization is limited while an impartial judge reviews the facts and makes a final determination. If the judge decides that all mail pertaining to the promotion should be returned, then a False Representation Order, authorized under 39 U.S.C. 3005 is issued. In addition, U.S. District Judges may hold a hearing on alleged fraudulent activity, and issue a permanent injunction regarding the operation pursuant to 18 U.S.C. 1345.

By requesting the court to withhold mail while a case is argued, Postal Inspectors have been successful in many cases in limiting the extent of victimization. Action under these statutes does not preclude criminal charges against the same target.

Customer Advisory Councils

In October 1988, the Postal Service introduced the concept of Customer Advisory Councils (CACs). The council concept was developed to encourage community interaction with local postal officials. CACs provide one more way for the Postal Service to listen to its customers. In 1994, the number of active councils grew to 1,719 nationwide, and 802 additional councils are planned for implementation in Fiscal Year 1995.

CAC membership usually includes up to 10 individuals who are representative of their community; small business owners, local government officials, university/college students, homemakers, and retired persons. Retired persons play an integral role in many of the council efforts, including "mystery shopping" where members "shop" the various post offices, stations and branches to rate the cleanliness of the facility, clerk knowledge, courtesy, and other related aspects of our retail services. The valuable feedback received from councils is often used by local postal officials to improve service.

Postal Answer Line

Postal Answer Line (PAL) is an automated telephone information service designated to provide recorded responses to common customer inquiries, including domestic parcel post rate calculations. Over 112 million customers with touch-tone telephones in 81 metropolitan areas may access PAL 24 hours a day, 7 days a week, PAL handles an average of 3.7 million calls per year for the Postal Service that would otherwise have been addressed directly to postal employees. First deployed in 1988, the average annual cost avoidance for this system to date has been calculated at $4.7 million. PAL provides a viable alternative for customers who are unable to visit their local post office.

The PAL system will soon be upgraded to take advantage of technological advancements which will serve more of our customers better. Preliminary improvements to the system will include the development of an interactive speech recognition system which will satisfy the needs of all Postal Service customers, opening the door to serving rotary dial telephone customers (38.5% of the population) and providing special text telephone modems which will allow PAL access via Telecommunications Device for the Deaf (TDD) equipment.

National Consumers Week

The Postal Service has sponsored an annual Consumer Protection Week since 1977. Since 1980, the Postal Service has scheduled its observance to coincide with the National Consumers Week sponsored by the U.S. Office of Consumer Affairs. Postmasters and facility managers are urged to sponsor special activities to educate

customers about postal products and services as well as Postal Inspection Service efforts to protect consumers from perpetrators of fraudulent schemes and other postal crimes. In conjunction with open houses and special gatherings scheduled during National Consumers Week, brochures are distributed to warn consumers about mail fraud and misrepresentations of products and services sold by mail. Helpful information about proper addressing of mail, packaging parcels correctly, temporary address changes, sending valuables through the mail, and how to report service problems are made widely available through planned events. As medical fraud and work-at-home schemes have traditionally ranked at the top of fraudulent promotions, the focus of material distributed is frequently directed toward alerting senior citizens of these other schemes.

STAMPS BY AUTOMATED TELLER MACHINE (ATM)

Stamps by ATM is one of the Easy Stamp Services and a convenient way to purchase stamps at a bank's automated teller machine. A specially designed sheetlet of 18 First-Class stamps is dispensed at the touch of a button. The cost is debited from your checking or savings account, treated like a cash withdrawal. Because many ATMs are accessible 24 hours a day, our customers are able to do banking and buy postage stamps at their convenience.

STAMPS BY MAIL

Stamps by Mail is another one of the Easy Stamp Services that allows postal customers to purchase postal products such as booklets, sheets, coils, postal cards, and stamped envelopes, by ordering through the mail.

The Stamps by Mail program benefits a wide variety of people and is particularly beneficial to elderly or shut-in customers who cannot travel to the post office. Stamps by Mail provides order forms incorporated in self-addressed postage-paid envelopes to customers for their convenience in obtaining products and services without having to visit a Postal Service retail unit. The form is available in lobbies or from the customer's letter carrier. The customer fills out the order form and returns it to the carrier or drops it in a collection box. Orders are normally returned to the customer within 2 or 3 business days.

STAMPS BY PHONE

Stamps by Phone is a convenience program that is intended to target business, professional, and household customers who are willing to pay a service charge for the convenience of ordering by phone and paying by credit card (VISA or Master Card) to avoid trips to the post office. The customer calls the (1–800–STAMPS–24) toll-free number, 24 hours a day, 7 days a week, and orders from a menu of postal products. There is no minimum amount and customers will receive their order within 3 to 5 business days.

WINDOW AUTOMATION AT RETAIL FACILITIES

The Postal Service is installing automated systems called Integrated Retail Terminals at the service windows in retail facilities in all medium to large cities. These terminals use video screens to display information about each transaction for the customer. The screens show some mailing restrictions and required mailing forms, total amount due, and change from the amount tendered. The display of this type of information is useful to many customers with hearing impairments, including some older Americans.

ALTERNATE POSTAL RETAIL SITES

Alternate postal retail sites include Contract Postal Units, and stamp consignment outlets (grocery stores, etc.). Providing alternate sites for routine postal retail transactions benefits both the Postal Service and our customers.

Contract postal units provide more convenient locations available for our customers to purchase stamps, which generally means less wait time for them to obtain these retail services. Purchasing stamps and postal money orders, registering a letter, and other postal errands, can be combined with a trip to the neighborhood shopping center. This is particularly advantageous to the elderly.

STAMPS ON CONSIGNMENT

The Postal Service consigns stamps to supermarkets, drug stores, and other large retail chains for resale to customers at no more than face value. This provides our

customers who need stamps an alternative to window service. This is especially convenient for our elderly customers who may have limited access to transportation and can purchase stamps while at the grocery or drug store.

ITEM 28. RAILROAD RETIREMENT BOARD

ANNUAL REPORT ON PROGRAM ACTIVITIES FOR THE ELDERLY—FISCAL YEAR 1994

The U.S. Railroad Retirement Board is an independent agency in the executive branch of the Federal Government, administering comprehensive retirement-survivor and unemployment-sickness benefit programs for the Nation's railroad workers and their families under the Railroad Retirement and Railroad Unemployment Insurance Acts. The Board also has administrative responsibilities under the Social Security Act for certain benefit payments and railroad workers' medicare coverage.

Under the Railroad Retirement Act, the Board pays retirement and disability annuities to railroad workers with at least 10 years of service. Annuities based on age are payable at age 62, or at age 60 for employees with 30 years of service. Disability annuities are payable before retirement age on the basis of total or occupational disability. Annuities are also payable to spouses and divorced spouses of retired workers and to widow(er)s, divorced, or remarried widower(er)s, children, and parents of deceased railroad workers. Qualified railroad retirement beneficiaries are covered by Medicare in the same way as social security beneficiaries.

Under the Railroad Unemployment Insurance Act, the Board pays unemployment benefits to railroad workers who are unemployed but ready, willing and able to work and pays sickness benefits to railroad workers who are unable to work because of illness or injury.

BENEFITS AND BENEFICIARIES

During fiscal year 1994, retirement and survivor benefits amounted to almost $8 billion, and unemployment and sickness benefits totaled $66 million. The number of beneficiaries on the retirement-survivor rolls on September 30, 1994, totaled 812,000. The majority (85 percent) were age 65 or older.

At the end of the fiscal year, 363,000 retired employees were being paid regular annuities averaging $1,095 a month. Of these retirees, 175,000 were also being paid supplemental railroad retirement annuities averaging $44 a month. In addition, approximately 201,000 spouses and divorced spouses of retired employees were receiving monthly spouse benefits averaging $441 and, of the 258,000 survivors on the rolls, 220,000 were aged widow(er)s receiving monthly survivor benefits averaging $652. Approximately 10,000 retired employees were also receiving spouse or survivor benefits based on their spouse's railroad service.

Railroad retirement annuities, like social security benefits, increase in January 1995 to reflect a 2.8 percent increase in the Consumer Price Index (CPI) during the 12 months preceding October 1994. Cost-of-living increases are calculated in each of the two tier portions of a railroad retirement annuity. Tier I portions, like social security benefits, increase in January 1995 by 2.8 percent, which is the percentage of the CPI rise. Tier II portions increase 0.9 percent, based on 32.5 percent of the CPI rise. In January 1995, the average regular railroad retirement employee annuity rises $24 to $1,119 a month and the average spouse benefit increases $9 to $450 a month. For aged widow(er)s, the average monthly benefit rises $16 to $668.

Some 737,000 individuals who were receiving or were eligible to receive monthly benefits under the Railroad Retirement Act were covered by hospital insurance under the Medicare program at the end of fiscal year 1994. Of these, 721,000 (98 percent) were also enrolled for supplementary medical insurance.

Unemployment and sickness benefits under the Railroad Unemployment Insurance Act were paid to 41,000 railroad employees during the fiscal year. However, only about $0.02 million (less than 1 percent) of the benefits went to individuals age 65 or older.

BENEFIT FINANCING

By the end of the 1994 fiscal year, the equity balance in the railroad retirement trust funds was $13 billion, an increase of $725 million over the preceding year.

The Board's 19th triennial actuarial valuation, submitted to Congress in June 1994, was favorable concerning intermediate-term railroad retirement financing and showed results similar to those in the previous valuation and recent annual financial reports. It concluded that, barring a sudden, unanticipated, large drop in railroad employment, the railroad retirement system will experience no cash-flow prob-

lems during the next 20 years. However, the long-term stability of the system, under its current financing structure, is still dependent on future railroad employment levels. The valuation did not recommend any change in the rate of the railroad retirement payroll tax imposed on employers and employees.

The Board's 1994 railroad unemployment insurance financial report, submitted to Congress in June 1994, was also favorable, indicating that experience-based contribution rates will keep the system solvent, even under the most pessimistic assumptions, while average employer contribution rates will remain below 1 percent through 1995. The report also noted that the balance of the Railroad Unemployment Insurance Account's 13-year debt to the Railroad Retirement Account was repaid in June 1993 and that, with current projections indicating the railroad unemployment insurance system will remain solvent under all employment scenarios, no new loans will be required during the projection period. No financing changes were recommended for the unemployment insurance system.

LEGISLATION

A provision in the Social Security Administrative Reform Act of 1994 enacted August 15, 1994, extended the transfer to the Railroad Retirement Account of revenues from Federal income taxes on tier II railroad retirement benefits.

The Social Security Act amendments of 1983 subjected social security level railroad retirement tier I benefits to Federal income taxes on the same basis as social security benefits, and subsequent Railroad Retirement Act amendments also subjected railroad retirement tier II benefits, paid over and above social security levels, to income taxes. Although the tax revenues from social security and social security equivalent tier I railroad retirement benefits are returned to the trust funds on a permanent basis, the transfer of tier II revenues (and revenues from tier I benefits in excess of social security equivalent levels) was placed on a temporary basis. Despite being extended three times, the legislative authority for these transfers expired at the close of fiscal year 1992.

This authority was extended on a permanent basis by the August 15, 1994, legislation, and a payment of $389 million covering the period October 1, 1992, through September 30, 1994, was made to the Railroad Retirement Account.

SERVICE AND ADMINISTRATIVE IMPROVEMENTS

During 1994, the Railroad Retirement Board began effecting some of the governmentwide Administration initiatives aimed at creating a government that works better, costs less, and is more responsive to its customers. These initiatives included the establishment of customer service standards based on customer satisfaction surveys and service benchmarking studies, a streamlining of agency operations in order to more effectively utilize a smaller workforce while simplifying internal organizational and administrative processes, and a substantial reduction in internal management regulations.

CUSTOMER SERVICE PLAN

The Board's new Customer Service Plan for railroad retirement beneficiaries is posted in every Board office and is also described in a leaflet available at any Board office.

The standard for answering letters under the plan requires that the Board reply to letters within 10 working days of receiving them. If for any reason the letter cannot be answered within that time frame, the Board will acknowledge the letter and advise how long it will be before the questions can be answered fully.

The plan also provides standards for the processing of claims. Persons filing for a railroad retirement employee or spouse annuity in advance can expect to receive their first payment, or a decision within 45 days of their date of retirement. Those filing for a railroad retirement disability annuity can expect to receive their first payment, or a decision, within 120 days from the date they filed their application.

Those filing an application for unemployment or sickness insurance benefits can expect to receive their first claim form, or a decision, within 15 days of the date their application is received. Likewise, persons filing a claim for unemployment or sickness insurance benefits can expect to receive their payment, or a decision, within 15 days of the date the Board receives their claim form.

While the Board's employees will strive to meet all of the criteria established in its Customer Service Plan, they may not always be successful; but the Board expects that its service will progressively improve to meet or exceed the Plan's standards of service and to demonstrate openness, accessibility and accountability.

MANAGEMENT IMPROVEMENT PLAN

In fiscal year 1994, the Board met or exceeded all of its goals under a management improvement plan agreed upon with the White House Office of Management and Budget as part of a 5-year, $14 million commitment to the agency by the Office of Management and Budget and the Congress. The Board has been using this commitment of funds to reduce claims processing backlogs, enhance debt collection activities, expand fraud controls, improve tax accounting operations, increase verification of payroll tax receipts, enhance automated claims processing systems and make other improvements in its administrative management operations.

OTHER INITIATIVES

The Board also implemented a number of other initiatives to improve operations, make the most of financial resources and provide the best possible service to the public. These included improvements in claims operations, the implementation of direct deposit for unemployment and sickness benefits, a single source medical exam procurement system, the consolidation of Chicago-area facilities, and energy conservation improvements.

OFFICE OF INSPECTOR GENERAL

President Clinton appointed Martin J. Dickman as Inspector General of the Railroad Retirement Board and his appointment was confirmed by the Senate in October 1994. As Inspector General, Mr. Dickman is responsible for promoting economy, efficiency, and effectiveness and for detecting any waste, fraud, or abuse in the programs and operations of the Board.

Before his appointment to the Board, Mr. Dickman served from 1991 as prosecutor for the Cook County, Illinois, State's Attorney's Financial and Governmental Crimes Task Force. His responsibilities included the investigation, indictment and prosecution of criminal cases involving governmental and white collar crimes. Mr. Dickman succeeded William J. Doyle III, the Board's first Inspector General, who retired from Federal service in April 1994.

During 1994, the Office of Inspector General continued to focus its efforts on long-term concerns and to address the major issues that affect overall service to the railroad community. The Office of Inspector General also continued its activities to identify and refer cases for prosecution of individuals who commit fraud against the Board's benefit programs, and to ensure that accurate and timely benefits are paid to railroad annuitants. Audit and investigative efforts resulted in monetary benefits totaling approximately $80 million during fiscal year 1994.

The Inspector General's Office of Audit issued 24 reports with actual and potential monetary benefits totaling $62 million. Additional financial benefits of $10.4 million were realized from interest and adjustments that resulted from prior audit reports. Actions by the Inspector General's Office of Investigations resulted in 260 criminal convictions, 116 indictments/informations and $7.4 million in court-ordered restitutions, fines recoveries and prevention of erroneous payments.

PUBLIC INFORMATION ACTIVITIES

The Board maintains direct contact with railroad retirement beneficiaries through its 86 field offices located across the country. Field personnel explain benefit rights and responsibilities on an individual basis, assist railroad employees in applying for benefits and answer any questions related to the benefit programs. The Board also relies on railroad labor groups and employers for assistance in keeping railroad personnel informed about its benefit programs.

At informational conferences held for railroad labor union officials, Board representatives describe and discuss the benefits available under the railroad retirement-survivor, unemployment-sickness and Medicare programs; and the attendees are provided with comprehensive informational materials describing in detail the benefit provisions as well as the administration and financing of the programs.

At seminars for railroad executives and managers, Board representatives review programs, financing, and administration, with special emphasis on those areas which require cooperation between railroads and Board offices. The Board also conducts informational seminars on benefit programs for employees at the request of railroad management.

The Board's headquarters is located at 844 North Rush Street, Chicago, Illinois 60611–2092, phone (312) 751–4500. In addition, the Board maintains an Office of Legislative Affairs in Washington, DC as a liaison for dealing with Members of Congress on matters involving the Railroad Retirement and Unemployment Insurance Acts and legislative issues that affect the Board. The Office of Legislative Affairs

is located at 1310 G Street, NW, Suite 500, Washington, DC 20005–3004, phone (202) 272–7742.

ITEM 29. SMALL BUSINESS ADMINISTRATION

The SBA is charged with the responsibility to create, implement and deliver technical and financial assistance programs for the benefit of the Nation's small business community. We currently do not have a program that gives specific focus to older Americans.

However, the SBA is the sponsoring Federal agency for the Service Corps of Retired Executives (SCORE) program. SCORE is an organization of nearly 13,000 business men and women who volunteer their time to provide management counseling and training to small businesses. They have extensive business experience, either as entrepreneurs and business owners or as former corporate executives. Their counseling is confidential and free of charge and is provided at more than 800 locations in the United States and its territories.

ITEM 30. VETERANS AFFAIRS

REPORT ON THE DEPARTMENT OF VETERANS AFFAIRS ACTIVITIES ON BEHALF OF OLDER VETERANS—FISCAL YEAR 1994

I. Introduction

The Department of Veterans Affairs has the potential responsibility for a beneficiary population of nearly 27 million veterans whose median age is approximately 56 years. Nearly 30 percent of the veteran population is age 65 and older. By the year 2005, almost 4½ million veterans will be 75 years or older.

This demographic trend will require VA to redistribute its resources to meet the different needs of this older population. Historically, older persons are greater users of health care services. The number of physician visits, short-term hospital stays, and number of days in the hospital all increase as the patient moves from the fifth to seventh decade of life.

VA has developed a wide range of services to provide care in a variety of institutional, noninstitutional, and community settings to ensure that the physical, psychiatric and socioeconomic needs of the patient are met. Special projects, a variety of innovative, medically-proven programs and individual VA medical center (VAMC) initiatives have been developed and tested that can be used for veteran patients and adapted for use by the general population.

VA operates the largest health care system in the Nation, encompassing 172 hospitals, 128 nursing home care units, 37 domiciliaries, and 366 outpatient clinics. Veterans are also provided contract care in non-VA hospitals and in community nursing homes, fee-for-service visits by non-VA physicians and dentists for outpatient treatment, and support for care in 78 State Veterans Homes in 41 States. As part of a broader VA and non-VA network, affiliation agreements exist between virtually all VA health care facilities and nearly 1,000 medical, dental, and associate health centers. This affiliation program with academic medical centers results in approximately 100,000 health profession students receiving education and training in VAMCs each year.

In addition to VA hospital, nursing home and domiciliary care programs, VA is increasing the number and diversity of noninstitutional extended care programs. The dual purpose is to facilitate independent living and keep the patient in a community setting by making available the appropriate supportive medical services. These programs include Hospital-Based Home Care, Community Residential care, Adult Day Health Care, Respite Care, and Psychiatric Day Treatment and Mental Hygiene Clinics, and Homemaker/Home Health Aide Services.

The need for both acute and chronic hospitalization will continue to rise as older patients experience a greater frequency and severity of illness, as well as a different mix of diseases, than younger patients, Cardiovascular diseases, chronic lung diseases, cancers, psychiatric and mental disorders, bone and joint diseases, hearing and vision disorders, and a variety of other illnesses and disabilities are all more prevalent in those persons age 65 and older.

II. Geriatrics and Extended Care Programs

VA NURSING HOME CARE

Nursing Home Care Units (NHCU), which are based at VA medical centers, provide skilled nursing care and related medical services. An inter-disciplinary ap-

proach to care is employed, which encourages diverse professional staff, working together, to meet the multiple physical, social, psychological, and spiritual needs of the patients. Nursing home patients typically require a prolonged period of care and/or rehabilitation services to attain and/or maintain optimal functioning.

In fiscal year 1994, more than 31,550 veterans were treated in 128 VA nursing homes, generating a total Average Daily Census (ADC) of 13,504.

VHA has contracted to fund a National Training Program to prepare staff to better meet the needs of the mentally ill in the nursing homes. At the same time, individual facilities continue efforts to reduce the incidence of both polypharmacy and restraint use, which is in keeping with the regulations of the Omnibus Reconciliation Act of 1987 (even though VA is not required to follow those regulations). A directive allowing VA nursing homes to develop psychogeriatric sections within each nursing home has resulted in the establishment of six such units. Eight test sites have continued implementation of a uniform minimum data base (known as the Minimum Data Set) which VHA hopes to introduce throughout the nursing home program.

COMMUNITY NURSING HOME CARE

This is a community-based, contract program for veterans who require skilled or intermediate nursing care when making a transition from a hospital setting to the community. Veterans who have been hospitalized in a VA facility for treatment, primarily for a service-connected condition, may be placed at VA expense in community facilities for as long as they need nursing care. Other veterans may be eligible for community placement at VA expense for a period not to exceed 6 months. Selection of nursing homes for a VA contract requires the prior assessment of participating facilities to ensure they meet our standards of care. Follow-up visits are made to veterans by teams from VA medical centers to monitor patient programs and quality of care.

In fiscal year 1994, 29,104 veterans were treated in the program. The number of nursing homes under contract was 3,500 and the average daily census in these homes was 8,783.

VA DOMICILIARY CARE

Domiciliary care in VA facilities provides necessary medical and other professional care for eligible ambulatory veterans who are disabled by disease, injury, or age and are in need of care but do not require hospitalization or the skilled nursing services of a nursing home.

The domiciliary offers specialized interdisciplinary treatment programs that are designed to facilitate the rehabilitation of patients who suffer from head trauma, stroke, mental illness, chronic alcoholism, heart disease and a wide range of other disabling conditions. With increasing frequency, the domiciliary is viewed as the treatment setting of choice for many older veterans.

Implementation of rehabilitation programs has provided a better quality of care and life for veterans who require prolonged domiciliary care and has prepared increasing numbers of veterans for return to independent or semi-independent community living.

Special attention is being given to older veterans in domiciliaries with a goal of keeping them active and productive as well as integrated into the community. The older veterans are encouraged to utilize senior centers and other resources in the community where the domiciliary is located. Patients at several domiciliaries are involved in senior center activities in the community as part of VA's community integration program. Other specialized programs in which older veterans are involved include Foster Grandparents, Handyman Assistance to senior citizens in the community, and Adopt-A-Vet.

In fiscal year 1994, 18,236 veterans were treated in 35 VA domiciliaries resulting in an average daily census of 6,051. Of these numbers, approximately 3,300 veterans and an average daily census of more than 1,200 were admitted to the domiciliaries for specialized care for homelessness. This latter group had an average age of 43 years, while the overall average age of domiciliary patients was 59 years.

STATE HOMES

The State Home Program has grown from 10 homes in 10 States in 1888 to 78 State homes, including 2 annexes, in 41 States. Currently, a total of 22,006 beds are authorized by VA to provide hospital, nursing home, and domiciliary care. VA's relationship to State Veterans Homes is based upon two grant programs. The per diem grant program enables VA to assist the States in providing care to eligible veterans who require domiciliary facilities. The other VA grant program provides up

to 65 percent Federal funding to States to assist in the cost of construction or acquisition of new domiciliary and nursing home care facilities, or the expansion, remodeling, or alternation of existing facilities.

HOSPICE CARE

VA has developed programs that provide pain management, symptom control, and other medical services to terminally ill veterans, as well as bereavement counseling and respite care to their families. The hospice concept of care is incorporated into VA medical center approaches to the care of the terminally ill. All VA medical centers have appointed a hospice consultation team, which is responsible for planning, developing, and implementing the hospice program.

HOSPITAL-BASED HOME CARE

This program provides in-home primary medical care to veterans with chronic illnesses. The family provides the necessary personal care under the coordinated supervision of a hospital-based interdisciplinary treatment team. The team prescribes the needed medical, nursing, social, rehabilitation and dietetic regimens, and provides the training of family members and the patient in supportive care.

Seventy-seven VA medical centers are providing hospital-based home care (HBHC) services. In fiscal year 1994, home visits were made by health professionals to an average daily census of 5,069 patients.

ADULT DAY HEALTH CARE

Adult Day Health Care (ADHC) is a therapeutically-oriented ambulatory program that provides health maintenance and rehabilitation services to veterans in a congregate setting during the daytime hours. ADHC in VA is a medical model of services, which in some circumstances may be a substitute for nursing home care. VA operated 15 ADHC centers in FY 1994, with an average attendance of 420 patients. VA also continued a program of contracting for ADHC services at 83 medical centers. The average daily attendance in contract programs was 737, and 2,508 patients were treated in FY 1994.

COMMUNITY RESIDENTIAL CARE

The Community Residential Care home program provides residential care, including room, board, personal care, and general health care supervision to veterans who do not require hospital or nursing home care but who, because of health conditions, are not able to resume independent living and have no suitable support system (e.g., family, friends) to provide the needed care. All homes are inspected by a multidisciplinary team prior to incorporation of the home into the VA program and annually thereafter. Care is provided in private homes that have been selected by VA, at the veteran's own expense. Veterans receive monthly follow-up visits from VA health care professionals. In FY 1994, an average daily census of 10,388 veterans was maintained in this program, utilizing approximately 2,800 homes.

HOMEMAKER/HOME HEALTH AIDE SERVICES (H/HHA)

In FY 1994, VA initiated a pilot program of health-related services for veterans needing nursing home care, implementing provisions of Public Law 101–336. These services are provided in the community by public and private agencies under a system of case management provided directly by VA staff. For the purpose of the initiative, health-related services are defined as homemaker/home health aide services only. Eligibility for H/HHA is limited to those in need of nursing home care who have a service-connected disability rated 50 percent or more, or those in need of nursing home care primarily for treatment of a service-connected disability. 108 VAMCs were purchasing H/HHA services by FY 1994. The average ADC for each contracted H/HHA service was 228 veterans.

GERIATRIC EVALUATION AND MANAGEMENT PROGRAM (GEM)

The Geriatric Evaluation and Management Program includes inpatient units, outpatient clinics, and consultation services. A GEM Unit is usually a functionally different group of beds (ranging typically in number from 10 to 25 beds) on a medical service or an intermediate care ward of the hospital where an interdisciplinary health care team performs comprehensive geriatric assessments. The GEM unit serves to improve the diagnosis, treatment, rehabilitation, and discharge planning of older patients who have functional impairments, multiple acute and chronic diseases, and/or psychosocial problems. GEM clinics provide similar comprehensive

care for geriatric patients not in need of hospitalization, as well as provide follow-up care for older patients to prevent their unnecessary institutionalization. A GEM unit also provides geriatric training and research opportunities for physicians and other health care professionals in VA medical centers.

Results from a controlled, randomized study of GEM efficacy that was conducted at the VA Medical Center Sepulveda, CA, and published in the New England Journal of Medicine in 1984, showed significant benefits such as improved survival, decreased rehospitalization rates, improved functional status, and decreased nursing home placement following admission to GEM units.

Currently, there are 133 VA medical centers with established Geriatric Evaluation and Management Programs.

CARE OF THE ACUTE AND CRITICALLY ILL ELDERLY

In 1994, VA Central Office had its third printing of a supplemental guide for medical center staff who care for the acutely-ill veteran (*Geriatric Pocket Pal*). This guide is used by residents, nurses, and allied health personnel in all VA medical centers. Many requests have been received from non-VA clinical staff for this popular VHA publication, developed by VA Central Office and field staff, and is now being revised to update reference materials and incorporate additional information.

RESPITE CARE

Respite Care provides planned, periodic, short-term care for a disabled person in order to temporarily relieve the caregiver from the physician and emotional burden of providing the needed care and supervision. VA provides respite care by admitting a veteran to a hospital or nursing home bed for up to 30 days a year. This institutionally based program not only supports the caregiver's role in caring for the veteran at home, but also provides an opportunity for VA staff to evaluate and treat the veteran's health care needs and offer guidance to the caregiver in the home treatment plan. In FY 1994, 132 VA medical centers provided this care to veterans and their families.

ALZHEIMER'S DISEASE AND OTHER DEMENTIAS

VA's program for veterans with Alzheimer's disease and other dementias is decentralized throughout the medical care system, with coordination and direction provided by the Office of Geriatrics and Extended Care. Veterans with these diagnoses participate in all aspects of the health care system including outpatient programs, acute care programs, and extended care programs. Approximately 56 medical centers have established specialized programs for the treatment of veterans with dementing illnesses.

In order to advance knowledge about the care for veterans with dementia, VA investigators conduct basic biomedical, applied clinical and health services research, much of which occurs at Geriatric Research, Education, and Clinical Centers (GRECCs), and which is supported through the Office of Research and Development. Rehabilitation Research and Development Service develops and evaluates new technologies and techniques designed to minimize disability associated with dementia. Continuing education for staff is provided through training classes sponsored by Regional Medical Education Centers, GRECCs, and Cooperative Health Manpower Education Programs.

VA Central Office has disseminated a variety of dementia patient care educational materials in the form of publications and videos to all VA medical centers. In FY 1990, all VA libraries received a revised edition of guidelines for diagnosis and treatment of dementia, a series of 21 dementia caregiver education pamphlets developed by the Minneapolis GRECC, and 3 videotapes on Alzheimer's disease developed by the Bedford Division of the Boston GRECC. In FY 1993, VA libraries received a series of 3 geriatric health care videotapes that are relevant to dementia patient care. A comprehensive instructional program, "Keys to Better Care," was made available to all VA medical centers through regional audiovisual delivery sites. This 14-part training package for health care providers caring for patients with Alzheimer's disease and other dementias addresses a wide range of issues related to quality care. Also, an audiovisual videotape on rehabilitation of the cognitively-impaired patient, produced by the Northeast VA Learning Resources Service, was made available at all VA libraries.

During 1990 and 1991, VA Central Office surveyed a sample of VA medical centers with established inpatient units for patients with dementia. A summary report of these dementia unit site visits was published by VA in September 1993, and has been disseminated widely throughout the VA system and to the non-VA community. The report details the organization and delivery of inpatient services to dementia

patients from admission to discharge. Results of these site visits will aid in planning future dementia programs and services, with information addressing such issues as dementia unit staffing patterns, programming, and overall organization. Criteria and standards for VA dementia units are currently under development and are now in draft form.

In FY 1994, VA conducted a teleconference that featured national experts on Alzheimer's disease. Presented were state-of-the art strategies or diagnosis and treatment of this devastating disease from a primary care perspective. Staff at both VA and non-VA sites, including State Veterans Homes, participated in this educational teleconference. In FY 1994, Va conducted a nationwide satellite teleconference on "Diagnosis and Treatment of Alzheimer's Disease."

GERIATRIC RESEARCH, EDUCATION, AND CLINICAL CENTERS (GRECCS)

The Geriatric Research, Education, and Clinical Centers assume an important role in further developing the capability of the VA health care system to provide cost-effective and appropriate care to older veterans. First implemented in 1975, GRECCs are designed to enhance the system's capability to develop state-of-the-art care in geriatrics through research, education, and clinical care. The goals of the GRECCs are to develop new knowledge regarding aging and geriatrics, to disseminate that knowledge through education and training to health care professionals and students, and to develop and evaluate alternative models of geriatric care.

GRECCs have developed many innovative approaches to educate and train VA clinical staff who care for elderly veterans. In 1994, GRECC staff expanded their outreach education and training to provide expertise to VA staff, particularly in the area of geriatric evaluation and management. Also, GRECCs have developed individual topic-specific education programs for the region they serve and have collaborated with other GRECCs to present this information to clinical staff in other regions of the country. This provides a significant number of clinical staff with state-of-the-art information on specific issues concerning care of the elderly.

Each GRECC has developed an integrated program of basic and applied research, education, training, and clinical care in select areas of geriatrics. Current focal areas include cardiology and prevention of cardiovascular disease; cognitive and motor dysfunction and neurobiology; endocrinology, swallowing disorders, metabolism and nutrition; geropharmacology; immunology, cancer and infectious diseases; osteoporosis and arthritis; falls; exercise physiology; geriatric rehabilitation; sensory impairment; depression; bio-ethical aspects of medical discisionmaking in the elderly; and cost-effectiveness and quality of geriatric care. Using an integrated approach, the GRECCs are developing practitioners, educators, and researchers to help meet the need for training health care professionals in the field of geriatrics; providing information for, as well as establishing models on, cost-effective approaches to care of the elderly; and researching better methods to diagnose and treat health care problems of the older person, as well as finding answers to fundamental questions on the processes and consequences of aging.

At present there are 16 GRECCs. Fifteen are fully operational and are located in VA medical centers at Ann Arbor, MI; Bedford and Brockton/West Roxbury, MA (2 divisions); Durham, NC; Gainesville, FL; Little Rock, AR; Madison, WI; Miami, FL; Minneapolis, MN; Palo Alto, CA; San Antonio, TX; St. Louis, MO; Salt Lake City, UT; Seattle/American Lake, WA (2 divisions); Sepulveda, CA; and West Los Angeles, CA. One new GRECC was designated in FY 1992 at the Baltimore, Maryland, VA Medical Center and is almost fully operational. Public Law 99–166, "Veterans Administration Health Care Amendments of 1985," increased from 15 to 25 the maximum number of facilities that the VA Secretary may designate for GRECCs.

III. Office of Clinical Programs

MEDICAL SERVICE

Medical Service in VAMCs serves as the primary source of physicians for the care of elderly patients. Due to the aging of the population, Medical Service is increasingly involved in all aspects of the delivery of health care to the aged. Acute and intermediate medical wards, coronary and intensive care units, nursing homes and outpatient clinics are all seeing an increased proportion of elderly patients with acute and chronic illnesses.

Some subspecialty areas are particularly impacted, such as cardiology, endocrinology (diabetes), rheumatology and oncology. Medical Service provides necessary subspecialty care in inpatient and outpatient settings in addition to participating in Geriatric Fellowship Training, GRECCs, Geriatric Evaluation and Management (GEM) Programs, Hospice, Respite, Nursing Home, and Hospital-Based Home Care.

The specialized care that is required by the elderly has been recognized by Medical Service at a number of medical centers, by their establishment of a Geriatric Medicine Section, which emphasizes clinical care, as well as coordinating research and education efforts related to geriatrics.

Age alone is less frequently used as a determinant of an individual patient's care. Geriatric patients undergo invasive diagnostic procedures as well. For example, the Sunbelt is experiencing an increasingly heavy cardiac catheterization workload. The average age of patients treated in coronary and intensive care units is increasing, producing a concomitant demand for cardiac rehabilitation and physical fitness programs that are targeted to the frail elderly and the physically handicapped of all ages. The special interest and involvement of Medical Service in geriatrics has also resulted in participation by internists in such programs as Adult Day Health Care, as well as in research problems in nutrition and treatment of hypertension.

Smoking cessation has been shown to benefit even elderly patients. Thus, the role of Preventive Medicine for this patient population has expanded. The Medical Service has been active in implementing preventive strategies in smoking cessation, immunization (influenza and pneumococcal vaccines), and colorectal screening (for cancer).

Evaluation and treatment of elderly patients by interdisciplinary teams during intermediate-length hospital stays will be an increasingly important role for the physicians of the Medical Service.

SOCIAL WORK SERVICE

Meeting the biopsychosocial health care need of an aging population of veterans and caregivers continues to be a major priority of Social Work Service and the Veterans Health Administration. The need to be competitive in a challenging and changing health care environment, as well as cost-effective and efficient in addressing the social components of health care, has led to a re-examination of social work priorities and their relevance to the VA health care mission, with special reference to the needs of chronically ill, older veterans. Without a support network of family, friends, and community health and social services, and with providers and agencies focused on integrating and coordinating care and providing access to the broad network of community services and resources, health care gains would be lost and VHA acute care resources would be over-utilized and in some cases overwhelmed. It is frequently not the degree of illness that determines the need for hospital care, but rather the presence or absence of family and community resources.

The expansion of homemaker/home health aide services, coordinated by VA in collaboration with the community health and social services network, is evidence of the importance of noninstitutionalized support networks in maintaining the veteran in the community. Social workers, as members of the veterans' health care team, continue to coordinate discharge planning and to serve as the focal point of contact between the VA medical center, the veteran patient, his family and the larger community health and social services network. The veteran and his family have, in many respects, become the "unit of care" for social work intervention. It is this "customer" focus which will undergird social work programming for vulnerable populations, including older veterans who are demanding that VHA be more responsive and sensitive to their psychosocial needs and those of their caregivers.

The role of the caregiver as a member of the VA health care team and as a key player in the provision of health care services continues to be a major area of social work practice and, will continue to be in the immediate future. This is consistent with the recognition that 80 percent of nursing care is provided in the home by family, neighbors, etc., and that the family, ordinarily the veteran's wife, is the key decisionmaker concerning health insurance issues and, most probably, access to health and community support services.

As VHA transitions from an acute care to a primary care/community interactive health care delivery system, Social Work Service has placed increased emphasis on its pivotal role in community services coordination, development, and integration. The development of a "seamless garment of care," with case management services as its centerpiece, is being given increased emphasis by Social Work Service and its National Committee. The National Committee functions in an advisory capacity concerning social work and systems issues, priorities, and practice concerns. While case management services have been a central component of social work practice in VHA, this service modality is being "re-discovered" by the VA health care system as an essential component of services provided to "at-risk" veterans and their caregivers. Case management, also known as "care coordination," was identified in veterans' discussion groups as a very important ingredient in meeting the veterans' health care needs and those of their caregivers. During 1994 and beyond, VHA, and par-

ticularly Social Work Service, will be challenged to expand case management services in concert with other community providers and to provide a perspective that addresses this critical ingredient of care in terms of its absolute relevance to successful health care outcomes. In a revitalized and reconfigured VA health care system, issues of coordination, access, cost, and appropriateness of VA and community services will be determined not only by the needs of the customers, but also by the experience and expertise of the providers.

Older Indians, including veterans, are at significant risk for the development of health care problems related to geographic isolation, economic deprivation, and cultural barriers. *The Interagency Task Force on Older Indians* continues to address issues of concern related to the provision of services to a population that has been underserved by the Federal sector. The Department of Veterans Affairs, represented by Social Work Service, has been an active member of this consortium. In March 1994, the interagency task force subcommittee on health met at VA Central Office for an orientation to the Department. The Executive Director of the Chief Minority Affairs Office and other key VA staff provided an orientation to programs and priorities of special interest to Native Americans. Social Work Service also served as resource staff and faculty in planning an interagency seminar held in November 1994 in Minneapolis, MN on "Meeting the Health Care Needs of Older Indians." This seminar, which included representatives from VA, Indian Health Service, State Veterans Affairs offices and consumers, focused on developing realistic action plans to address health care priorities in Minnesota and adjacent States.

REHABILITATION RESEARCH AND DEVELOPMENT

The mission of the Rehabilitation Research and Development (Rehab R&D) Service is to investigate and develop concepts, products, and processes that promote greater functional independence and improve the quality of life for impaired and disabled veterans. Aging, particularly the aging of persons with disabilities, is a high priority of the service. Efforts in this area include:

A national VA program of merit-reviewed, investigator-initiated research, development and evaluation projects targeted to meet the needs of aging veterans with disabilities.

Support of a Rehabilitation Research and Development Center on Aging at Decatur (Georgia) VA Medical Center.

Transfer into the VA health care delivery system of developed rehabilitation technology and dissemination of information to assist the population of aging veterans and those who care for them.

In addition to specific projects on aging, many of the investigations supported through the Service's nationwide network of research of VAMCs and at four Rehabilitation Research and Development Centers have relevance for impairments commonly associated with aging.

Some examples of investigator-initiated studies currently being carried out are:

A Low-Vision Enhancement System (LVES)
Liquid Crystal Dark-Adapting Eyeglasses
Electronic Travel Aid for the Blind
Non-Auditory Factors Affecting Hearing Aid Use in Elderly Veterans
The Influence of Strength Training on Balance and Function in the Aged
Epidemiologic Study of Aging in Spinal Cord Injured Veterans

The Rehab R&D Center on Aging is structured around five interdisciplinary research sections to address the multidimensional nature inherent to problems of aging and disability: Environmental Research; Vision Rehabilitation; Neuro-Physiology; Engineering and Computer Science; and Social, Behavioral, and Health Research. Areas of study include:

Design-related problems that affect the quality of life of older people, including least restrictive environments, falls, independence and safety.

Orientation and mobility for the blind, low vision, and rehabilitation outcomes measurement for older persons with visual impairment.

The neurologic and physiologic changes that accompany aging and behavioral coping problems.

Development and application of new technologies to a variety of prototypes for the design of assistive devices and assistive software.

Special programs in 1994 included the sponsorship of 13 research studies funded by the Rehabilitation Research and Development Service in conjunction with the 1994 National Veterans Golden Age Games at the Hines VAMC. The Associate Chief of Staff for Extended Care and Geriatrics at Hines initiated and steered this program to discover better methods of promoting rehabilitation and health for elderly veterans.

In April 1994, the Decatur R&D Center sponsored an International Conference on Aging and Vision Impairment in Atlanta. This conference drew over 300 participants, including presenters and attendees from seven countries. The meeting marked the first major conference on aging and vision impairment in over 10 years. A follow up research forum identified needs in aging and vision impairment.

PHYSICAL MEDICINE AND REHABILITATION SERVICE

Physical Medicine and Rehabilitation Service (PM&RS) strives to provide all referred older veterans with comprehensive assessment, treatment and follow-up care for psychosocial and/or physical disability affecting functional independence and quality of life. The older veteran's abilities in the areas of self-care, mobility, endurance, cognition and safety are evaluated. Professional therapists utilize physical agents, therapeutic modalities, exercise, and prescription of adaptive equipment, to facilitate the veteran's ability to remain in the most independent life setting.

The extent of rehabilitation services available at any VA medical center varies. Inpatient rehabilitation bed units, usually directed by a board-certified physiatrist, exist within approximately 75 medical centers. Current data indicates that the average age of veteran patients discharged from those rehabilitation bed units continues to increase (currently 69 years). Recognizing the special needs of the elderly patient, rehabilitation professionals routinely collect and analyze outcome date to assist in determining appropriate functional goals and lengths of stay for each admission. The patient is an integral member of the interdisciplinary treatment team that plans his/her care.

A uniform assessment tool, the Functional Independence Measure (FIM) has been implemented throughout the VA rehabilitation system. Patients are evaluated on 18 elements of function at the time of admission, regularly during treatment and at discharge. Application of FIM results to quality management activity will assist local and national rehabilitation clinicians and managers to maximize effective and efficient rehabilitation care delivery. An administrative database called the Uniform Data System of Medical Rehabilitation (UDS/mr) monitors outcomes of care and increases the accuracy of developing predictors and ideal methods of treatment for the older veteran with various diagnoses. A centralized, national contract with the UDS/mr service permits 75 facilities with PM&RS bed units to provide data and receive outcome reports as part of the national and international UDS/mr data bank.

Rehabilitation therapists are leading and participating in innovative treatment, clinical education, staff development and research. Rehabilitation professionals work with patients who are home-bound, work in independent living centers, Geriatric Evaluation and Management Units, Adult Day Health Care, Day Treatment Centers, domiciliaries, Interdisciplinary Team Training Programs, Geriatric Research, Education, and Clinical Centers, and also in hospice care programs.

Driver training centers are staffed at 40 VA medical centers to meet the needs of aging and disabled veterans. With the growing numbers of older drivers, the VA has put emphasis on the training of the mature driver. Classroom education and defensive driving techniques are supported with behind-the-wheel evaluation by driver specialists.

NURSING SERVICE

Care of the elderly veteran continues to be one of the highest priorities for Nursing Service. Nurses at every level of the organization are committed to providing leadership in the clinical, administrative, research, and educational components of gerontological nursing.

Professional nurses function as part of interdisciplinary teams to coordinate and provide care in settings beginning with GEMS and progressing along many care settings including ambulatory care, acute care, intermediate care, long-term care, and community agencies. Gerontological nurse practitioners and clinical nurse specialists provide primary care and continuity of care as clinical care managers and coordinators of care.

Preventive care and health promotion incentives continue to preserve independence, foster self-care, improve productivity, and enhance the quality of life by improving the health status of aging veterans. Proper screening, education, and referral of elderly veterans are vital to meeting their health care needs in the least restrictive environment. Nurses in wellness clinics and other ambulatory care settings provide supervision, screening, and health education programs to assist veterans in maintaining healthy life styles.

Nurses play a key role in restoring the functional abilities of aging veterans with chronic illness and disabilities. Programs for the physically disabled and cognitively impaired have been established and are administered by nurses and nurse practi-

tioners in home care, ambulatory care settings, and inpatient units. Treatment programs are goal-directed toward physical and psychosocial reconditioning or retraining of patients with biological and psychosocial disturbances. Patient and family teaching is a major part of each program. Family and significant others have a key role in providing support to aging veterans and are assisted in learning and in maintaining appropriate caregiver responsibilities. VA nurses contribute to planning and implementing health care services for the elderly in the community-at-large. They serve on task forces and participate in self-help and support groups related to specific diseases such as Alzheimer's. Nurses are also advisors to local health planning councils, and share VA educational activities and research seminars with other health care professionals.

Nursing leaders continue to collaborate with schools of nursing to offer positive learning experiences in both undergraduate and graduate nursing education. Nursing schools are encouraged to focus more attention on programs in geriatrics, rehabilitation, and chronic care. An affiliation agreement between three VAMCs (Fargo, ND; St. Cloud, MN; Minneapolis, MN) and the University of Minnesota School of Nursing is an example of the collaboration needed to address the critical shortage of nurses in geriatric care. Graduate nursing students receive clinical experiences in Geriatric Evaluation and Management Programs, Nursing Home Care Units, and Hospital Based Home Care programs. Nursing Service is committed to leadership that will ensure the patient care needs of aging veterans are addressed. The preceptorship training program for the position of Associate Chief or Supervisor Nursing Home Care Unit continues to receive priority. Other opportunities to enhance career development for leadership in long-term care include the following examples:

Nursing Service, in collaboration with the Office of Academic Affairs (OAA), presented a program entitled, "Charting a Vision for Nursing Leadership," for 150 nurse leaders of VA nursing home care units. Follow-up to the program includes action plans with strategies for implementation by cluster groups within VHA regions.

Recommendations from the task force to enhance recruitment, retention and leadership/executive development are being implemented at the Central Office, regional, and local levels.

Continuing education is essential to ensure that all levels of staff have knowledge and skills to meet the needs of this rapidly-growing age group. The sixth national training program, "Long Term Care of the Mentally Ill," was presented for interdisciplinary teams from 15 Nursing Home Care Units in April 1994. Outcomes of this program have improved the quality of care and quality of life of aging patients and include the following:

Enhancement of the interdisciplinary teams;

Formation of consultation teams to assess and assist in providing improved therapeutic care to aging patients in other areas of the medical center;

Reduction of physical and chemical restraints; and

Projects to establish more therapeutic environments.

The interdisciplinary program to improve the quality of life of aging patients in VA nursing home continues. Significant decreases in the number of medications prescribed for patients in VA nursing homes have been documented. The project will continue with the goal to reduce the number of prescribed medications to four or less.

A new program at the VA Medical Center, Washington, DC, NHCU illustrates an innovative approach to restorative care and improving the quality of life of patients. The NHCU received regional funding in 1992 to foster patient creative expression through the use of the multi-arts. Based on the success of the first year, the program was refunded in 1993 and a position was created through Nursing Service for a full-time Restorative Care/Creative Arts Therapist. The Creative Arts Therapist now coordinates the efforts of volunteers, NHCU nursing staff, and area artists and therapists in an expanded program to meet a broad range of patient rehabilitative, supportive, and comfort care needs. A variety of art inventions include:

Art Appreciation
Hands on Art
Creative Movement
Ballroom Dancing
Rhythm and Music
Sign Language
Creative Writing
Discussion of Great Ideas
Museum Trips
Patient Care Displays and Performance

In FY 1994, the program received funding to prepare a video to assist other long-term care practitioners to develop a therapeutic creative art program. Information on this program was also shared at a nursing leadership conference, and at three other professional conferences.

Nursing Service has established the goal to create restraint-free environments throughout the VA health care system. This initiative will begin with multi-site proposals for nursing home care units leadership conference. One nursing home care unit opened restraint-free in 1992. It remains restraint-free and serves as a model for others.

Several NHCUs responded to a request from the Office of Quality Management (OQM) to submit interventions that had improved the quality of care. Interventions submitted will be published and shared throughout the system by OQM. Many of the interventions submitted improved the quality of life of patients as well as the quality of care. These include the following:

Interdisciplinary walking rounds resulting in more active involvement of patients in their care and enhanced patient and staff interactions.

Grouping patients on the unit by their activities of daily living (ADL) potential, resulting in therapeutic groups to address specific patient populations and more effective patient and family education.

Implementing an outdoors program for physically and cognitively challenged residents has resulted in their increased social interaction, and improvement in their appetite, and sleep habits.

Consultations by psychiatrists with professional nurses and nursing assistants on the care of patients with behavior problems, resulting in a reduction in the frequency and intensity of disruptive behaviors and increased empathy and tolerance of the staff caring for these patients.

Implementation of protocols to reduce the use of physical and chemical restraints resulting in a reduced number of falls, reduction in restraints and more appropriate use of psychotropic drugs.

Evaluation of high risk patients by an interdisciplinary dysphagia team, with a reduction in choking episodes at meal times and the resultant aspiration pneumonia.

Professional nurses are encouraged and supported in their efforts to conduct research, especially in clinical settings. Nine VA Nursing Home Care Units are participating in the Minimum Data Set (MDS) Demonstration Project. This project provides the opportunity for the VA NHCUs to collect and compare data with community nursing homes nationwide.

Research is needed to advance health care for older persons and to improve gerontological nursing practice. Areas in which nursing research is urgently needed to improve the quality of care include:

Urinary incontinence;
Common eating patterns programs and nutrition;
Falls;
Enhancing socialization skills;
Care of Alzheimer's patients;
Wandering behavior;
Dementia;
Exercise and mobility;
Medications, including effectiveness of psychotropic medications, types and incidence of medication abuse among the elderly;
Health promotion;
Frail elderly in the home setting;
Alternatives to institutional care; and
Coping mechanisms of patients, families, and caregivers.

Studies are needed to enhance the quality of life for aging female veterans in a health care system largely focused on a male model of care. Osteoporosis is a serious metabolic bone disease which affects postmenopausal women to a greater degree than men. Women veterans who served during and prior to the Korean War are a prime risk group for this disease. Timely application of research findings to clinical care in all practice settings will improve the quality of care and quality of life to aging veterans.

DIETETIC SERVICE

Medical nutrition care saves money, improves patient outcomes and enhances the quality of life for our older veterans. To better serve the veteran and identify his/her nutritional needs, many VA health care professionals are now using *Determine Your Nutritional Health Checklist* and *Level I and II Nutrition Screen* developed by

the American Dietetic Association's American Academy of Family Physician's and National Council on Aging's National Screening Initiative. The *Checklist* or *Level I Screen* identifies those at high risk for poor nutritional status, while *Level II Screen* provides provides specific diagnostic nutritional information. In FY 1994 the National Screening Initiative emphasized educating the physician in nutritional care. The booklet, *Incorporating Nutrition Screening and Interventions into Medical Practice,* has been nationally disseminated to doctors. This information complements the handbook, *Geriatric Pocket Pal,* our service developed with the Office of Geriatrics and Extended Care.

Many medical centers have Geriatric Nutrition Specialist positions. Dietitians in these positions have developed easy-to-read educational materials for their audience and shared this information with other medical centers. Several medical centers are providing outreach services for the elderly in their community. For example, the Bronx VAMC provides outreach to local senior centers and the Dallas VAMC has bimonthly visits by their health screening team to facilities in their area. A variety of nutrition education programs have been offered for health care providers and patients. Salisbury VAMC offered a workshop on "Dining Skills: Practical Interventions for the Caregivers of the Eating-Disabled Older Adult." Chillicothe VAMC just completed its 14th annual multidisciplinary Gerontological Seminar.

Dietetic Service continues to provide guidance on quality care. In response to an Office of the Inspector General's audit of VHA activities for assuring quality care for veterans in community nursing homes, Dietetic Service proposed revisions to M–5, Part II, Chapter 3, Community Nursing Homes to strengthen the frequency of dietitian follow-up visits to assess nutrition. Several practice guidelines have been distributed to all the medical centers to ensure quality care for our elderly. In addition, Tomah VAMC has developed interdisciplinary guidelines for the care of dysphagia. The clinical indicator to ensure that the patient not only receives his food, but is fed, will be released soon. Northampton VAMC developed an indicator for high-risk geriatric patients who are underweight. VAMC Alexandria's geriatric dietitian completed her research on the acceptability of pureed foods thickened with selected products. Another geriatric dietitian at Little Rock VAMC recently presented her research to the American Dietetic Association on the nutritional status of people seen at their outpatient geriatric evaluation clinic.

IV. Office of Dentistry

Dental care for the geriatric patient involves restoration of function through rehabilitation of the dentition, and elimination of pain and suffering attributable to oral disease. It is important that older adults are able to effectively masticate a variety of foods so that convalescence after surgery, chemotherapy, or other significant medical interventions is expedited.

Interpersonal skills, which are highly dependent upon physical appearance and effective communication, can be enhanced by improving the teeth's appearance and by properly aligning and restoring the anterior teeth to maintain clarity of speech. The goals of dental care are consistent with those of all disciplines involved in geriatrics—to maximize function and foster independence in living. Dentistry should be an integral part of any comprehensive health care program for the elderly.

The nature of dental disease in late life—chronic, asymptomatic (even in advanced stages), aggravated by coexistent medical problems, and perceived as a low priority by health funding agencies—requires an increased emphasis on preventive services. Innovative, individualized, preventional dental programs are often necessary for each patient. Preventive modalities include the use of home-applied fluoride solutions, anti-microbial mouth rinses, specially fabricated toothbrushes, instruction to family or caregivers on oral hygiene techniques, and more frequent dental examinations. These are low-cost yet effective measures that can obviate the need for future expensive or invasive dental care. VA has been a world leader in developing preventive dental therapies and field testing them for clinical efficacy.

Oral cancer is a disabling and disfiguring disease that primarily affects middle-aged and older adults. Ninety-five percent of all cases occur in those over 40. Alcohol, tobacco, and advanced age are important risk factors in the development of this disease. Early detection of frequently asymptomatic lesions can significantly reduce the disease's morbidity. Through a long-standing program of oral screening examinations, VA dentists have been able to expeditiously detect incipient oral cancers. Such interventions minimize the need for ablative surgery, which may precipitant swallowing and eating difficulties, and can also significantly reduce mortality rates.

Most VA medical centers have established Geriatric Evaluation and Management Programs. Dental Services contribute to the GEM's interdisciplinary team effort, conducting admission oral assessments, collaborating on treatment planning, provid-

ing specialty consultations and needed care, and preparing summaries of oral care protocols to be maintained after discharge. Oral examinations conducted during GEM admissions commonly identify problems previously undetected that can impede chewing efficiency, safe swallowing, and clearly articulated speech. Interdisciplinary treatment planning takes advantage of the synergy associated with group efforts. Patients are rehabilitated more rapidly with properly staged and coordinated care. Unexpected outcomes of a specific discipline's therapies or newly exposed problems often warrant expedited specialty consultation. For matters involving the oral-dental complex, dentistry has responded with timely assessments, definitive diagnosis, and recommended treatment. At discharge, a review of the patient's response to treatment, plan for maintenance, and guidance for future care are prepared. The GEM Program has been an ideal environment for dentistry to demonstrate its relative merit and range of contributions to the interdisciplinary team.

The VA Program Guide, *Oral Health Guidelines for Long Term Care Patients,* developed by the Offices of Dentistry, Clinical Programs, and Geriatrics and Extended Care, continues to serve as the primary handbook for management of the multidisciplinary oral health efforts. It describes the goals, implementation, and monitoring of oral care provision for patients in VA long-term care programs.

The VA Dentist Geriatric Fellowship Program has proven to be an excellent recruitment source for dentists who have been uniquely trained in the care of the elderly. Approximately 30 graduated fellows currently serve as staff dentists throughout the VA system. Others have assumed leadership positions in geriatric dentistry at academic institutions. They have enhanced patient care and other geriatric initiatives at their own, as well as regional, medical centers, and have also contributed to the geriatric efforts at affiliated health centers and in the community. Nationally, former fellows have made significant contributions to the professional literature and are actively involved in geriatric dental research.

The impact of VA programs in geriatric dentistry is not limited to its own health care system, but extends to a broader level. VA dentistry is represented on both National Institute of Dental Research (NIDR) reviews and the U.S. Surgeon General's workshop on oral health promotion and disease prevention. The American Association of Dental Schools (AADS) has an ongoing Geriatric Education Project that has developed curricular guidelines for teaching concepts in gerontology and geriatrics to dental and dental hygiene students. VA dentists have been noteworthy contributors to these efforts to define geriatric educational objectives and identify resource materials for dental faculty members.

In December 1994, the VA Office of Research and Development's Health Services Research and Development Service sponsored the national conference, "Oral Health for Aging Veterans—Making a Difference: Priorities for Quality Care." The conference convened in Washington, DC, with 110 VA and non-VA clinicians, managers, policymakers, and researchers represented. An important outcome of the program was publication of an "Oral Health for Aging Veterans" research agenda. This document identifies areas of oral health services research that are critical to improving the delivery of oral health care to veterans.

In summary, the Office of Dentistry continues to support efforts that will benefit older veterans in three general areas. First, optimizing the quality of care received by elderly patients at VA facilities is a priority. Second, education in geriatric oral health will continue to be made available to patients, dental staff, and nondental care providers such as nurses, physicians, and family members. Third, research to broaden our understanding of oral disease and its treatment in older adults will be encouraged.

V. Office of Research and Development

VA MEDICAL RESEARCH SERVICE (VAMRS)

Research on Aging

VA Medical Research Service (VAMRS) strives to meet the health care needs of the veteran population. As the needs of the veteran population change, so must the areas of research and development funded by VAMRS. Aging is fast becoming a vital area of research in the VA system. Currently, 50 percent of the veteran population (about 13.2 million) are over age 56. It is estimated that 37 percent of the veteran population will be 65 or older by the year 2000. Medical problems specific to this population, such as dementia, prostate cancer, lung cancer, and heart disease are crucial areas of study.

VAMRS has met these rising needs with successful biomedical research on the neurobiology of Alzheimer's disease (AD), hormone regulation in prostate cancer,

larynx preservation in advanced laryngeal cancer, and drug therapy and/or vitamin supplementation for prevention of heart disease and stroke.

In 1994, over 35,000 veterans age 65 or older were hospitalized with primary diagnoses of congestive heart failure, prostate cancer, pneumonia, and lung cancer. In the same year, VAMRS spent over $37 million on research focusing on heart disease, pulmonary disease, and cancer. Additionally, investigators on 169 VA research projects specifically designated their work as crucial to health concerns of the aging. Their research expenditures totaled $14.7 million (some of which is included in the aforementioned $37 million).

Age-related dementia, which affects 10 percent of people over age 65, is a major health concern of the elderly. VHA predicts that 600,000 veterans will suffer from dementia by the year 2000. Currently, VA investigators are stepping up efforts to understand and treat this devastating disorder. The following are three examples of investigator-initiated, merit-reviewed VA research projects on Alzheimer's disease (AD)-related dementia:

Proper diagnosis is a frequent problem in treating Alzheimer's disease. Dr. Richard Mohs, of the Bronx VAMC, is researching the cognitive changes associated with Alzheimer's disease and has developed the Alzheimer's Disease Assessment Scale. This diagnostic tool aids early diagnosis and identifies risk factors associated with AD.

Dr. Patricia Prinz, of the American Lake/Tacoma VAMC, is working on early diagnosis of AD by examining sleep electroencephalogram patterns. This protocol can predict dementia outcomes over a 6–8 year period with an accuracy rate of 80–90 percent.

Research into the cause of AD has led Dr. Lissy Jarvik, a researcher at the West Los Angeles VAMC, to postulate that a microtubule system impairment may cause deficient cellular functioning. Continued examination of this system may lead to insights into the cause of AD, as well as lead to improved diagnostic abilities.

Osteoporosis is a crippling disease that affects millions of post-menopausal women. VA studies concentrate on various aspects of this disease, from early detection methods to prevention and treatment procedures. Working out of the Indianapolis VAMC, Dr. Stavros Manolagas and Dr. Robert Jilka have discovered that the lack of the female hormone estrogen, a consequence of women completing menopause, causes an overproduction of bone scavenger cells. These cells, called osteoclasts, produce pits and craters in bones, weakening their basic structure. The knowledge gained by this work will open the door to improved therapies for female veterans. Other researchers from the Indianapolis VAMC are also making progress in the treatment of osteoporosis. They have found that when female hormones are depleted due to menopause, a substance called interleukin-6 is overproduced and leads to the breakdown of bones. Control of this substance may someday lead to treatment for this disabling disorder.

VAMRS achievements in aging research take the form of new medical inventions, improved treatment therapies, and improved understanding:

Dr. Steven Linder, a pulmonary specialist at the Palo Alto, California VAMC, has invented a device to induce coughing, designed for those who may be unable to perform this ordinary and vital function, such as elderly persons, quadriplegic persons, and persons with spinal cord injuries. The device is a sort of abdominal corset which delivers a mild electrical stimulus to the wearer, provoking a cough reflex. The device greatly reduces the risk of retained secretions, pneumonia, and death due to impaired respiratory function.

Dr. Frederick L. Brancati, et al., of the Pittsburgh VAMC, have found that elderly patients with pneumonia are almost as likely to benefit from aggressive treatment as are their younger counterparts, and that age should not be the sole criterion for withholding aggressive treatment of pneumonia in older patients.

In her study of aging patients at the Tucson VAMC, Dr. Margaret Kay has discovered the chemical marker on red blood cells that single out the cells for destruction. This work has led to a better understanding of the natural aging process, and the effect of aging on cellular function.

Research is the backbone of health care, and researchers and clinicians agree that treatments and cures that exist for major diseases could not have been developed if not for medical research. VA physicians and clinician/nonclinician Ph.D. investigators comprise the VA medical research team conducting research at over 100 VA medical centers nationwide. Advances in VA research are applied to the veteran population throughout the 172 VA medical centers, as well as the entire U.S. population once results have been established and reported.

New breakthroughs in treatment occur continuously. In only the past few years, we have seen such VA research achievements as laser surgery for prostate cancer, improved treatment for patients with Post Traumatic Stress Disorder, and a new drug therapy for high blood pressure. Research not only leads to advances in patient care, it also saves money in long-term health care costs. The National Institutes of Health predicts that for every dollar spent on medical research, $8 are saved in medical care costs. Progress in health care begins with medical research. It is vital that the importance of medical research is kept in mind and also its impact on health care for the aging veteran.

HEALTH SERVICES RESEARCH AND DEVELOPMENT

Health Services Research and Development (HSR&D) is an area of research designed to enhance veterans' health by improving the quality and cost effectiveness of the care provided by the Department of Veterans Affairs. The focus of VA HSR&D is on (1) advancing the state of knowledge about health services in VA and the Nation and (2) disseminating that knowledge for practical use. The large number of aging veterans and their increasing health care needs make this population particularly important for HSR&D to study. The Service's four major program areas emphasized aging during FY 1994.

(1) The *Investigator Initiated Research (IIR)* Program encourages and supports projects proposed and conducted by VA researchers, clinicians, and administrators from throughout the Nation. In this intramural program of HSR&D, VA staff conduct merit-reviewed and approved projects in VA medical centers with oversight and advice from Central Office. The IIR Program also includes career development, which encourages interested clinicians and researchers to pursue careers in VA by guaranteeing salary support.

Forty-nine percent of the 57 HSR&D investigator-initiated projects addressed questions important to aging veterans. New projects initiated in FY 1994 included studies of the home measurement of peak expiratory flow rate in Chronic Obstructive Pulmonary Disease; social factors in the occurrence of cardiac events; the effects of exercise training in the frail group of elderly veterans; rehospitalization following surgery; the magnitude, costs, and prevention strategies of diabetic foot problems; and Simulated Presence Therapy (SPT), a new nonpharmacologic technique, to reduce problem behaviors in Alzheimer's disease patients.

Ongoing geriatric-related investigations included studies of the benefits of arthritic knee-joint rehabilitation; risk assessment for cardiac complication after noncardiac surgery; follow-up strategies for home oxygen programs; the potential demand for bone marrow transplantation, resource use, and effectiveness; institutional long-term care and hospital utilization; and factors that influence mortality and inpatient health care utilization 1 year following admission to a medical intensive care unit (ICU).

Eleven IIR projects related to aging were completed in FY 1994. These projects included studies of coronary artery disease because of elevated serum cholesterol levels; the effect of physical therapy on nursing home patients; methods to improve glycemic control; low-vision rehabilitation programs; nonpharmacological means of lowering cholesterol; disruptive behavior of the cognitively-impaired elderly; behaviors and characteristics of Alzheimer's disease patients and the effects on caregivers; post-treatment management for lung cancer; abdominal aortic aneurysm surgery outcome; an identification screening method for patients who may experience complications during their hospital stay; and comparison of the cost structure of VA and non-VA hospitals.

(2) The HSR&D *Cooperative Studies in Health Services (CSHS)* projects are multisite health services research studies based on the model of VA's Cooperative Studies Program. Because of VA's health care system size, complexity, and data availability, it offers unique opportunities to conduct large-scale research projects, such as the CSHSs. These studies are expected to yield more definitive findings than may be available in other health care research environments. Three Centers for Cooperative Studies in Health Services (CCSHS) provide scientific, technical, and management support to the CSHS investigators. In addition to six ongoing CSHS projects relevant to the concerns of the aging population, preparations for two new CSHS Geriatric Evaluation and Management (GEM) trials began in February 1994.

(3) The HSR&D *Field Program* is a network of core VA staff assigned to selected medical centers. In FY 1994, the Service funded nine ongoing HSR&D Field Programs. Field Program staff conduct independent research projects and collaborate with community institutions in support of program objectives.

Field Programs serve as Centers of Excellence in selected subject matter areas. While all Field Programs have research interests in the health care issues affecting

aging veterans, four include aging as a primary research focus. The Northwest Center for Outcomes Research in Older Adults at the Seattle VAMC continues to provide leadership in geriatric care issues. The Midwest Center for Health Services and Policy and Research at the Hines VAMC in Illinois emphasizes gerontology and rehabilitation issues. The Field Program at the VAMC Bedford, Massachusetts, is a Center of Excellence for Health Maintenance for Aging Veterans, and it is examining such issues as nursing home care, quality life, and use of advance directives. The Great Lakes HSR&D Field Program at the Ann Arbor VAMC emphasizes service delivery and quality of care research with a special focus on the older veteran. A new HSR&D Field Program, the Center for the Study of Healthcare Provider Behavior, was founded in November 1993, at the Sepulveda VAMC. The Center is dedicated to the improvement of health care quality and outcomes in VA and non-VA health systems.

Field Program investigations during FY 1994 included the Normative Aging Study (NAS), a multidisciplinary and longitudinal investigation of human aging, and the Dental Longitudinal Study, a companion study addressing oral health and risk factors for oral disease in an aging population; the impact of polypharmacy on health-related quality of life; the effectiveness of managed care for improving the health status and quality of care of aging veterans; and the impact of rehabilitation services on inpatients newly diagnosed with a disabling disorder. Recently funded Field Program projects include studies of pressure ulcer development in long-term care, as well as malnutrition among elderly patients.

(4) The *Special Projects Program* encompasses the HSR&D Service Directed Research (SDR) Program, the Management Decision Research Center (MDRC), and special activities such as conferences and seminars. Special projects may include evaluation research, information syntheses, feasibility studies and other research projects responsive to specific needs identified by Congress, other Federal agencies, or Department of Veterans Affairs executive and management staff. This is a centrally directed program of health services research conducted by VA field staff, VA Central Office staff, and/or contractors engaged to analyze specific problems.

Five ongoing HSR&D Service-Directed Research projects focus on issues relevant to the aging veterans population. These projects include an interactive videodisk project aimed at an educational intervention for primary care physicians working in the outpatient setting: an examination of the National Nursing Home Resident Assessment Instrument Minimum Data Set for potential use in VA extended care facilities; a study of health-related quality of life; and a study of the care of acute myocardial infarction (AMI) patients. Additionally, four SDR Program initiatives are currently focusing on prostate cancer. Two projects are emphasizing education—one is assessing the impact of an educational intervention on patent preferences for prostrate cancer treatment, and other project is examining the impact of education on prostate cancer screening decisions. Two other studies include an investigation of familial patterns in prostate cancer and patient preference in end-state prostate cancer.

A new HSR&D Service-Directed Research investigation initiated in FY 1994 relevant to geriatrics is evaluating the diagnosis, treatment, and outcomes of veterans hospitalized for acute ischemic stroke. One project, designed to teach patients about advance directives, was completed.

In addition to these special research initiatives, the HSR&D Service Management Decision and Research Center convened the first research agenda-setting conference, in December 1993, to improve the delivery of oral health care to veterans. As a result of the conference, an 11 page research agenda on oral health was distributed systemwide; an overview of dental health services research activities and resources available to investigators was published in the October 1994 Special supplement of FORUM, the HSR&D Service newsletter; and a follow-up supplement of the conference will be published in the Journal, *Medical Care* in the spring of 1995.

VI. Office of Academic Affairs

All short- and long-range plans for VHA that address health care needs of the Nation's growing population of elderly veterans include training activities supported by the Office of Academic Affairs (OAA). The training of health care professionals in the area of geriatrics/gerontology is an important component for a variety of programs conducted at VA medical centers in collaboration with affiliated academic institutions. Clinical experiences with geriatric patients is an integral part of health care education for the nearly 100,000 health trainees, including 35,000 resident physicians and 45,000 nursing and associated health students. These residents and students train in VA medical centers annually as part of affiliation agreements between VA and nearly 1,000 health professional schools, colleges, and university

health science centers. Recognizing the challenges presented by the ever-increasing size of the aging veteran population, the OAA has made great strides in promoting and coordinating interdisciplinary geriatric and gerontological programs in VA medical centers and in their affiliated academic institutions.

The Office of Academic Affairs, in VHA, supports geriatric education and training activities through the VA Fellowship Programs in Geriatrics for Physicians and Dentists.

Geriatric Medicine

The issue of whether or not geriatrics should be a separate medical specialty or a subspecialty was resolved in September 1987 when the Accreditation Council for Graduate Medical Education (ACGME) approved Geriatric Medicine as an area of special competence. Effective January 1988, the American Board of Internal Medicine and the American Board of Family Practice specified procedures for the certification of added qualifications in geriatric medicine. VA played a critical role in the development and recognition of geriatric medicine in the United States, and since 1989, any VA medical center may conduct fellowship training in geriatrics, providing an ACGME-accredited program is in place.

The demand for physicians with special training in geriatrics and gerontology continues unabated because of the rapidly advancing numbers of elderly veterans and aging Americans. The VA health care system offers clinical, rehabilitation, and follow-up patient care services, as well as education, research, and interdisciplinary programs that constitute the support elements that are required for the training of physicians in geriatrics. Since FY 1978–79 this special training has been accomplished through the VA Fellowship Program in Geriatrics conducted at VA medical centers affiliated with medical schools. The initial 12 training sites increased to 20 in FY 1986 and to 40 in FY 1993–94.

These fellowships are designed to develop a cadre of physicians who are committed to clinical excellence and to becoming leaders of local and national geriatric medical programs. Their dedication to innovative and thorough geriatric patient care is expected to produce role models for medical students and for residents. The 2-year fellowship curriculum incorporates clinical, pharmacological, psychosocial, education, and research components that are related to the full continuum of treatment and health care of the elderly.

During its 16-year history, the program has attracted physicians with high quality academic and professional backgrounds in internal medicine, psychiatry, neurology, and family practice. Their genuine interest in the well-being of elderly veterans is apparent from high VA retention rate after completing the fellowship training. Many of the fellows have published articles on geriatric topics in nationally recognized professional journals, and several fellows have authored or edited books on geriatric medicine and medical ethics. The number of recipients of important awards and research grants (AGS/Pfizer, AGS/Merck, Kaiser, National Institutes on Aging and VA) increases each year.

As of June 1994, 390 fellows had completed special training in geriatric medicine. About 40 percent remain in the VA system as full- or part-time employees. Close to 50 percent of all graduates hold academic appointments. The VA fellowship alumni/ae continue to represent the largest single agency contribution to the pool of trained geriatricians in the United States.

Geriatric Dentistry

In July 1982, a 2-year Dentist Geriatric Fellowship Program commenced at five medical centers that are affiliated with Schools of Dentistry. The goals of this program are similar to those described for the Physician Fellowship Program in Geriatrics. In FY 1988, the number of training sites increased to six for a final 3-year cycle. As of June 1992, 45 Dentist Fellows had completed their special training. About 75 percent of the program alumni have accepted offers of post-fellowship employment in the VA system.

The format of these fellowships, however, has changed from predesignated sites to individual awards. Candidates from any VA medical center with the appropriate resources may compete for postdoctoral fellowships for dental research. In FY 1994, seven fellows participated, four elected to do a third year of research, and five program alumni are pursuing academic careers.

Geriatric Psychiatry and Geriatric Neurology

In FY 1990–91, the Department of Veterans Affairs established a 2-year Fellowship Program in Geriatric Psychiatry to develop a cadre of physicians with expertise

in two areas: (1) Specialized knowledge in the diagnosis and treatment of elderly patients with dementia and other psychiatric problems; (2) innovative teaching and research skills for academic potential.

Two competitive review cycles (FY 1990 and FY 1991) selected nine VA medical centers that are affiliated with U.S. medical schools as training sites for these fellowships. The FY 1991 review also added four sites for geriatric neurology. As of June 1994, 34 psychiatrists and 3 neurologists have completed special training in geriatrics.

The American Board of Psychiatry developed criteria for ACGME-accredited training in geriatric psychiatry, and the approval of Geriatric Psychiatry became official on September 28, 1993. VA expects to continue funding for fellow-level training at the current fellowship sites during the transition to accredited program status. This is another example of VA's initiative in establishing programs in areas of need. Beginning in FY 1995–96, any accredited VA training site may request positions in Geriatric Psychiatry as part of the residency allocation.

NURSING AND ASSOCIATED HEALTH PROFESSIONS

Interdisciplinary Team Training Program

The Interdisciplinary Team Training Program (ITTP) is a nationwide systematic educational program that is designed to include didactic and clinical instruction for VA faculty practitioners and affiliated students from three or more health professions such as physicians, nurses, psychologists, social workers, pharmacists, and occupational and physical therapists. The ITTP provides a structured approach to the delivery of health services by emphasizing the knowledge and skills needed to work in an interactive group. In addition, the program promotes an understanding of the roles and functions of other members of the team and how their collaborative contributions influence both the delivery and outcome of patient care.

The ITTP has been activated at 12 VA medical centers. Two sites located at VA Medical Centers (VAMCs) Portland, Oregon, and Sepulveda, California, were designated in 1979. Three additional VA sites at Little Rock, Arkansas; Palo Alto, California; and Salt Lake City, Utah, were selected in 1980; and VAMCs Buffalo, New York; Madison, Wisconsin; Coatesville, Pennsylvania; and Birmingham, Alabama, were approved in 1982. In the spring of 1983, three sites were selected at VAMCs Tucson, Arizona; Memphis, Tennessee; and Tampa, Florida.

The purposes of the ITTP are to develop a cadre of health practitioners with the knowledge and competencies that are required to provide interdisciplinary team care to meet the wide spectrum of health care and service needs for veterans, to provide leadership in interdisciplinary team delivery and training to other VA medical centers, and to provide role models for affiliated students in medical and associated health disciplines. Training includes the teaching of staff and students in select VA priority areas of health care needs, e.g., geriatrics, ambulatory care, management, nutrition, etc.; instruction in team teaching and group process skills for clinical core staff; and clinical experiences in team care for affiliated education students with the core team serving as role models. During FY 1994, more than 168 students from a variety of health care disciplines were provided monetary support at the 12 model ITTP sites.

Advanced Practice Nursing

Advanced Practice Nursing, i.e., master's level clinical nurse specialist and nurse practitioner training, is another facet of VA education programming in geriatrics. The need for specially trained graduate nurses is evidenced by the sophisticated level of care needed by VA patient populations, specifically in the area of geriatrics. Advanced nurse training is a high priority within VA because of the shortage of such nursing specialists who are capable of assuming positions in specialized care and leadership.

The master's level Advanced Practice Nursing Program was established in 1981 to attract specialized graduate nursing students to VA and to help meet requirement needs in the VA priority areas of geriatrics, rehabilitation, psychiatric/mental health, adult health and critical care, all of which impact on the care of the elderly veteran. Direct funding support is provided to master's level nurse specialist students for their clinical practicum at the VA medical centers that are affiliated with the academic institutions in which they are enrolled. During FY 1994, 126 master's level advanced practice nursing student positions were supported at 48 VA medical centers: 35 in geriatrics, 1 in rehabilitation, 32 in psychiatric/mental/health, 25 in critical care, and 33 in adult health/med-surgery.

VA Gerontological Nurse Fellowship Program

Gerontological nursing has been a nursing specialty since the mid-1960's. As society changes, particularly in terms of the demographic trend in aging, more attention is being focused on both the area of gerontological nursing and the education of nurses in this specialty. Doctoral-level nurse gerontologists are prepared for advanced clinical practice, teaching, research, administration, and policy formulation in adult development and aging.

In FY 1985, a 2-year nurse fellowship program was initiated for registered nurses who are doctoral candidates, and whose dissertations have clinical research foci in geriatrics/gerontology. The first competitive review was conducted in 1986. One nurse fellow was selected for the FY 1986 funding cycle. Since that time, two nurse fellowship positions are available for selection at approved VA medical center sites each fiscal year.

Initial appointments for nurse fellows are for 1 year. Reappointments of 1 additional year are subject to satisfactory first year's performance evaluations. It is anticipated that at least half of the participants who complete this VA fellowship will be recruited into VA.

Expansion for Associated Health Training in Geriatrics

A special priority for geriatric education and training is recognized in the allocation of associated health training positions and funding support to VA medical centers hosting GRECCs, and to VA medical centers (non-ITTG/GRECC sites) that offer specific educational and clinical programs for the care of older veterans. In FY 1994, a total of 211 associated health students received funding support at 71 VA facilities in the following disciplines: Social Work, Psychology, Audiology/Speech Pathology, Clinical Pharmacy, Advanced Practice Nursing, Dietetics, and Occupational Therapy.

Employee Continuing Education

In support of the VA's mission to provide health care to the aging veteran population, education and training continues to be offered to enhance VA medical center staff skills in the area of geriatrics. These educational activities are designed to respond to the needs of VA health care personnel throughout the entire Veterans Health Administration. Annually, funding is provided for employee education and distributed to two levels of the organization for support of continuing education activities in priority areas.

First Level.—Funds are provided directly to each of the VA medical centers to meet the continuing education needs of its employees. VA Central Office also allocates funds for VAMC-initiated programs to allow health care facilities, with assistance from the Employee Education Network, to conduct education programs within the hospital to meet locally identified training needs. VAMC-initiated funds were used to support 23 separate activities specifically having geriatrics as the primary content.

Second Level.—The Office of Academic Affairs, through the Employee Education Network, meets education needs by conducting programs at the regional and local medical center level. Examples of recent programs are:

Dementia, Depression, and Addiction
JCAHO-Long Term Care Standards
Alzheimer's Dementia
Nursing Role in Caring for the Older Adult
Geriatric Treatment Update
Suicide and Depression in the Elderly
Identification and Treatment of Depression in the Elderly
Issues Facing Older Women
Elder Abuse
Myths of Aging
Geropharmacology
Geriatric Care—Unresolved Problems

Employee education programs are also conducted in cooperation with the GRECCs, which received $276,835 in training funds in fiscal year 1994 to support their identified needs. This collaborative effort ensures the efficient use of existing resources to meet the increasing demands for training in geriatrics/gerontology.

In response to systemwide training needs, National Training Programs were conducted during the year. Workshops were held for VA medical center health care staff on "Medication Management in the Elderly," "Long Term Care in Psychiatric Hospitals," and "Nursing Home Care of the Mentally Ill." A "Hospice Medicine"

medical videotape was produced and was released to all VA medical centers in December 1994.

In addition, funds are provided to support continuing education experiences for the Geriatric Fellows and the Interdisciplinary Team Training Program staff members.

The Office of Academic Affairs continues to work cooperatively with the Office of Geriatrics and Extended Care. A collaborative initiative was the printing and distribution of the updated "Geriatric Pocket Pal," a supplemental reference guide for clinicians.

Health Professional Scholarship Program

The Scholarship Program was established in 1980 and funded from 1982 through 1985 to assist in providing an adequate supply of nurses for the VA and the Nation. Beginning in 1988, the Scholarship Program was reactivated to provide scholarships to students in full-time nursing and physical therapy baccalaureate and master degree programs in certain specialties specified by VA.

By FY 1990, additional scholarships were available to students enrolled in baccalaureate and master's degree occupational therapy programs, and students enrolled in their final year of associate degree nursing programs. In FY 1992, scholarships were available for students enrolled in master's degree nurse anesthetist programs. Beginning in 1994, Respiratory Therapy scholarships became available through this program.

Since the beginning of the program, 94 awards have been given to students studying for advanced master's degrees in gerontological nursing and occupational therapy. Of this number, 44 students have completed degrees and fulfilled their obligations by working as professionals in VA medical centers. Thirty of these professionals are still employed by VA. The remaining students are in the process of completing their degrees, completing their service obligations, or beginning their service obligation in the near future.

Learning Resources

The widespread education and training activities in geriatrics have generated a broad spectrum of requirements for learning resources throughout the VA system. Local medical media services continue to provide thousands of audiovisual products that meet educational and clinical needs in the areas of geriatrics and gerontology. Local library services continue to perform hundreds of on-line searches on data bases such as MEDLINE and AGELINE (available through Bibliographic Retrieval Services), and continue to add books, journals, and audiovisuals on topics related to geriatrics and aging. OAA has produced and/or sponsored a number of satellite programs on Alzheimer's and other dementias. Taped copies of three of these satellite programs ("Diagnosis and Treatment of Alzheimer's Disease," "Dental Care of Cognitively Impaired Older Adult: Prioritizing Service Needs," and "Progressive Aphasis: Overview and Case in Point") can be obtained from the local Library Service at every VA medical center.

VII. Veterans Benefits Administration

COMPENSATION AND PENSION PROGRAMS

Disability and survivor benefits such as pension, compensation and dependency and indemnity compensation administered by the Veterans Benefits Administration provide all, or part, of the income for 1,720,880 persons age 65 or older. This total includes 1,247,117 veterans, 453,758 surviving spouses, 17,705 mothers and 2,300 fathers.

The Veterans' and Survivors' Pension Improvement Act of 1978, effective January 1, 1979, provided for a restructured pension program. Under this program, eligible veterans receive a level of support meeting a national standard of need. Pensioners generally receive benefits equal to the difference between their annual income from other sources and the appropriate income standard. Yearly cost of living adjustments (COLAs) have kept the program current with economic needs.

This act provides for a higher income standard for veterans of World War I or the Mexican border period. This provision was in acknowledgement of the special needs of the Nation's oldest veterans. The current amount added to the basic pension rate is $1,819 as of December 1, 1994.

VETERANS ASSISTANCE SERVICE

Veterans Services Division personnel maintain liaison with nursing homes, senior citizen homes, and senior citizen centers in Regional Office areas. Locations are visited as the needs arises. Pamphlets and application forms are provided to personnel at these homes during visits and through frequent use of regular mailings. State and Area Agencies on Aging have been identified and are provided information about VA benefits and services through workshops and training sessions. Seminars are conducted for nursing home operators and other service providers that assist and serve elderly patients. Regional Office coordinators continue to serve on local and State task forces that deal extensively with the problems of the elderly.

The elderly, as a group, encounter problems with transportation due to rising costs, limited income, and most importantly, physical ailments. Thus, Veterans Assistance Service continues to emphasize to veterans and dependents the use of the toll-free telephone service—(800) 827–1000—as a means of contacting VA offices for information and assistance.

A special list of aged beneficiaries has been furnished to Regional Office Veterans Services Divisions for individualized outreach use. Veterans and/or dependents are being contracted and provided with information and claims assistance on any additional VA benefits that may be applicable to them. One of the reasons for this outreach program is VA's concern that large numbers of older veterans who are "at risk" and, as such, may be unaware of the higher income limitations available under the pension program, i.e., housebound status and aid and attendance. VA is convinced that many are unaware of the impact of unreimbursed medical expenses on pension eligibility. The change resulting from the Omnibus Budget Reconciliation Act, regarding a veteran, without dependents, who is eligible for Medicaid and is in a Medicaid-approved nursing home, and may not receive improved pension in excess of $90 monthly, requires extensive explanation to the veterans, his or her family and the care provider. The Veterans Benefits Act of 1992 has extended these same provisions to a surviving spouse without children. This law was signed on October 29, 1992, and has resulted in an increased amount of inquiries and requests from veterans and dependents to Regional Office Veterans Services Divisions for an explanation of their changed benefits.

ITEM 31. TRANSMITTAL LETTERS FROM AGENCIES

JANUARY 31, 1995.

DEAR MR. CHAIRMAN: I am pleased to submit to you the Federal Council on the Aging's Annual Report, the twenty-first such document provided to you and your predecessors.

While the accompanying report may be lengthy and detailed, it reflects just a few of the many challenges we face with the aging of our society. Your leadership on the 1995 White House Conference on Aging underscores your commitment to seeking effective solutions to these challenges.

Briefly, the Federal Council on the Aging is making our citizens conscious of the need to continue to be productive, no matter what the age. At the same time, we are identifying those instances where vulnerable older persons and their families may need assistance so that they are better able to help themselves live with dignity and respect.

Your interest in our work has been of great help and we are grateful. We are making progress and with your encouragement we shall continue to do so.

Respectfully Yours,

John E. Lyle,
Chairman,
Federal Council on Aging.

JANUARY 18, 1995.

DEAR MR. CHAIRMAN: Enclosed is the information requested on the Department of Agriculture's activities or initiatives on behalf of older Americans and their families. If we can be of any further assistance, please feel free to contact us.

Sincerely,

RICHARD E. ROMINGER,
Acting Secretary,
Department of Agriculture.

Enclosures.

JANUARY 30, 1995.

DEAR MR. CHAIRMAN: We are enclosing our report for 1994 for inclusion in Developments in Aging. The report includes programs relevant to the older population.

If you need further information, please have a member of your staff call Mr. Anthony Black, Chief, Congressional Affairs Office, Bureau of the Census, on (301) 457–2171.

Sincerely,

Ronald H. Brown,
Department of Commerce.

Enclosure.

JANUARY 19, 1995.

DEAR MR. CHAIRMAN: This is in response to your letter of November 25, 1994, requesting information on what the Department of Defense has done on behalf of older Americans.

I have enclosed a summary of eldercare activities that the Department of Defense has undertaken this past year. These activities are part of a continuum of special initiatives, developed over the past several years, to increase informational resources for military members and families facing eldercare issues. The summary also describes health care efforts for our elder beneficiaries.

I hope that this information is helpful to you and to the Special Committee on Aging.

Sincerely,

CAROLYN H. BECRAFT,
Deputy Assistant Secretary of Defense,
(Personnel Support, Families and Education),
Department of Defense.

Enclosure:

JANUARY 13, 1995.

DEAR MR. CHAIRMAN: This is in reference to the Committee's letter of November 25 requesting the Department of Education's FY 1994 report chronicling activities on behalf of older Americans.

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

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

Sincerely,

KAY CASSTEVENS,
Assistant Secretary,
Department of Education.

Enclosures

JANUARY 11, 1995.

DEAR MR. CHAIRMAN: In response to your letter of November 25, 1994, the Department of Energy is providing a report of its current and planned activities of interest to older Americans. Our efforts focus on energy efficiency, information collection and dissemination, and research into the biological and physiological aspects of aging.

The Department is proud of its activities and contributions on behalf of older Americans.

Sincerely,

HAZEL R. O'LEARY,
Department of Energy.

Enclosure.

JANUARY 30, 1995.

DEAR MR. CHAIRMAN: On behalf of Secretary Shalala, I am submitting the Department of Health and Human Services' annual report for 1994 summarizing the Department's activities on behalf of older Americans. We are pleased that we could be

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

I hope the enclosed information will be of value to the Committee. Should your staff need further assistance, the point of contact on my staff is Barbara Clark on 690–6311.

Sincerely,

Jerry D. Klepner,
Assistant Secretary for Legislation,
Department of Health and Human Services.

Enclosures.

MARCH 20, 1995.

DEAR MR. CHAIRMAN: I am pleased to send you HUD's accomplishments in providing activities and initiatives to assist older Americans and their families during Fiscal Year 1994 for inclusion in Developments in Aging.

With the elderly population the fastest growing group in the United States, the programs HUD develops and administers today are important for the future comfort of this expanding population. The Department is quite proud of the variety of approaches available in HUD programs which allow older Americans to maintain their independence, remain a part of the community, and live their lives with dignity and grace.

If you have any questions regarding the attached information, please call William J. Gilmartin, Assistant Secretary for Congressional and Intergovernmental Relations at 202–708–0005.

Sincerely,

HENRY G. CISNEROS,
Department of Housing and Urban Development.

Enclosure.

MARCH 27, 1995.

DEAR MR. CHAIRMAN: On behalf of Secretary Babbitt, I am submitting the Department of the Interior's report summarizing the Department's activities in support of older Americans. The Department is aware that the elderly make up the fastest growing segment of America's population. We at Interior believe that the welfare of our Nation's older citizens must be a matter of particular concern to each of the Department's employees. The Department's policies and practices are designed to assist older Americans in maintaining a comfortable and dignified life style so that they may remain an active part of their communities.

I hope the enclosed information will be of help to our senior citizens and their families.

I appreciate the Committee's interest in the programs of the Department of the Interior. Should your staff have any questions concerning the enclosed descriptive materials, please do not hesitate to contact E. Melodee Stith, Director, Office for Equal Opportunity at (202) 208–5693.

Sincerely,

BONNIE R. COHEN,
Assistant Secretary, Policy,
Management and Budget,
Department of Interior.

Enclosure.

JANUARY 6, 1995.

DEAR MR. CHAIRMAN: I am pleased to transmit in response to your request the submission of the Department of Justice for the Annual Report of the Special Committee on Aging entitled, Developments in Aging.

The Office of Justice Programs (OJP) is the Department's primary resource for innovative programs to address the problem of crime against the elderly and to encourage older Americans to become involved in efforts to prevent crime in their communities. In addition, OJP's research and statistical bureaus work to increase our knowledge about the impact of crime on the elderly and the most effective ways to prevent and treat victimization. Two other OJP bureaus also sponsor programs related to the elderly. The Office for Victims of Crime (OVC) sponsors programs to improve the treatment of elderly and other crime victims, and the Office of Juvenile

Justice and Delinquency Prevention (OJJDP) provides support for the National Alzheimer's Patient Alert Program.

These and other initiatives are described in the enclosed report. If I can provide additional information or assistance, please contact this office.

Sincerely,

SHEILA F. ANTHONY,
Assistant Attorney General,
Department of Justice.

Enclosure.

MARCH 20, 1995.

DEAR CHAIRMAN: Enclosed is a summary of the programs and activities of the Department of Labor for Fiscal Year 1994 related to aging.

Described in this report are programs administered by the Employment and Training Administration, the Pension and Welfare Benefits Administration, the Bureau of Labor Statistics, the Womens' Bureau, and the Employment Standards Administration.

Sincerely,

ROBERT B. REICH,
Department of Labor.

Enclosure.

DECEMBER 30, 1994.

DEAR MR. CHAIRMAN: I am writing in response to your November 25 request for information about programs undertaken by the Department of State on behalf of older Americans. Foreign Service families face unique challenges when caring for elderly parents or other older relatives. Assisting mobile families as they attempt to provide adequately for their relatives, both those residing in the United States and those who have accompanied a member of the Service on an overseas assignment, is the focus of much of our programming. In addition, several programs and extensive counseling exist for Civil Service employees and Foreign Service personnel assigned to Washington, D.C. who have concerns about their elderly family members or who are themselves facing the need for additional care.

Programs for older Americans are vitally important; I am pleased to have this opportunity to inform you of those offered by the Department of State.

I hope this report is useful to you. Please do not hesitate to contact me if we can be of further assistance.

Sincerely,

WENDY R. SHERMAN,
Assistant Secretary Legislative Affairs,
Department of State.

JANUARY 3, 1995.

DEAR MR. CHAIRMAN: I am pleased to forward to you the enclosed report, which summarizes significant actions taken by the Department of Transportation during 1994 to improve transportation facilities and services for older Americans. The report is being sent in response to your letter to Secretary Peña, requesting information for Volume II of the Committee's annual report, "Developments in Aging."

I hope you will find our submission helpful. Any questions about it can be directed to Dr. Ira Laster of my staff ((202) 366–4859).

Sincerely,

FRANK E. KRUESI,
Assistant Secretary for Transportation Policy,
Department of Transportation.

Enclosure.

FEBRUARY 10, 1995.

DEAR MR. CHAIRMAN: I am pleased to submit, for inclusion in Developments in Aging, the Treasury's report on the Department's activities during 1994 which af-

fected the aged. I hope our report will be of use to the Special Committee on Aging and others studying the challenges faced by older Americans.

Sincerely,

ROBERT E. RUBIN,
Department of Treasury.

Enclosure.

JANUARY 19, 1995.

DEAR MR. CHAIRMAN: This is in response to the letter from the Special Committee on Aging requesting information from the U.S. Commission on Civil Rights for the annual report entitled *Developments in Aging*.

During FY 1994, the Commission continued to process complaints received from individuals alleging denials of their civil rights. Specifically, 33 complaints alleging discrimination on the basis of age were received by the Commission and referred to the appropriate agency for resolution.

Should you or your staff desire any additional information from the Commission in preparation of the Aging Report, please do not hesitate to contact me on 202–376–7700.

Sincerely,

MARY K. MATHEWS,
Staff Director,
Commission on Civil Rights.

DECEMBER 15, 1994.

DEAR MR. CHAIRMAN: Enclosed, as you requested, is a report by the U.S. Consumer Product Safety Commission on activities to improve safety for older consumers.

I appreciate the opportunity to submit this information to your committee.

Sincerely,

ANN BROWN,
Consumer Product Safety Commission.

Enclosure.

JANUARY 27, 1995.

DEAR MR. CHAIRMAN: Thank you for your letter of November 25, 1994, requesting the Corporation for National and Community Service's report on our 1994 accomplishments for Volume II of the Senate Special Committee on Aging's annual report, Developments in Aging.

Fiscal year 1994 was another very successful one for the Retired and Senior Volunteer Program (RSVP), Foster Grandparent Program (FGP), and Senior Companion Program (SCP) as these programs were merged into the new Corporation for National and Community Service created by passage of the National and Community Service Trust Act of 1993.

In 1994, the Corporation continued cooperative efforts with a nationwide network of over 1,200 public and private sector agencies and organizations which operate projects at the local level. Almost half a million volunteers contributed approximately 115 million hours getting significant things done for their communities. Our accomplishments this year include:

Participation at a White House Human Needs Forum,

Launching the Senior Summer Corps which focused on issues of public safety,

Convening a Leadership Roundtable of prominent leaders in the fields of aging and service to consider the future of senior service in America, and

Participation with the Administration on Aging to conduct Leadership Training Institutes for representatives of community-based organizations having a mission in service and aging.

The Corporation is very proud to submit the enclosed report on these programs.

Sincerely,

ELI J. SEGAL,
Chief Executive Officer,
Corporation for National and Community Service.

Enclosure.

JANUARY 28, 1995.

DEAR MR. CHAIRMAN: This is in response to a November 25, 1994, letter from former Chairman David Pryor requesting an update on activities at the U.S. Environmental Protection Agency (EPA) for the annual report, "Developments in Aging." As reported last year, EPA began a collaborative effort in 1988 with the World Health Organization (WHO) to review the existing knowledge on the effects of chemicals on the elderly. This effort, involving many international scientists, culminated in 1993 with the publication of the WHO Environmental Health Criteria 144, Principles for Evaluating Chemical Effects on the Aged Population. The report concluded that it is likely that the aged population is more susceptible to the harmful effects of environmental chemicals even though very few chemicals have been specifically tested for this outcome. This is likely for a variety of reasons including the intrinsic deterioration of physiological and psychological processes associated with aging, increased susceptibility because of age-associated diseases, and other lifestyle changes (e.g., diet).

Results from recent EPA research support the conclusion of the WHO report that the aged population is likely to be more susceptible to the harmful effects of environmental chemicals. These and other research results that address two primary issues in environmental health research, namely the direct effects of toxic chemicals on the aged and the effect of environmental exposures on the aging process, are summarized in the enclosure. This research is conducted at the EPA Health Effects Research Laboratory in Research Triangle Park, North Carolina.

Sincerely,

CAROL M. BROWNER,
Environmental Protection Agency.

Enclosure.

DECEMBER 15, 1994.

DEAR MR. CHAIRMAN: On behalf of Chairman Casellas, I am responding to your November 25, 1994 request for the Equal Employment Opportunity Commission's (EEOC) submission for the committee's annual report, *Developments in Aging.*

Enclosed are copies of fiscal year 1993 annual reports from EEOC's Office of General Counsel and Office of Program Operations. These reports contain information on EEOC's compliance and litigation enforcement efforts on behalf of victims of employment discrimination.

Please call me at 663–4900 if I can be of further assistance.

Sincerely,

CLAIRE GONZALES,
Director of Communications and Legislative Affairs,
Equal Employment Opportunity Commission.

Enclosures.

JANUARY 10, 1995.

DEAR MS. LAROCCA: This is in response to your letter requesting a summary of the activities undertaken by the Federal Communications Commission (FCC) on behalf of older Americans. I am pleased to report that we have expanded our outreach to recruitment activities. Through our contacts within organizations such as Forty Plus of Greater Washington we have been successful in employing several individuals who have brought great breadth of experience to the FCC.

I hope this information is helpful and encourage you to call Sandra Canery, Chief of the EEO Staff, at (202) 418–0128, if you have any questions.

Sincerely,

ANDREW FISHEL,
Managing Director,
Federal Communications Commission.

MARCH 31, 1995.

DEAR MR. CHAIRMAN: I am pleased to forward the enclosed staff summary of Federal Trade Commission activities on behalf of older consumers and their families for fiscal year 1994. This report reflects the extent to which many of our law enforcement initiatives, while not specifically aimed at the older population, provide special benefits to this group.

I hope this information will be helpful to the Committee. Please let me know if we can provide any additional assistance.

By direction of the Commission.

DONALD S. CLARK,
Secretary,
Federal Trade Commission.

Enclosure.

DECEMBER 29, 1994.

DEAR MR. CHAIRMAN: This report was prepared in response to the Committee's November 25, 1994, request for a compilation of our fiscal year 1994 products and ongoing work regarding older Americans and their families.

As arranged with your office, we are sending copies of this report to interested congressional committees and subcommittees. Copies will also be made available to others on request.

This report was prepared under the direction of Jane L. Ross, Director, Income Security Issues, who may be reached at (202) 512–7215 if you have any questions. Other major contributors are listed in appendix V.

Sincerely yours,

JANET L. SHIKLES,
Assistant Comptroller General,
General Accounting Office.

FEBRUARY 21, 1995.

The Legal Services Corporation (LSC) is a private nonprofit corporation established by Congress to help provide equal access to justice under the law for all Americans. It receives funds annually from Congress and makes grants directly to local programs that provide civil legal assistance to those who would otherwise be unable to afford it.

LSC currently provides funds to 323 programs operating in over 900 neighborhood law offices. Together they serve every county in the Nation. Programs funded by LSC serve 1.7 million poor Americans a year in the areas of family, housing, income maintenance, and consumer law, to name just a few.

However, please do not hesitate to contact me it you have any questions. Thank you once again.

JAMES R. LAMB, JR.,
Director of Communications,
Legal Services Corporation.

DEC. 23, 1994.

DEAR CHAIRMAN: I am pleased to report to you on the Fiscal Year 1994 activities of the National Endowment for the Arts involving older Americans. Through technical assistance and funding, the Arts Endowment seeks to ensure that older adults have opportunities to participate in and enjoy the best of our Nation's art as creators, educators, administrators, volunteers, students and audiences.

This year marked the first government sponsored nationwide arts conference, ART–21: Art Reaches Into the 21st Century, that was convened in Chicago on April 14–16, 1994. Over 1,100 artists, arts administrators, educators, foundation leaders and government policy makers at the Federal, State, and local levels from across the country came together to discuss the status of American culture. This landmark forum included breakout sessions on a variety of topics, all centered around moving the arts into the 21st century. One such session, "Reaching Special Constituencies," featured artist Eleanor Schrader from Elders Share the Arts (ESTAR) in Brooklyn, New York. She emphasized the critical need for older adults to be involved in the best art, and discussed ESTAR's wide variety of programs including. "Pearls of Wisdom," their senior theater group.

Further, the Endowment worked in partnership with the National Assembly of State Arts Agencies (NASAA) to produce the most comprehensive arts access book published to date, Design for Accessibility: An Art Administrator's Guide. The overall theme of the book is universal design: designing spaces and programs that accommodate individuals throughout their lifespan. This 700-page Guide should help thousands of cultural organizations in making their facilities and programs more available to older adults and citizens with disabilities. We are distributing 3,500

free copies of the Guide to grantees through the State arts agencies, and it is being marketed by NASAA.

The report that follows provides a description of our efforts to support increased participation in the arts by older Americans. I am grateful for the opportunity to present the Special Committee on Aging with this overview of the Arts Endowment's work in progress for older adults.

Sincerely,

JANE ALEXANDER,
Chairman,
National Endowment for the Arts.

Enclosure.

MARCH 14, 1995.

DEAR MR. CHAIRMAN: I am pleased to enclose a report summarizing the activities of special significance to older Americans supported by the National Endowment for the Humanities in fiscal year 1994.

Many of the projects that received Endowment support during the past year involved older Americans as grant recipients or project contributors or were of particular interest to them. Several NEH-sponsored programs for the general public specifically addressed older persons as an audience, but most of the programs for television and radio, the museum exhibitions, and the reading and discussion programs in local libraries that the Endowment supported were conveniently accessible to older Americans for their personal enjoyment and enrichment.

The state humanities councils have also been very active in developing programs for or about the aging, and a number of their efforts are summarized in the report. Anyone wishing further information on the State councils' activities in this area is invited to contact NEH or any one of the councils.

I hope that you and your Committee will find this material useful. Please let me know if we can be of any further assistance.

Sincerely,

Enclosure.

SHELDON HACKNEY,
Chairman,
National Endowment for the Humanities.

JANUARY 9, 1995.

DEAR MR. CHAIRMAN: This is in response to your November 25, 1994, letter to Dr. Lane.

The Foundation's activities related to aging have not changed materially since I reported to you last year. As you may recall, I mentioned that the National Science Foundation does not have any research programs focused specifically on problems confronting the older members of our population. However, I also went on to say that some projects funded at NSF have implications for enhancing the well-being of this population. In particular, most of the projects having a tangential bearing on aging would tend to be supported through the Division of Integrative Biology and Neuroscience in the Directorate for Biological Sciences; the Social, Behavioral and Economic Sciences Directorate; and the Division of Bioengineering and Environmental Systems in the Engineering Directorate.

I have enclosed a copy of the report submitted last year which discusses in more detail our activities related to aging. As indicated above, this report is still up to date.

If you have additional questions, please do not hesitate to call me. I look forward to receiving a copy of the annual report on aging.

Sincerely,

CORA B. MARRETT,
Assistant Director,
National Science Foundation.

Enclosure.

MARCH 30, 1995.

DEAR MR. CHAIRMAN: I am pleased to send you the enclosed copy of the Pension Benefit Guaranty Corporation's Annual Report for Fiscal Year 1994.

For PBGC and the working people it protects, 1994 was a very productive and successful year. Under the leadership of President Clinton, and with the bipartisan support of the Congress, our yearlong efforts in support of comprehensive pension reforms were rewarded with enactment of the Retirement Protection Act. Our negotiations and enforcement efforts led to notable successes. PBGC's deficit fell and, with the new reforms, the Corporation will remain on a sound financial basis.

Now that the reforms are law, workers and employers can have greater confidence in a stronger pension system and in PBGC.

Sincerely,

MARTIN SLATE,
Executive Director,
Pension Benefit Guaranty Corporation.

Enclosure.

DECEMBER 29, 1994.

DEAR MR. CHAIRMAN: This responds to your letter requesting information from the Postal Service on activities and programs which assist elderly Americans.

The enclosed document describes Postal Service programs which are designed to meet the mailing needs of older Americans and prevent them from being victimized by mail fraud.

The Postal Service is pleased to contribute to this endeavor and will continue to develop programs to assist in improving the quality of life for the aging.

Best regards,

MARVIN RUNYON,
Postal Service.

DECEMBER 23, 1994.

DEAR MR. CHAIRMAN: In response to your letter of November 25, 1994, we are enclosing a report summarizing the U.S. Railroad Retirement Board's program activities for the elderly during fiscal year 1994.

We look forward to your committee's report, *Developments in Aging: 1994.* If we can be of further assistance, please feel free to contact the Secretary to the Railroad Retirement Board, Bea Ezerski, at (312) 751–4920.

Sincerely,

GLEN L. BOWER,
V. M. SPEAKMAN, JR,
JEROME F. KEVER,
Railroad Retirement Board.

Enclosure.

DECEMBER 22, 1994.

DEAR MR. CHAIRMAN: Thank you for asking the U.S. Small Business Administration (SBA) to provide information to the Special Committee on Aging's annual report, Developments in Aging (DIA). The mission of this Agency has not changed since our report to you last year. The SBA is charged with the responsibility to create, implement and deliver technical and financial assistance programs for the benefit of the Nation's small business community. We currently do not have a program that gives specific focus to older Americans.

However, the SBA is the sponsoring Federal agency for the Service Corps of Retired Executives (SCORE) program. SCORE is an organization of nearly 13,000 business men and women who volunteer their time to provide management counseling and training to small businesses. They have extensive business experience, either as entrepreneurs and business owners or as former corporate executives. Their counseling is confidential and free of charge and is provided at more than 800 locations in the United States and its territories.

I hope the information provided is beneficial in the development of the Committee's annual report for 1994.

Sincerely,

DOROTHY D. KLEUCHULTE,
(For Mary Jean Ryan, Associate Deputy Administrator,
Office of Economic Development),
Small Business Administration.

MARCH 6, 1995.

DEAR MR. CHAIRMAN: Enclosed is a report of the Department of Veterans Affairs' activities on behalf of older persons for the fiscal year 1994.

VA has developed a high quality system that provides health care for thousands of elderly veterans every day. Meeting the medical needs of older veterans constitutes one of VA's current greatest challenges.

Thank you for allowing us the opportunity to share this information with you.

Sincerely yours,

JESSE BROWN,
Veterans Affairs.

Enclosure.