DEVELOPMENTS IN AGING: 1999 AND 2000
VOLUME 2

A REPORT
OF THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
PURSUANT TO
S. RES. 54, SEC. 17(c), MARCH 8, 2001
Resolution Authorizing a Study of the Problems of the Aged and Aging

JUNE 4, 2002.—Ordered to be printed

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WASHINGTON : 2002
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U.S. SENATE,
SPECIAL COMMITTEE ON AGING

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

DEAR MR. PRESIDENT: Under authority of Senate Resolution 54 agreed to March 8, 2001, I am submitting to you the annual report of the U.S. Senate Special Committee on Aging, Developments in Aging: 1999 and 2000, 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 1999 and 2000 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,

JOHN B. BREAUX, Chairman.
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DEVELOPMENTS IN AGING: 1999 AND 2000

VOLUME 2

JUNE 4, 2002.—Ordered to be printed

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

REPORT

REPORT FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1—AGRICULTURE

COOPERATIVE STATE RESEARCH, EDUCATION AND EXTENSION SERVICE (CSREES)

Since early 1999, USDA's CSREES has been working with families with older Americans in small towns and rural areas to make improved health care decisions. One of the strategies focuses on how 4-H Youth Technology Teams can help other Americans to bridge the Digital Divide. The program is known as Teens Teaching Internet Skills (TTIS). In a partnership with the Health Care Finance Administration, 4-H Technology Leadership Teams are helping families with older Americans to learn how to use the internet to improve the quality of decisions they make in choosing health care, housing and transportation. As a result of collaboration between young 4H member volunteers and older Americans, seniors are increasingly accessing internet web sites such as www.medicare.gov, www.seniors.gov and www.workers.gov.

In 1999, 4-H Youth Technology piloted Teens Teaching Seniors State Teams in Maryland, Virginia, Connecticut, Florida, Iowa and Washington to test approaches to help older adults to gain Internet skills. At the National Youth Technology Conference, held in July 2000 in College Park, Maryland, more than 250 youth leaders from 29 States met and learned from the six original teams, and, since then, twenty-nine States have taken the initiative to develop State action plans and to identify state youth technology leadership
teams that, when provided with proper resources, will be able to implement efforts for their own TTIS program. Many of the individual State action plans call for the establishment of Community Technology Centers to serve as learning centers where youth can take the role of mentors to adults in helping them become technologically literate. Many States are planning public-private partnerships to establish technology learning places in their communities. Today, 4-H Youth Technology teams are converting the digital into digital opportunity across the generations. Communities are now seeking support to grow these efforts especially in under-served communities.

CSREES provided key leadership in the framing of a new national extension initiative "Financial Security in Later Life," which will be implemented in FY 2001. The purpose of the initiative is to focus new resources of the Land-grant University System on research, resident education, and extension/outreach programs related to an aging population. Particular attention will be paid to retirement planning especially the potential financial effects of long term care on family finances. A significant contribution of USDA-CSREES will be partnership building with other Federal agencies, the financial services sector, foundations, and non-profit organizations. Work already is underway on training for extension educators, research on retirement issues of farm families, and an interactive web site for consumers on long term care decisions. It is expected the initiative will span 5 years.

AGRICULTURAL RESEARCH SERVICE (ARS)

The Department of Agriculture Research Service (ARS) conducts research at the Jean Mayer Human Nutrition Research Center on Aging (HNRCA) in Boston, Massachusetts, on behalf of older Americans. Center scientists are determining the ways in which diet and nutritional status influence the onset and progression of aging, employing experimental animals, tissue cultures, and human subjects for such studies. They are exploring the ways in which diet, alone and in association with other factors, can delay or prevent the onset of degenerative conditions commonly associated with the aging process. This research will determine nutrient requirements during aging and the ways in which an optimal diet, in combination with exercise, genetic, physiological, psychological, sociological and environmental factors, may provide health and vigor over the life span of man.

Scientists at the HNRCA are addressing three general questions of central importance to this mission:
- How does nutrition influence the progressive loss of tissue functions with aging?
- What is the role of nutrition in the genesis of major chronic degenerative conditions associated with the aging process?
- What are the nutrient requirements necessary to maintain the optimal functional well-being of older people?

ARS is strengthening its integrated multidisciplinary human nutrition research program to develop means for promoting optimum human health and well-being through improved nutrition. ARS research is also seeking to improve understanding of the functional
roles dietary patterns play in human health maintenance. The goals of the ARS Human Nutrition Initiative are to:

- Reduce health care costs and enhance the quality of life.
- Improve the scientific basis for more effective Federal food assistance programs.
- Generate a more nutritious food supply.
- Improve the resistance to acute infections and immune disorder.
- Enhance the capacity to promote changes in diet habits.
- Individualize dietary guidance for nutritionally vulnerable groups within the United States.

The ARS Human Nutrition Initiative Focuses on Five Vital Concerns:

- Food, Phytonutrients, and Health
- Health Body Weight
- Brain Function/Resistance to Mental Decline
- Bone Growth and Protection from Osteoporosis
- Foods to Fight Infectious Disease

Recent accomplishments include findings that fortification or folic acid has reduced the prevalence of low circulating folate and high homocysteine concentrations. The implementation of the FDA-mandated folic acid fortification of enriched grain products was completed by early 1998. Researchers at HNRCA assessed the impact of fortification on the folate status of adult Americans. They have conducted a long-term follow-up of folate and homocysteine concentrations in the population-based Framingham Heart Studies. This work indicated that the current levels of fortification were able to reduce the prevalence of low circulating folate and high homocysteine concentrations to levels seen in multivitamin supplement users. This was the first demonstration of the effectiveness of this important national program.

Researchers at HNRCA in collaboration with Framingham Osteoporosis Study researchers evaluated associations between dietary vitamin K intake, apoE genotype, bone mineral density and rate of hip fracture among elderly men and women participating in the original cohort of the Framingham Health Study. Low vitamin K intakes were significantly associated with increased incidence of hip fractures in men and women. In contrasts, neither low intakes of vitamin K nor apoE4 allele were associated with low bone mineral density.

ECONOMIC RESEARCH SERVICE (ERS)

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

The following publications on the rural elderly have been prepared by ERS staff in the past year:


FOOD AND NUTRITION SERVICE (FNS)

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

The Food Stamp Program (FSP) provides monthly benefits to help low-income families and individuals purchase a more nutritious diet. In fiscal year 1999, $18 billion in food stamps were provided to a monthly average of 18 million persons.

Households with elderly members accounted for approximately 20 percent of the total food stamp caseload. However, since these households were smaller on average and had relatively higher net income, they received only 8 percent of all benefits issued.

Brief description of accomplishments

The FSP has been at the forefront of efforts to reduce hunger and food insecurity among the elderly. The initiatives include:

- Development of a guide titled "Help for the Elderly and Disabled: A Primer for Enhancing the Nutrition Safety Net for the Elderly and Disabled" that was distributed to appropriate agencies and organizations. The purpose of this guide is to: 1) assist State policy makers and others in understanding the special rules embedded in the Food Stamp Act of 1977 (as amended) and the FSP regulations for elderly and disabled individuals, 2) assist States and others in identifying participation barriers the elderly and disabled face when seeking nutrition assistance through the FSP, and 3) assist States and others in identifying possible outreach activities to increase participation among the elderly and disabled.

- Development of easily reproducible posters and fliers as part of a public information campaign to increase awareness of the FSP among target audiences, including the elderly.

- Announcing the availability of $3 million dollars in research grants to be awarded in January 2001 to improve FSP access through partnerships and new technology. The purpose of the grants is to explore various strategies to reach potentially eligible households and to educate food stamp eligible persons not currently participating in FSP about the benefits of the Program and how to apply for these benefits. One of the target populations for these grants is the elderly.

The Food and Nutrition Service (FNS) 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 (SSI) households.

In response to recommendations for joint processing improvements, FNS and SSA have stepped up efforts to ensure that SSI applicants are counseled on their potential eligibility to receive food stamps. Additionally, a joint Supplemental Security Income/Food Stamp processing demonstration—the South Carolina Combined Application Project (SCCAP)—was begun in the fall of 1995. An independent evaluation of SCCAP was completed in January 2000 and showed that the rate of food stamp participation among SSI recipients in South Carolina increased from 38 percent in 1994 to 50 percent in 1998 while the national rate decreased from 42 percent to 38 percent during the same period. Net potential savings at the South Carolina Department of Social Services are estimated at $575,000 per year. Based on the success of the project, FNS agreed to extend SCCAP for a maximum of three additional years (through September 2000). During this time, Congress will have a chance to review the findings of the evaluation and determine whether the results warrant amending the Food Stamp Act so that South Carolina may continue to use the special provisions of SCCAP as part of its normal FSP operations.

**COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)**

*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 education to infants and children up to age 6, pregnant, postpartum or breastfeeding women, and the elderly (at least 60 years of age) who have low incomes and reside in approved project areas.

Service to the elderly began in 1982 with pilot projects. In 1985, 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 1999, approximately $45 million was spent on the elderly component.

*Brief description of accomplishments*

About 65 percent of total program spending provides supplemental food to approximately 270,000 elderly participants a month. Older Americans are served by 23 eligible State agencies.

**FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR)**

*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 households with elderly persons, living on or near Indian reservations. Under this program, commodity assistance is provided in lieu of food stamps.

Approximately $27 million of total costs went to households with a lease 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 15,000 households with elderly participants per month.

**CHILD AND ADULT CARE FOOD PROGRAM (CACFP)**

*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, the 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 1999, $36 million was spent on the adult day care component.

**Brief description of accomplishments**

The adult day care component of CACFP served approximately 32 million meals and supplements to over 62,000 participants a day in fiscal year 1999.

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.

**THE EMERGENCY FOOD ASSISTANCE PROGRAM (TEFAP)**

*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 $17 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.

NUTRITION PROGRAM FOR THE ELDERLY (NPE)

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

The Nutrition Program for the Elderly 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 addresses dietary inadequacy and social isolation among older individuals. USDA currently supplements the Department of Health and Human Services’ Administration on Aging with approximately $141 million worth of cash and commodities.

Brief description of accomplishments

In fiscal year 1999, over 247 million meals were reimbursed at a cost of almost $150 million. On an average day approximately 932,000 meals were provided.

CENTER FOR NUTRITION POLICY AND PROMOTION (CNPP)

On September 28, 2000, CNPP hosted a symposium titled “Nutrition and Aging: Leading a Healthy, Active Life.” This is the fifth in a series of symposiums hosted by CNPP that has included topics such as Childhood Obesity, Breakfast and Learning in Children, and Dietary Behavior. The purpose of the symposiums is to provide participants with the latest available scientific information, to increase the awareness of important nutritional issues, and to examine how these issues influence nutrition policy.

The following publication on the elderly have been prepared by CNPP staff in calendar years 1999–2000:


FOOD SAFETY INSPECTION SERVICES (FSIS)

NEW EDUCATION PROGRAM FOR SENIORS:

With input from experts on aging, the Food Safety and Inspection Service has worked cooperatively with the Food and Drug Administration to produce a new educational program for seniors: a 14 minute video and accompanying publication both titled To Your Health, Food for Seniors.

In developing this educational program, FSIS staff drew on the expertise of varied groups including the Administration on Aging, the National Institutes of Health, AARP and the State Units on Aging. As a result of those consultations, the program materials
are targeted to address unique behaviors that can contribute to the risks of foodborne illness for seniors. They are also presented in formats designed to be “senior friendly.” The 17-page publication is printed in 14 point type to make reading easier to older eyes. The publication is presented in a large format—8½ by 11 inches—to make it easy to hold and use. The video presents information in a clear and concise manner with key points highlighted and repeated for emphasis. The video is broken into two segments, one addressing safe food handling at home and the other, food safety when eating out.

The key food safety messages in the campaign—clean, separate, cook and chill—are drawn from the national food safety education campaign called Fight BAC!™ Support of these four key food safety messages is a goal of Healthy People 2010 and the new Dietary Guidelines for Americans.

The educational program will be distributed early in 2001 and will include distribution to the Administration on Aging’s area offices and direct mail to more than 10,000 senior centers. The publication will also be available through the Consumer Information Center in Pueblo, CO. In all, more than a half a million copies of the publication and nearly 50,000 copies of the video will be distributed.

ON-GOING FOOD SAFETY ADVICE FOR SENIORS:

To help communicate the importance of safe food handling for seniors—and their special risks—all press releases issued by FSIS include a box with safe food handling advice for at-risk audiences. This advice is also routinely featured in video news releases as well as feature stories. The Food Safety Education staff also develops special features and fact sheets designed to help educate seniors about safe food handling—available through the FSIS web site: http://www.fsis.usda.gov/oa/pubs/consumerpubs.htm

MARKETING AND REGULATORY PROGRAMS

The Agricultural Marketing Service facilitates the accessibility of agricultural products to older Americans by promoting and developing wholesale, collection, farmers, and direct markets. The support provided for these markets has made fresh, nutritious foods available in communities where older Americans have previously not had access to such products. The number of farmers markets has increased from 1,755 in 1994 to over 2,800 in 2000.
ITEM 2—DEPARTMENT OF COMMERCE

UPDATES TO THE DEVELOPMENTS IN AGING REPORT FOR 1999 AND 2000

This report provides short descriptions and listings of products that contain demographic and socioeconomic information on the elderly population, 65 years of age and older, in the United States and abroad. All of the items included in this report were released by the U.S. Census Bureau during calendar years 1999 and 2000. The items listed are available to the public in a variety of formats including print, electronic data bases, microcomputer diskettes, and CD-ROM. Many of these products can be found on the Internet at the Census Bureau's Web site at: <http://www.census.gov>.

1. Population, Housing, and International Reports.—Three of the Census Bureau's major report series (Current Population Reports, Current Housing Reports, and International Population Reports) are important sources of demographic information on a wide variety of population-related topics. This includes information on the United States' elderly population, ranging from their numbers in the total population to socioeconomic characteristics, such as income, health insurance coverage, need for assistance with activities of daily living, and housing situation. Data on the elderly around the world also are found in these series of reports.

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

Additionally, the Census Bureau's population projection program and Special Studies Report series contain information about the future estimated size of the elderly population and information pertaining to statistical methods, concepts, and specialized data.

2. Decennial Products.—A large number of printed reports, computer tape files, CD-ROMs, and summary tape files are produced after each decennial census. Included in these materials are information and data on the numbers and characteristics of persons 65 years of age and older.

3. Data Base on Aging/National Institute on Aging Products.—The data provide a summary of analytical studies and other ongoing international aging products. Reports are based on compilations
of data obtained from statistical offices of individual countries, various international organizations, and estimates and projections prepared at the Census Bureau. This work is funded by the National Institute on Aging.

4. Federal Interagency Forum on Aging-Related Statistics Summary.—The Forum, for which the Census Bureau is one of the lead agencies, encourages cooperation, analysis, and dissemination of data pertaining to the older population. A summary of the activities of the Forum lists a number of aging-related statistics.

5. Other Products.—In addition to the major products listed separately, we include a list of other data products that contain demographic and socioeconomic information on the elderly population.

1. POPULATION, HOUSING, AND INTERNATIONAL REPORTS

POPULATION

Series P–20 (Population Characteristics): Regularly recurring reports in this series contain data from the Current Population Survey. Topics include geographical mobility, fertility, school enrollment, educational attainment, marital status and living arrangements, households and families, the Black and Asian and Pacific Islander populations, 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 1997
The Foreign-Born Population in the United States: March 1999
Geographical Mobility 1997 to 1998
School Enrollment—Social and Economic Characteristics of Students: (Update) October 1998
Computer Use in the United States: October 1997
Voting and Registration in the Election of November 1998
The Hispanic Population in the United States: March 1998
Fertility of American Women: June 1998
The Hispanic Population in the United States: March 1999
Educational Attainment in the United States: March 1999
The Asian and Pacific Islander Population in the United States: March 1999
The Black Population in the United States: March 1999
Geographical Mobility (Update): March 1998 to March 1999
The Older Population in the United States: March 1999

Series P–23 (Special Studies): Information pertaining to methods, concepts, or specialized data is furnished in these publications. Reports in this series contain data on mobility rates, home ownership rates, and the Hispanic population for both the general and older populations.

Profile of the Foreign–Born Population in the United States
Trends in Premarital Childbearing
Coresident Grandparents and Grandchildren
Centenarians in the United States
Geographical Mobility: 1990–1995

Population estimates data include monthly estimates of the total U.S. population; annual midyear estimates of the U.S. population by age, sex, race, Hispanic origin (nativity was added for the 1998 series of estimates); States by age and sex; and population totals for counties, metropolitan areas, and approximately 36,000 cities and other local governments. The estimates for counties appeared in Series P–26 during the 1970s and 1980, as did estimates for the approximately 36,000 local governments during the 1980s. Estimates for Puerto Rico and the outlying areas were published in Series P–25 through the 1980s. Estimates of the population for Puerto Rico, outlying areas, and United States and state housing unit estimates are available in the P–25 series and more recently in press releases mentioned in this publication. At present, most estimates formerly published in the P–25 series are released only through the Internet, with future plans to archive annual estimates data on CD-ROM.

Projections of the United States and state populations are also included in the P–25 series. Beginning in the 1980's, projections are available not only by age and sex, but also by race and Hispanic origin. There also can be occasional research/developmental reports in this series. The Census Bureau's plan for releasing projections include CD–ROM and the Internet.

Population Trends in Metropolitan Areas and Central Cities

Population Estimates Available on the Census Bureau's Web Site

National Population Estimates:
Annual Population Estimates—Median and Mean Age; 5-year Age Groups; Sex; and Special Age Categories for Selected Years from 1990 to 2000. July 1 dates, plus the most recent month for which data are available.
Annual Population Estimates by Age, Sex, Race and Hispanic Origin; Median Age; Sex; Race (White; Black; American Indian, Eskimo, and Aleut; and Asian and Pacific Islander); Hispanic (of any race) and Non-Hispanic by Race for Selected Years 1990 to 2000. July 1 dates, plus the most recent month for which data is available.

1990 to 1999 Annual Time Series of State Population Estimates by Age and Sex; By 5-Year Age Groups and Sex, Selected Age Groups and Sec, and Single Year of Age and Sex, Median Ages: 1990 and 1999.

County Population Estimates:
1990 to 1999 Annual Time Series of County Population Estimates by Age, Sex, Race and Hispanic Origin: By Age, Sex, Race, Hispanic Origin, and Selected Age Groups.

Household and Housing Unit Population Estimates:

Population Projections

National Population Projections:
The Population Projections Program produces projections of the United States resident population by age, sex, race, Hispanic origin, and nativity. The projections are based on assumptions about future births, deaths, and international migration. Although alternative series are produced, the preferred, or middle series, is most commonly used. The Census Bureau releases new national population projections periodically.
Press Releases Available on Population Projections:
(NP-T3) Projections of the Total Resident Population by 5-Year Age Groups and Sex with Special Age categories: Middle Series, 1999 to 2100.
(NP-T4) Projections of the Total Resident Population by 5-Year Age Groups, Race, and Hispanic Origin with Special Age categories: Middle Series, 1999 to 2100.
(NP-D1-A) Annual Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin: Lowest, Middle, Highest, and Zero International Migration Series, 1999 to 2100.
(NP-D1-B) Quarterly Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin: Middle Series, January 1, 1999 to January 1, 2010.
(NP-D2) Projections of the Foreign-Born Population by Age, Sex, Race, and Hispanic Origin: Lowest, Middle, Highest Series, 1999 to 2100.
(NP-D5) Components of Change: Component Assumptions of the Resident Population by Age, Sex, Race, and Hispanic Origin: Lowest, Middle, Highest Series, 1999 to 2100.

Series PPL (Population Paper Listings):
This series of reports contains estimates of population and projections of the population by age, sex, and origin. Other topics appear as well some of which address issues related to aging.
The Asian and Pacific Islander Population in the United States: March 1998 (Update) ................................................................. 113
Computer Use in the United States: October 1997 ................................................................. 114
Fertility of American Women: June 1998 ...................................................................................... 116
The Foreign-Born Population in the United States: March 1998 ..................................................... 117
Geographical Mobility: March 1997 to March 1998 ....................................................................... 118
School Enrollment—Social and Economic Characteristics of Students: October 1998 (Update) ........................................................................ 119
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Technical Working Papers Series:
This series contains papers of a technical nature on various topics, which have been written by staff of the Population Division of the Census Bureau. Evaluation of population projections, estimates and 1990 Census results, examination of immigration issues, race and ethnic considerations, and fertility patterns are some of those topics.
"Are There Differences in Voting Behavior Between Naturalized and Native-born Americans?" by Loretta E. Bass and Lynn M. Casper, Issued 1999 .................................................................................................................................................. 28
Evaluation of Relationship, Marital Status, and Grandparents Items on the Census 2000 Dress Rehearsal by Charles Clark and Jason Fields, Issued April 1999 .................................................................................................................................................. 33
Unbinding the Ties: Edit Effects of Marital Status on Same Gender Couples by Jason Fields and Charles Clark, Issued April 1999 .................................................................................................................................................. 34
HOUSING

Series H–150 (Housing Characteristics):
These data are from the American Housing Survey. The survey presents data on apartments; single-family homes; mobile homes; vacant housing units; age, sex, and race of householders; housing and neighborhood quality; housing costs; equipment and fuels; and size of housing units. Reports are present data on homeowner's repairs and mortgages, rent control, rent subsidies, previous units of recent movers, and reasons for moving. A wall chart accompanies each report.

Series H–170 (Housing Characteristics for Selected Metropolitan Areas):
A separate report presents data for individual metropolitan areas for the same characteristics shown in Series H–150. Eleven to 13 metropolitan areas are interviewed each year. They are surveyed on a rotating basis, with a total of 48 metropolitan areas being surveyed within a 6-year period.

2. DECENNIAL PRODUCTS


State Chartbook on Aging, forthcoming. This report presents state-level data for the population aged 65 and older for several key indicators; population, race and ethnic group, marital status, living arrangements, and poverty. Most of the data are from the 1990 Census of Population and Housing for the United States.

3. DATA BASE ON AGING/NATIONAL INSTITUTE ON AGING PRODUCTS

The following reports, articles, and book chapters are based on information contained in the International DataBase on Aging and other related holdings of the International Programs Center, Population Division, Census Bureau. This work is carried out with the support of the National Institute on Aging and is intended to highlight the present and future worldwide dimensions of aging and portray the diversity among nations.


WORK IN PROGRESS

An Aging World 2000, forthcoming. This report gives a cross-national comparison of aging in 52 study countries. It focuses on both the demographic aspect of aging in these countries and the socioeconomic impact of aging. The report highlight projected trends into the 21st century for the world's older population.

Aging in Africa, forthcoming. This report examines the demographic and socioeconomic characteristics of the older population in Sub-Saharan Africa and will highlight the impact of HIV/AIDS on the older populations in these countries.

World Population Profile: 2000, forthcoming. This report provides comprehensive demographic data for all countries and regions of the world. There are two special focus sections in the report, “Child
Mortality in the Developing World" and “Focus of the AIDS Pan-
demic in the 21st Century."

4. THE FEDERAL INTERAGENCY FORUM ON AGING-
RELATED STATISTICS SUMMARY

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

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

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

As part of the Forum's work to improve access to data on the
older population, in 1999, the Census Bureau published a report
entitled DataBase News in Aging, which includes developments in
databases of interest to researchers and others in the field of aging.
Much of the information comes from government-sponsored surveys
and products. All federal agencies are invited to contribute to the
report, which is produced in hard copy and is available on the Cen-
sus Bureau's Internet site.

In 2000 the Forum produced the report, Older Americans 2000:
Key Indicators of Well-Being. This report described the overall sta-
tus of the U.S. population 65 and over. It compiled data to focus
on several important areas in the lives of older people—including
economic status, health status, health risks and behaviors, and
health care.

5. OTHER PRODUCTS

Profile on Racial and Ethnic Diversity Among Older Americans,
forthcoming. This report focuses on racial and ethnic differences in
America's older population using data from the Current Population
Survey (CPS).

AMERICAN HOUSING SURVEY

Computer data tapes and CD-ROM are available for the 1997
survey efforts. The survey is designed to provide information on the
housing situation in the United States. Information is available by age.

**CPS and Survey of Income and Program Participation**

Data for both surveys are available in electronic media.

**Statistical Abstract of the United States: 1999**

As the National Data Book, these annually released products contain an enormous collection of statistics on social and economic conditions in the United States. Selected international data also are included. The abstract appears in both print and CD-ROM versions.

**International Data Base**

The International Data Base (IDB) is a computerized data bank containing statistical tables of demographic and socioeconomic data for all countries of the world. Most demographic information comes from country-specific estimates and projections made by the Census Bureau's International Programs Center. Country-specific data on social and economic characteristics are obtained from censuses and surveys or from administrative records. Country files are regularly updated as new information becomes available. Selected information from the IDB is highlighted in the Census Bureau's various international reports and publications mentioned previously.
ITEM 3—DEPARTMENT OF DEFENSE

ELDERCARE SUPPORT

Military members and their families face unique challenges when facing Eldercare issues. Military members and families are often stationed far away from elderly relatives who may need their assistance. These demands seem to be increasing as life expectancies increase. Military families often find themselves trying to deal long-distance, even from overseas, with finding quality, affordable care for elderly family members. The situation is often further complicated by military family separations that are the norm of military life.

In the 1999 Department of Defense Survey of active duty members, of those responding to the survey, we estimate that 4.1 percent of the force has caregiver responsibilities for elderly loved ones. Of the 4.1 percent, 72 percent of those indicated that they have responsibility for one elder person, 23.5 percent indicated responsibility for 2 elderly persons, and 4.5 percent indicated responsibilities for 3 or more.

The Information and Referral (I&R) function of the Department of Defense Family Support programs is a critical source of information to families struggling to balance the demands of military life with the need to ensure the well-being and safety of elderly parents and loved-ones. Internet resources have proved to be a valuable tool for family support specialists who can research information and help military families start on the right path in sifting through this mountain of information. The I&R specialists often use the Eldercare Locator which directs them to appropriate local resources. The I&R specialists will filter a quantity of information in order to assist the inquiring service member with the appropriate resource and advice. While the assistance family support I&R specialists can provide is limited, they make every effort to connect military families with the best and most reliable resources for making informed choices.

The I&R specialists often receive inquiries about making an elderly loved one a legal dependent of the service member. The specialists will caution the member to carefully consider this option since the elderly loved one may lose state benefits if they relocate with the service member. In addition, if they become a legal dependent of the military person, they are not eligible for TRICARE.

The Family Centers also have a number of useful pamphlets and handouts on eldercare which they provide to military family members seeking assistance for a particular eldercare issue. The Family Centers often work with the local Retired Affairs Offices across the country in sponsoring Retired Affairs Seminars which draw thousands of military retirees and their families. For these seminars,
staff bring in experts to present eldercare topics such as: long-term care insurance, respite care, medical information, social security benefits and eldercare legal issues. These seminars are an important vehicle to update the military retiree community on current eldercare issues.

HEALTH CARE

TRICARE is the health plan for uniformed services beneficiaries. It is a regionally organized managed care program that integrates the military health facilities of the Army, Navy and Air Force and supplements the care these facilities offer with civilian networks of providers. TRICARE offers three choices for health care delivery: TRICARE Prime, TRICARE Extra, and TRICARE Standard. TRICARE Prime, a voluntary enrollment option, offers patients the advantage of primary care management, assistance in making specialty appointments, and additional preventive and primary care services. For eligible beneficiaries, TRICARE Prime generally is the least expensive option.

TRICARE Extra allows eligible beneficiaries to receive an out-of-pocket discount when using preferred network providers. Eligible beneficiaries who do not enroll in TRICARE Prime may participate in Extra on a case-by-case basis just by using network providers. Beneficiaries selecting TRICARE Extra do incur deductibles and co-payments. TRICARE Standard offers comprehensive healthcare coverage from any authorized provider. Beneficiaries selecting this option incur deductibles and co-payments at a slightly higher rate than those selecting TRICARE Extra.

All active duty members enroll in TRICARE Prime without cost to the member. Family members, survivors and retirees under the age of 65 may enroll in TRICARE Prime. Retirees and their family members pay a small enrollment fee and all eligible beneficiaries except active duty members incur nominal co-payments for care received from network providers. Care received in military medical facilities is without cost to beneficiaries; for those not enrolled in TRICARE Prime, care in military medical facilities is received on a space available basis.

During this reporting period, the law stipulated that military retirees and their families up to age 65 are eligible for the three TRICARE options. Military retirees and their dependents over the age of 65 may not participate in TRICARE, but they are eligible for care in military medical facilities on a space available basis. Included in this space available coverage are prescription drugs provided the needed medications are on the facility's formulary. Additionally, the Department of Defense sought ways to enhance its services to its over-65 beneficiaries through a number of demonstration programs. Specifically, the Department tested alternatives to expand healthcare coverage to Medicare-eligible beneficiaries through Medicare reimbursement of military medical facilities, opening access to the Federal Employee Health Benefit Program, expanding pharmacy options, and offering supplemental coverage to Medicare.

Implementation of the Floyd D. Spence National Defense Authorization Act of fiscal year 01 will directly impact these demonstration programs and significantly change the healthcare coverage of-
ferred by the Department of Defense to its Medicare eligible beneficiaries. This new legislation is the most dramatic modification to military health care coverage since the establishment of the Civilian Health and Medical Program of the Uniformed Services in 1965. By April 2001, the Department of Defense will offer these senior beneficiaries the same prescription drug benefit enjoyed by other uniformed services beneficiaries. They will continue to use the military pharmacies with no cost for medications; and on April 1, 2001, they will be entitled to use the mail order pharmacy program, network retail and non-network retail pharmacies. Medications through these sources will require a nominal copayment of $3 for generic and $9 for branded medications; by mail order patients may receive up to a 90-day supply for this amount, and in the network retail pharmacies they may receive up to a 30-day supply for this amount. The non-network retail pharmacies will cost a bit more. Also in the next year, senior beneficiaries will become eligible for TRICARE for Life benefits, the most significant of which is the secondary pay program. Beginning October 1, 2001, TRICARE will supplement Medicare benefits of these uniformed services beneficiaries, and, in most cases, with no additional claims processing required by the patient. To participate, these beneficiaries must be eligible for Medicare Part A and enrolled in Medicare Part B. They may continue to seek care from their Medicare providers and have TRICARE pick up the cost of their deductible, co-payments and other costs not paid by Medicare. TRICARE will also cover any TRICARE benefit that Medicare does not offer. Out-of-pocket expenses for these dual eligible beneficiaries will be a nominal copayment for medications and Medicare Part B fees. This legislation brings to the senior military retirees and their dependents a health benefit that is unparalleled. It provides low-cost access to an extraordinary range of healthcare benefits, and offers choice in selection of providers. This legislation brings healthcare coverage by the Department of Defense as an entitlement to our senior beneficiaries.
ITEM 4_DEPARTMENT OF EDUCATION

Literacy Education for Senior Adult Learners

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

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

In program year 1999-2000, more than 2.8 million adult learners were served through the Adult Education and Family Literacy Act programs nationwide. Of these learners, approximately 123,982 were 60 years of age or older. Programs are offered to older adults through local education agencies, community colleges, nursing homes, senior centers, private homes, community-based organizations, churches, and libraries and include adult basic education, adult secondary education, and English literacy classes.

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

Division of Adult Education and Literacy, Office of Vocational and Adult Education
U.S. Department of Education
September 2001
According to the National Adult Literacy Survey (NALS) report, Literacy of Older Adults in America, older adults are projected to outnumber those under age 18 by the year 2030. A challenge of our society is to find new and better ways to enhance the opportunities of older adults to live full, independent, and productive lives through their later years.

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

Three major factors that affect the language and literacy instruction for older learners are as follows according to the Growing Old in America: Learning English Literacy in the Later Years. ERIC Digest, 1993.

- **Physical factors.** Because of decline in visual and hearing abilities for some learners, it is important to create a comfortable learning environment that compensates for these impairments. This may involve using educational materials with large print, using well-lighted space, and eliminating background noise;
- **Cognitive factors.** Older learners have strategies for learning that they have been using for more than half a century. For this reason, it is important to observe how they learn best, to be flexible in teaching approach, and to draw on their life experiences; and
- **Social factors.** Older learners may be uncomfortable in mixed-generational classes where the needs and pace of other learners do not match their own. In addition, older learners may be motivated primarily by the desire to break their social isolation and to spend time with peers engaged in the positive endeavor of lifelong learning.

According to the Adult Education Annual Performance and Statistical Reports for program year 1999, the states with the highest enrollment for adults aged 60 years or more were: California, 25,804; Florida, 18,113; South Carolina, 11,625; New York, 8,221; and Ohio 4,402. In Florida, the State Legislature outlined in 1999 a process on how funding should be allocated to providers. The primary purpose of the funds is to provide adults with disabilities and senior citizens the opportunity for enhancement of skills that is consistent with their abilities and needs through the Education for Senior Adult Learners program. These older adult learners are individuals 55 years of age or older. In addition, 18,113 adults who were age 60 or older participated in the Florida Adult Education Act program. Louisiana experienced an 18 percent increase in the...
Literacy Education for Senior Adult Learners

The number of older learners aged 60 and older in their adult education program during that period.

The adult education program addresses the needs of older learners 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 adults 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.

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

An emerging area for senior adult learners served in the Adult Education and Family Literacy Program is health literacy. A recent Health Literacy Symposium, Health Literacy: Implications for Seniors, held in Washington, DC, was designed to engage states and organizations in dialogues to address strategies to help older learners with limited basic skills and their families to communicate more effectively with their health-care providers. Senior learners who have low literacy skills have difficulty navigating the health-care system because they are more likely to take a variety of medications, have difficulty understanding prescription labels and are less likely to communicate with their health-care provider concerning their illness. A report summary on the symposium will be completed in the fall of 2001.

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

Division of Adult Education and Literacy, Office of Vocational and Adult Education
U.S. Department of Education
September 2001
Postsecondary Education

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

In fiscal year 2000, $44 billion was made available to an estimated 7.8 million students through the student financial assistance programs authorized by Title IV of the Higher Education Act of 1965, as amended. There are no age restrictions for participation in the Title IV programs. An estimated 6.4 percent, or nearly 500,000 recipients, were age 40 or older.

The Federal TRIO programs fund postsecondary education outreach and student support services that encourage individuals from disadvantaged backgrounds to enter and complete postsecondary education. 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 student-centered programs, OPE administers the Fund for the Improvement of Postsecondary Education (FIPSE) which supports innovative projects, including some designed to meet the needs of older Americans. Among these are current projects at the Albany Law School, the University of Findlay, and UCLA. These projects, respectively, offer mediation assistance for tenants of the Albany Housing Authority, many of whom are elderly; develop an Intergenerational Associate Degree Program for individuals who work simultaneously with young children and senior adults; and revamp the curriculum for medical students to incorporate geriatric content in a greater number of required courses.

The Learning Anytime Anywhere Partnerships (LAAP) program authorizes a new grant competition to promote student access to high quality technology-mediated learning opportunities that are not limited by the constraints of time and place. For fiscal year 2000, the Congress appropriated approximately $23 million to fund partnerships among colleges, industry, community organizations, and others, whose projects will have a national or regional impact and will encourage innovative solutions to the biggest challenges facing technology-mediated learning. The LAAP program will expand access to all learners, young and old, who seek undergraduate education, career-oriented lifelong learning, or who can benefit from the removal of time and place constraints.
I. Status of the Department of Education's Implementing Regulation

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

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

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

II. Age Discrimination Act Implementation

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

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

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

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

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

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

III. Complaints

(a) Receipts

OCR received 694 age complaints in Calendar Years 1999-2000. Of these, 127 were age-only complaints and 567 were multiple bases complaints. As shown on Table 1, 544 of the 694 receipts were processed in OCR and 150 were referred to other Federal agencies for processing. The most frequently cited issues in complaint receipts involving students were "health benefits and
services, "procedural requirements," "academic evaluation/grading," "selection for enrollment," "application for admission," "discipline," and "harassment." The most frequently cited issues in complaint receipts involving employees were "demotion/dismissal/disciplinary action," and "harassment."

The most frequently cited issues in complaint receipts involving employees were "demotion/dismissal/disciplinary action," and "harassment."

(b) Resolutions

During Calendar Years 1999-2000, OCR resolved 700 age-based complaints, including 122 age-only complaints and 578 multiple-based age complaints.

The resolution of the complaints are shown in Table 2.

**TABLE 1: CALENDAR YEARS 1999-2000 AGE-BASED COMPLAINT RECEIPTS**

<table>
<thead>
<tr>
<th>processed by OCR</th>
<th>544</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred to FMCS</td>
<td>96</td>
</tr>
<tr>
<td>Referred to EEOC</td>
<td>49</td>
</tr>
<tr>
<td>Referred to Other Federal Agencies</td>
<td>5</td>
</tr>
</tbody>
</table>

Total Receipts 694

<table>
<thead>
<tr>
<th>Table 2: Calendar Years 1999-2000 Age-Based Complaint Resolutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate for OCR Action</td>
</tr>
<tr>
<td>OCR Facilitated Change</td>
</tr>
<tr>
<td>No Change Required</td>
</tr>
</tbody>
</table>

Total Resolutions 700
Of the 700 complaint resolutions, 412 were resolved because they were "Inappropriate for OCR Action." These would include a resolution achieved by (1) referral of a complaint to another federal agency; (2) lack of jurisdiction over recipient or allegation contained in a complaint; (3) complaint was not filed in a timely manner; (4) complaint did not contain sufficient information necessary to proceed; (5) complaint contained similar allegations repeatedly determined by OCR to be factually or legally insubstantial or were addressed in a recently closed OCR complaint or compliance review; (6) subject of a complaint was foreclosed by previous decisions by federal courts, Secretary of Education, Civil Rights Reviewing Authority, or OCR; (7) there was pending litigation raising the same allegations contained in a complaint; (8) allegations were being investigated by another federal or state agency or through a recipient's internal grievance procedures; (9) OCR treated the complaint as a compliance review; (10) allegation(s) was moot and there were no class implications; (11) complaint could not be investigated because of death of the complainant or injured party or their refusal to cooperate; and (12) complaint was investigated by another agency and the resolution met OCR standards.

OCR Facilitated Change

There were 126 complaints resolved because "OCR Facilitated Change." These would include a resolution achieved by (1) a recipient resolving the allegations contained in the complaint; (2) OCR facilitating resolution between the recipient and complainant through Resolution between the Parties; (3) OCR negotiating a corrective agreement resolving a complainant's allegations; and (4) settlement achieved after OCR issued a letter of findings.

No Change Required

In 162 complaints, there was "No Change Required." These would include a resolution achieved by (1) complainant withdrawing his or her complaint without benefit to the complainant; (2) OCR determining insufficient factual basis in support of complainant's allegations; (3) OCR determining insufficient evidence to support a finding of a violation; and (4) OCR issuing a no violation letter of findings.
The National Institute on Disability and Rehabilitation Research (NIDRR), authorized by Title II of the Rehabilitation Act, has specific responsibilities for promoting and coordinating research that relates directly to the rehabilitation of disabled persons. The mission of NIDRR is to generate, disseminate and promote knowledge that will improve the lives of persons with disabilities in their communities. NIDRR conducts comprehensive and coordinated programs of research and related activities to assist in the achievement of the full inclusion, social integration, employment, and independent living of people with disabilities.

NIDRR's research focus includes such areas as: employment outcomes, health and function, technology for access and function, independent living and community integration, associated disability research areas, knowledge dissemination and utilization, and capacity building for rehabilitation and international activities.

NIDRR's research is conducted via a network of individual research projects and centers of excellence throughout the country. Most NIDRR grantees are universities or providers of rehabilitation or related services. NIDRR's largest funding programs are the Rehabilitation Research and Training Centers (RRTCs) and Rehabilitation Engineering Research Centers (RERCs). NIDRR also makes awards for information dissemination and utilization centers and projects, field initiated projects, research and development projects, advanced research training projects, Mary E. Switzer fellowships, small business innovative research, and model systems of care. NIDRR also administers the State Technology Assistance Projects and the Disability and Business Technical Assistance Centers. Additional information on NIDRR programs is available on the web at http://www.ed.gov/offices/OSERS/NIDRR from the National Center for the Dissemination of Disability Research (NCDDR) at http://ncddr.org and also from the National Rehabilitation Information Center (NARIC) at http://www.naric.com

Disability and Rehabilitation Research Projects

The Disability and Rehabilitation Research Projects (DRRP) program allows for projects with special emphasis on research, demonstrations, training, dissemination, utilization, and technical assistance. Projects may include combinations of these activities. True to the mission of NIDRR, these projects may develop methods, procedures, and rehabilitation technology to assist in achieving the full inclusion and integration into society, employment, independent living, family support, and economic and social self-sufficiency of individuals with disabilities, especially individuals with the most significant disabilities, or to improve the effectiveness of services authorized under the Rehabilitation Act.

Model Systems

NIDRR administers programs that have become world-renowned model systems of care for persons with spinal cord injuries, burns, and traumatic brain injuries. The Model Systems establish innovative projects for the delivery, demonstration, and evaluation of comprehensive medical, vocational, and other rehabilitation services. The work of the Model Systems begins at the point of injury and ends with successful re-entry into full community life.

Advanced Rehabilitation Research Training Projects

The Advanced Rehabilitation Research Training (ARR'T) Program (formerly known as the Research Training Grants Program) expands the capacity of the field of rehabilitation research by providing advanced training opportunities. These projects provide rehabilitation research training for persons with clinical or other experience, who may be lacking certain formal research training. Grants are made to institutions to recruit qualified persons with doctoral or similar advanced degrees with clinical,
management, or basic science research experience, and prepare them to conduct independent research on problems related to disability and rehabilitation. This research training may integrate disciplines, teach research methodology in the environmental or new paradigm context, and promote the capacity for Disability Studies and rehabilitation science. These training programs must operate in interdisciplinary environments and provide training in rigorous scientific methods.

Rehabilitation Research and Training Centers
NIDRR’s Rehabilitation Research and Training Centers (RRTCs) conduct coordinated and integrated advanced programs of research targeted toward the production of new knowledge, which may improve rehabilitation methodology and service delivery systems, alleviate or stabilize disabling conditions, or promote maximum social and economic independence for persons with disabilities. Operated in collaboration with institutions of higher education or providers of rehabilitation or other appropriate services, RRTCs serve as centers of national excellence in rehabilitation research. Also, they are national or regional resources for research information for individuals with disabilities and the parents, family members, guardians, advocates, or authorized representatives of the individuals. These centers also conduct related training programs, including graduate, pre-service and in-service training. The centers also disseminate and promote the utilization of research findings.

Rehabilitation Engineering Research Centers
Rehabilitation Engineering Research Centers (RERCs) conduct programs of advanced research of an engineering or technical nature designed to apply advanced technology, scientific achievement, and psychological and social knowledge to solve rehabilitation problems and remove environmental barriers. Each center is affiliated with one or more institutions of higher education or nonprofit organizations. The RERCs’ work in a rehabilitation setting provides an environment for cooperative research and the transfer of rehabilitation technologies into rehabilitation practice. Involved at both the individual and systems levels, RERCs seek to find and evaluate the newest technologies, products, and methods that ultimately can benefit the independence of persons with disabilities and the universal design of environments for all people of all ages. The centers also exchange technical and engineering information worldwide and improve the distribution of technological devices and equipment to individuals who need them.

State Technology Assistance Projects
This program supports statewide, consumer-driven, technology-related assistance networks for individuals of all ages and disabilities. States and territories are eligible to apply for one grant per entity, which spans a total of ten years of Federal funding. The first phase is a development grant and lasts for three years. The second phase is known as the first extension and can last for two more years. The third and final phase is known as the second extension and lasts for five additional years. The Assistive Technology Act of 1998 (AT Act) authorized three additional years for States that have completed ten years, at a reduced funding level.

Fellowships
Fellowships, named for the late Mary E. Switzer, give individual researchers the opportunity to develop new ideas and gain research experience. There are two levels of fellowships: Distinguished Fellowships and Merit Fellowships. Distinguished Fellowships go to individuals of doctorate or comparable academic status, who have had seven or more years of experience relevant to rehabilitation research. Merit Fellowships are given to persons with rehabilitation research experience, but who do not meet the qualifications for Distinguished, usually because they are in earlier stages of their careers. Fellows work for one year on an independent research project of their design.

ADA Technical Assistance Projects
NIDRR administers a network of grantees to provide information, training, and technical assistance to businesses and agencies with responsibilities under the Americans with Disabilities Act (ADA). Ten
regional Disability and Business Technical Assistance Centers (DBTACs) are funded to provide information and referral, technical assistance, public awareness, and training on all aspects of the ADA. Several National Training Projects target particular groups, organizations, or subject areas for ADA training and the ADA Technical Assistance coordinator contract assists all of the grantees with their activities.

Small Business Innovative Research
Small Business Innovative Research (SBIR) grants help support the production of new assistive and rehabilitation technology. This two-phase program takes a product from development to market readiness.

NIDRR Contracts
Through its contracts, NIDRR seeks improved methods, systems, products, and practices to add to its work. The contracts are for specific activities related to management, research, and information dissemination.

Employment Outcomes
NIDRR seeks to improve employment outcomes for people with disabilities by funding research into a wide spectrum of employment and disability issues, including economics; Federal, State, and community employment programs; accommodation; technology; education; and ergonomics and the work environment.

1. Title: Research and Training Center on Maintaining the Employment Status and Addressing the Personal Adjustment Needs of Individuals Who Are Hard of Hearing or Late Deafened
   Address: California School of Professional Psychology-San Diego
   Principal Investigator: Raymond J. Trybus, PhD
   Abstract: This Center implements a series of projects involving hearing loss and workplace issues through collaboration with business, professional, and consumer organizations. The primary target populations are accessed through a network of schools and state agencies. Project examples include the identification of factors that have a negative impact on the employment status of people with hearing impairments. Data sources include affiliations through career planning at schools, patients in Veteran's Affairs hospitals, local minority communities, the Council of Latino Agencies, Howard University, and the University of Arizona Research and Training Center on Native Americans. Interventions include review of assistive technology, career planning, mental health, and "rights training" in relation to the ADA. The project provides workshops for families and employers, establishes support groups for people with cochlear implants, and creates a family life center project: a "one stop shopping" facility where individuals with hearing loss can obtain a variety of interventions, information, and guidance regarding services and devices. Dissemination includes information on the ADA and Tech Act. Training targets groups, including employers, consumers, and human resource organizations.

2. Title: Rehabilitation Research and Training Center on Blindness and Low Vision
   Address: Mississippi State University
   Principal Investigator: J. Elton Moore, EdD
   Abstract: The Center conducts a series of research, training, and dissemination projects relating to blindness and low vision, using a multidisciplinary strategy. The project works to investigate and document
employment status, identify barriers to employment and techniques and reasonable accommodations to overcome these barriers, identify training needs in the Business Enterprise Program, and develop and deliver training programs. Training and dissemination activities include an information and referral center, national conferences, inservice training and technical assistance, advanced training for practitioners, advanced training in research, and publication and distribution of a variety of materials in accessible media.

3. Title: Rehabilitation Research and Training Center on Rural Rehabilitation Services  
   Address: University of Montana  
   Principal Investigator: Tom Seekins, PhD  
   Abstract: This RRTC conducts and disseminates research and provides training that improves the capacity of rural environments to support people with disabilities in living and working independently. Rural Employment and Economic Development Projects concentrate on employment and vocational rehabilitation service needs, including self-employment as a vocational option for rural people with disabilities. These project components explore the role of rural economic development in meeting the needs of people with disabilities, and ways that rural citizens with disabilities can assume community leadership. Rural Community Development, Independent Living, and Telecommunications components look at how rural independent living services, transportation services, accessible housing, and telecommunications are funded, and ways to improve rural access to these services. Health Care projects conduct research to improve access to rural health care services, including health promotion activities that might reduce the incidence of secondary conditions. American Indian project components work with American Indian tribes to develop culturally sensitive ways to discuss disability issues, such as ensuring environmental, programmatic, and social access for tribal members with disabilities; and developing appropriate long-term care options for elders and people with disabilities or chronic conditions.  
   Methodology: the RR.TC approaches its research areas from a community psychology perspective. Cross-cutting measures of importance include participation, engagement, and a psychological sense of community.

4. Title: Rehabilitation Research and Training Center on Drugs and Disability  
   Address: Wright State University  
   Principal Investigator: Dennis C. Moore, EdD  
   Abstract: This project conducts epidemiological and evaluative studies of substance abuse and substance abuse services for consumers of state vocational rehabilitation (VR) programs. Activities address substance abuse as it co-exists with other disabilities; all components of the RRTC are designed to interrelate and synergistically build on each other. The research components include longitudinal and multisite studies to address more advanced research questions, and quantitative/qualitative methods to investigate vocational rehabilitation issues for people with HIV. The training components use a variety of materials, venues, and trainers in order to address needs within pre- and inservice populations. Training and dissemination components also include extensive use of distance learning media, especially use of the Internet to provide professionals and consumers with timely and relevant information. Stakeholder concerns and interests are addressed by several mechanisms, including a formal subcontract with the National Association on Alcohol, Drugs, and Disability. This project is one component of a number of state and federally funded entities in the SARDI (Substance Abuse Resources & Disability Issues) center. Multiple collaborations are delineated with federal agencies, including the Substance Abuse and Mental Health Services Administration, as well as professional and consumer organizations, national clearinghouses, other RRTC's, and institutions of higher education.
Health and Function

NIDRR's research focus for health and function addresses problems in individual care, services, and supports for people with disabilities. Research topics include: medical rehabilitation; health and wellness programs; service delivery; short and long-term interventions; systems research; and new and emerging disabilities.

1. Title: Rehabilitation Research and Training Center on Secondary Conditions of Spinal Cord Injury: Promoting General Health, Well-Being, and Community Integration Through Home-Based, Self-Directed Care
   Address: University of Alabama/Birmingham

   Principal Investigator: Amie B. Jackson, MD

   Abstract: This RRTC conducts coordinated, integrated, and advanced research in the prevention and treatment of secondary conditions of Spinal Cord Injury (SCI). The eight interrelated projects include: (1) determine the effectiveness of cranberry pills to prevent and treat urinary tract infections (UTIs); (2) evaluate interventions used to prevent and treat UTIs in people with SCI using the University of Alabama/Birmingham SCI Urologic Database; (3) study the relationship of beverage consumption and water hardness to the risk of urinary tract stones; (4) address pain following SCI by evaluating SCI pain classification systems, studying the effectiveness of gabapentine and methadone in relieving certain types of pain, and developing a method to target those at risk; (5) determine the duration of immune response to pneumococcal vaccine and the need for revaccination; (6) evaluate a screening tool to identify people with SCI at high risk for sleep apnea, and evaluate treatments to improve their health and quality of life; (7) study the use of telemedicine to reduce depression and secondary conditions among people with SCI and their caregivers through problem solving interventions; and (8) evaluate and adapt a nationally recognized weight-loss project for a population of people with SCI. A collaborative project with another Center evaluates a computer-based risk assessment and feedback tool for assessing secondary conditions. This RRTC provides training on research methodology and information based on research activities to people with disabilities, their families, service providers, and rehabilitation professionals. Information is disseminated through print media (information sheets and newsletters), electronically (through the Internet and a fax information service), and through technical assistance.

2. Title: Rehabilitation Research and Training Center in Neuromuscular Diseases
   Address: University of California/Davis

   Principal Investigator: Craig McDonald, MD

   Abstract: This project conducts research designed to enhance the quality of life of people with neuromuscular diseases. Through multidisciplinary research and a comprehensive program of training and information services, the Center serves consumers, physicians, and health care workers. Program areas include: Interventions to preserve functional capacity including management of weakness and respiratory insufficiency due to muscle wasting, exercise interventions, treatment of exercise related fatigue, pain interventions, lower limb orthotic interventions, and dietary interventions; interventions to enhance community integration, including incorporating goal-based approaches to community integration, facilitation of healthy adaptation through development of stress management and coping skills, and resource training for acquisition of disability-related information through the Internet; genetic testing, information, and research; and training and information services.
Title: Aging with Spinal Cord Injury (SCI)
Address: Los Amigos Research and Education Institute, Inc.
Principal Investigator: Bryan J. Kemp, PhD; Robert L. Waters, MD
Abstract: The Rehabilitation Research and Training Center (RRTC) on Aging with Spinal Cord Injury (SCI) is devoted to understanding the unique problems people with spinal cord injury experience as they age. Topics of research include: the natural course of aging with SCI, cardiovascular disease (CVD) and risk factors of CVD, pulmonary aspects of aging with SCI, bone loss, functional changes associated with age and duration of SCI, maintaining employment, treatment of depression, and informal and formal care systems for people aging with SCI. The RRTC has several goals for education, training, dissemination, and utilization: (1) to train current and future health, allied health, and rehabilitation professionals about aging with SCI; (2) to train and develop rehabilitation research professionals in the area of aging with SCI; (3) to improve adoption and use of RRTC-developed knowledge and treatment regimens by health and rehabilitation professionals; (4) to disseminate information about aging with SCI to people with SCI and their families; and (5) to train graduate students and medical students in advanced knowledge and techniques from studies about aging with SCI. Training and dissemination occurs through advanced and continuing education courses, local and national conferences, workshops, publications in professional and consumer oriented journals, and the Internet.

Title: Rehabilitation Research and Training Center on Aging with a Disability
Address: Los Amigos Research and Education Institute, Inc.
Principal Investigator: Bryan J. Kemp, PhD
Abstract: This project assists people who are aging with a disability by conducting a series of research studies using a database of over 1,000 people who represent a variety of disabilities (for example, cerebral palsy, rheumatoid arthritis, stroke, spinal cord injury, polio). Research projects include: (1) the natural course of aging with a disability, (2) assisting family caregivers of people aging with a disability, (3) improving community integration and adjustment, (4) preventing secondary complications such as diabetes and thyroid disorders, (5) improving bone density through a regimen of exercise and vitamins, and (6) understanding the role of assistive technology (AT) and environmental interventions (EI) in maintaining functional performance. Training, dissemination, and technical assistance activities focus on students and professionals in the health, allied health, and rehabilitation fields, as well as people aging with a disability and their families. Goals include training rehabilitation researchers knowledgeable about aging with a disability, improving the adoption and utilization of RRTC-developed assessment and treatment regimens by health and rehabilitation professionals, and disseminating information about aging with a disability to people with disabilities and their families. Training and dissemination occurs through advanced and continuing education courses, local, national, and international conferences, workshops, publications in professional and consumer oriented journals, and the Internet.

Title: Managed Health Care for Individuals with Disabilities
Address: MedStar Research Institute NRH Center for Health & Disability Research
Principal Investigator: Gerben DeJong, PhD
Abstract: This project provides national leadership on the major health service and health policy issues facing consumers with disabilities in managed health care arrangements. It: (1) conducts research;
(2) prepares special policy analyses; (3) hosts forums for discussion; (4) presents expert testimony to Congress and governmental agencies; (5) publishes in the health policy, consumer, and trade literature; (6) trains graduate students with disabilities in health service research; and (7) disseminates findings to diverse consumer, provider, payer, academic, and policy-making audiences. On the state and national levels the project seeks to make managed care and the larger health care system more responsive to the needs of people with disabilities by acting as a catalyst for the development of new ideas. Program partners are the National Rehabilitation Hospital Research Center (NRH-RC) in Washington DC and the Independent Living Research Utilization (ILRU) center in Houston Texas.

6. Title: Rehabilitation Research and Training Center on Aging with Developmental Disabilities
   Address: University of Illinois at Chicago
   Principal Investigator: Tamar Heller, PhD; David Braddock, PhD
   Abstract: This project promotes the independence, productivity, community inclusion, full citizenship, and self-determination of older adults with mental retardation through a coordinated program of research, training, technical assistance, and dissemination activities. The research program aims to increase knowledge about the changing needs of older adults with mental retardation and their families as they age, and to increase the effectiveness of innovative approaches, public policies, and program interventions that provide needed supports and that promote the successful aging of these adults and their families. It examines how age-related changes in physical and psychological health affect the ability to function in the community, including home, work, and leisure settings. The research program also identifies best practices and current public policies that support these adults and their families. The primary goal is to translate the knowledge gained into practice through broad-based training, technical assistance, and dissemination to people with mental retardation, their families, service providers, administrators and policy makers, advocacy groups, and the general community. Dissemination vehicles include the Center's Clearinghouse, Web page, and newsletters.

7. Title: Rehabilitation Research and Training Center on Stroke Rehabilitation
   Address: Rehabilitation Institute Research Corporation
   Principal Investigator: Elliot J. Roth, MD
   Abstract: This project tests the effectiveness of several stroke rehabilitation strategies and tactics, trains stroke survivors and professionals, and disseminates knowledge relevant to stroke care. In order to extend the knowledge base of stroke rehabilitation, produce changes in clinical practice, and enhance the quality of life of stroke survivors and their families, the Center: (1) identifies, develops, and evaluates rehabilitation techniques in order to address coexisting and secondary conditions and improve outcomes for all stroke patients; (2) develops and evaluates standard aerobic exercise protocols; (3) identifies and evaluates methods to identify and treat depression and other psychological problems associated with stroke; (4) determines the effectiveness of stroke prevention education provided in a medical rehabilitation setting; (5) evaluates the impact of changes in diagnosis and medical treatment of stroke on rehabilitation needs; (6) evaluates long-range outcomes for stroke rehabilitation across different treatment settings; (7) evaluates the impact of stroke practice guidelines on delivery and outcomes of rehabilitation services; (8) provides training on new approaches, innovations, and the specialized principles and practices of rehabilitation care of individuals with stroke; (9) provides applied research experience and training in research principles and methods; (10) disseminates information of new developments in the area of stroke care and research to
people with stroke and their families, rehabilitation professionals, and service providers; and (11) conducts a state-of-the-science conference. The Center has a large database of information regarding stroke rehabilitation patients and continues ongoing systems and activities to collect and analyze data concerning stroke impairment, disability, and social functioning.

8. Title: Missouri Arthritis Rehabilitation Research and Training Center (MARRTC)
Address: University of Missouri/Columbia
Principal Investigator: Jerry C. Parker, PhD
Abstract: MARRTC helps to prevent and manage disability in people with arthritis and related musculoskeletal disease by providing leadership at the national level, through three strategies: (1) MARRTC conducts state-of-the-art rehabilitation and health services research that addresses the needs of people with arthritis and related musculoskeletal diseases in the following areas: exercise and fitness, interventions for psychological well-being and pain, job accommodations and employment, and health and wellness, using participatory action research (PAR) strategies to emphasize the inclusion of consumers in all phases of the research process; (2) MARRTC provides training for physicians and other health care professionals in the rehabilitative aspects of rheumatologic practice, including university-based programs, national presentations, research capacity-building, and publications aimed at improving clinical skills; (3) MARRTC disseminates rehabilitation research and technology transfer for the empowerment of people with arthritis to help them to minimize disability, maintain employment, and improve functional status.

9. Title: Multiple Sclerosis Rehabilitation Research and Training Center
Address: University of Washington
Principal Investigator: George H. Kraft, MD
Abstract: This Center promotes health and wellness of people with Multiple Sclerosis (MS) and improves their functioning and employment status. Fundamental to the project is a health survey administered to people with MS throughout the Northwest region. Information from the survey is fed into six project components: (1) promoting wellness among people with MS through brief counseling methods; (2) improving the functioning of people with MS through three studies: improving psychological distress using pharmacological intervention, evaluating the combined effect of cooling and exercise on performance, and improving function through cognitive rehabilitation interventions; (3) exploring the employment status of people with MS; (4) designing practical interventions and workplace modifications; (5) studying the interaction between aging and MS; and (6) exploring the effects of gender, culture, socio-economic status, ethnicity, place of residence, and insurance coverage on people with MS, in regard to symptomology and response to treatments. Researchers develop and apply interventions and conduct follow-up surveys to evaluate the effectiveness of the intervention strategies. This Center collaborates with the RRRTC on Substance Abuse, the Consortium of MS Centers, the National MS Society, and the MS Association of America.
10. Title: Exercise and Recreation for Individuals with a Disability: Assessment and Intervention  
   Address: Rehabilitation Institute of Chicago  
   Principal Investigator: Jeffery Jones  
   Abstract: This project demonstrates that participation in exercise and physical activity improves function, facilitates community reintegration, and enhances the quality of life of people with disabilities. The project: (1) investigates the long-term effects of an exercise fitness program on the physiology, metabolic performance, and quality of life of people with spinal cord injury, stroke, and cerebral palsy; (2) examines the role of self-efficacy in maintaining participation in an exercise fitness program; (3) describes the types and frequency of recreation and fitness activities among people who have had a stroke, people with spinal cord injury, and people with cerebral palsy; (4) examines the relationships between participation in recreation and exercise programs and health status, life satisfaction, and depression in the above populations; and (5) delineates barriers and deterrents to participation in recreation and exercise programs that exist for a variety of disability groups.

11. Title: Treatment of Shoulder Dysfunction in Polio Survivors and Elderly Adults with Lower Extremity Impairment  
   Address: MossRehab.  
   Principal Investigator: Mary G. Klein, PhD  
   Abstract: This project demonstrates how a well-structured exercise program can help to alleviate shoulder symptoms in polio survivors. Research is needed to determine the effectiveness of treatment modalities, such as exercise, on shoulder overuse disorders in polio survivors and other populations with lower extremity impairments. Previous research has determined that shoulder pain is one of the most frequent overuse symptoms seen among post-polio survivors. Additionally, elderly adults who have lower extremity impairments, but no history of polio, also develop overuse symptoms. This research uses a predictive model of shoulder pain that demonstrated that lower extremity weakness and weight were associated with the presence of shoulder overuse symptoms, thus suggesting that these symptoms may arise from use of the upper extremities to compensate for lower extremity weakness during transfers, stair climbing, and other activities. Exercise training is a potential means of reducing the burden of both primary and secondary impairments in post-polio and elderly populations with significant lower extremity weakness, and an effective treatment for improving function and quality of life. Other populations with lower extremity weakness who may benefit from this research include those with muscular sclerosis or incomplete spinal cord injuries.

12. Title: Rocky Mountain Regional Spinal Injury System  
   Address: Craig Hospital  
   Principal Investigator: Daniel P. Lammertse, MD  
   Abstract: This project is a research and demonstration model of a comprehensive service-delivery system from point of injury through intensive and acute medical care, rehabilitation management, and long-term community follow-up. The scope of work emphasizes collaborative clinical research to solve the medical management and acute rehabilitation problems of spinal cord injury. The model system concept has been maintained for continued study of service delivery.
13. Title: Marketing Health Promotion, Wellness, and Risk Information to Spinal Cord Injury Survivors in the Community
   Address: Craig Hospital
   Principal Investigator: Gale Whiteneck, PhD

   Abstract: Building on experience gained from the RRTC in Aging with Spinal Cord Injury (SCI) at Craig Hospital, this project offers health promotion, wellness, and risk information to SCI survivors. Recent reports from survivors, caregivers, and researchers are demonstrating that SCI is not the unchanging disability it was once thought to be; over time many survivors face medical complications, psychosocial concerns, and diminishing quality of life. Although many of these adverse outcomes could be averted or lessened with active health maintenance and wellness strategies, SCI survivors in the community face a dearth of the information they need to make such positive lifestyle choices. This project creates: (1) a Wellness and Risk Assessment Profile that provides individualized SCI-specific health risk appraisals via the Internet; (2) regular health information columns in three widely-read consumer journals; (3) custom brochures targeting the prevention and health promotion needs of SCI survivors in the community; (4) a handbook offering information about making wise health and lifestyle choices for recently injured SCI survivors; (5) a handbook targeting caregivers of SCI survivors; and (6) a curriculum for people who teach and provide support to caregivers.

14. Title: Toward a Risk Adjustment Methodology for People with Disabilities
   Address: Medlantic Research Institute
   Principal Investigator: Gerben DeJong, PhD

   Abstract: This knowledge dissemination project provides information to health care policymakers and payers that advances development of a risk adjustment system for working- and retirement-age people with disabilities. Risk adjustment reduces the incentive for risk selection and promotes access to needed health services. To achieve this goal, the project assembles a panel of leading experts on risk adjustment and disability to guide the development of a consensus report that: (1) details the state of science in risk adjustment, (2) evaluates the appropriateness of health care outcome indicators for people with physical and mental disabilities, and (3) provides a set of recommendations for modifying and implementing risk adjustment methodologies that enhance access to health services for people with disabilities enrolled in public sector and private sector health plans.

15. Title: Aging and Adjustment After Spinal Cord Injury: A Twenty-Five-Year Longitudinal Study
   Address: Shepherd Center, Inc.
   Principal Investigator: J. Stuart Krause, PhD

   Abstract: People are now living longer after spinal cord injury (SCI), yet only limited research has addressed issues of aging and life adjustment after SCI. The purpose of this study is to implement the fifth stage of data collection to a 25-year longitudinal study that has traced the course of life adjustment after SCI over the past two decades. The unique contributions of this data collection include: (1) inclusion of nearly 100 participants who have been injured more than 30 years, (2) first-time longitudinal comparisons among large samples of women and racial/ethnic minorities (including more than 200 minority participants, 63 of whom are women), and (3) use of consumer advisory groups to help to identify factors accounting for change.
Address: Rehabilitation Institute Research Corporation
Principal Investigator: Julius Dewald, PhD

Abstract: This study investigates use of a novel computer-assisted isometric training regime to overcome abnormal movement synergies following hemiparetic stroke. In most stroke patients, these synergies are reflected, in part, by the existence of abnormal coordination between the activations of shoulder and elbow muscles. These stereotypic movement patterns found in stroke survivors are functionally disabling and often debilitating, yet are not well understood in the rehabilitation setting. Current neurotherapeutic approaches to the amelioration of these abnormal patterns have produced, at best, limited functional recovery. Therefore, the objectives of this investigation are to evaluate and demonstrate the usefulness and effectiveness of a novel static training regime to enhance the quality of life of consumers with stroke. The effect of two training regimes on functional arm movement are being investigated in 40 hemiparetic stroke subjects. The first protocol uses a general, classical strengthening regimen to increase torque production in specific directions. The second approach strengthens subjects using torque combinations that require the subject to deviate progressively from their abnormal torque synergies. Assessment of the effectiveness of these two protocols is based on quantitative comparisons of voluntary upper limb movements performed pre- and post-training.

17. Title: Secondary Prevention Trial of Exercise and Diet for Improvement of Physical Fitness, Independence, and Overall Health in Adult Paraplegics
Address: University of Illinois/Chicago
Principal Investigator: Carol Braunschweig, PhD

Abstract: This project investigates the impact of an exercise intervention coupled with nutrition education on the strength and fitness of a sample of overweight paraplegics with chronic illnesses. This intervention improves cardiovascular fitness and strength leading to improved independence and improved overall health. The primary research objectives are to recruit adult paraplegics with chronic disease for involvement in the program, and compare the effects of the program on physical fitness in participants who have completed the program to physical fitness in those participants randomized but waiting, during the same 12 weeks, to begin the intervention. The impact of the program is assessed using changes in strength and body composition, levels of independence, dietary knowledge and intakes, blood pressure, the total-to-high-density lipoprotein cholesterol ratio, bone mineral density, and fasting glucose concentrations.

18. Title: Consumers' Participation in Nursing Home Decision-making Preferences and Perceptions
Address: University of Maryland
Principal Investigator: Nancy Miller, PhD.

Abstract: This project examines decisionmaking about long-term care, as it relates to institutional admission and discharge, viewing these decisions as having a critical influence on the opportunities individuals have to attain valued long-term care goals. The study explores the decisionmaking process of a nursing home population for which little information is available—working-age residents. Current research has focused on acute care for the most part; limited attention has been given to consumer values and preferences in long-term care and the role, if any, these play in long-term care decisions. Specific
objectives and analyses include describing the level of consumer participation in the nursing home admission decision and describing the perceived adequacy of participation in decisionmaking by consumers.

19. Title: *Measuring Functional Communication: Multicultural and International Applications*  
Address: American Speech-Language-Hearing Association  
Principal Investigator: Diane Paul-Brown  
Abstract: The long-term objective of this project is to improve the quality of life for adults with communication disabilities by expanding and validating an assessment tool for multicultural and international populations. Assessments can then be made regarding communication functions and needs, and rehabilitation can be individualized to optimize the person's ability to communicate in their natural environments. Reliable communication skills are a requisite for individuals to achieve their social, educational, and vocational potentials, and for patients to understand and participate in their care and recovery. Activities of this project include: (1) development of a measure of quality of communicative life; (2) validation of the extended American Speech-Language-Hearing Association Functional Assessment of Communication Skills for Adults with multicultural groups including African Americans, Asian Americans, Caucasian, Hispanic, and Native Americans; (3) validation with various populations with communication disorders such as those caused by brain injury, stroke, Alzheimer's disease and related dementias, and acquired neurological disorders; and (4) validation in other English-speaking countries.

20. Title: *Effect of Motor Learning Procedures on Brain Reorganization in Subjects with Stroke*  
Address: University of Minnesota  
Principal Investigator: James Carey, PhD  
Abstract: This project determines whether elements of motor learning can promote brain reorganization and recovery of function in individuals with stroke. Two interventions have been shown to be effective in helping people recover from stroke, "forced use" of the weak side and electrical stimulation. Investigators have hypothesized that these treatments may unmask dormant motor centers or improve synaptic effectiveness, but no evidence has been forthcoming. The project involves two experiments: (1) subjects with stroke receive 20 training sessions at a finger movement tracking task in which they are forced to process the perceptual motor information mentally and learn to respond accurately, and (2) different subjects with stroke receive 20 days of electrical stimulation to the weak forearm muscles. For both experiments, changes in finger function are measured with tracking and manual dexterity tests. Neuroplastic changes in the brain are measured with functional magnetic resonance imaging. This project may show for the first time that physical rehabilitation procedures may stimulate beneficial reorganization of the brain following stroke and invite further experiments to optimize treatments.

21. Title: *Acupuncture as an Adjunctive Treatment in Stroke Rehabilitation*  
Address: Kessler Medical Rehabilitation Research and Education Corporation  
Principal Investigator: Samuel C. Shiflett, PhD  
Abstract: The purpose of this research is to design and evaluate the efficacy and safety of acupuncture in ways that may be beneficial, in addition to standard rehabilitation, in restoring and improving functional recovery of stroke survivors. The project directly addresses the medical, cognitive, and psychological
sequelae of stroke. The following acupuncture issues are addressed: (1) which acupuncture points and model to use, (2) when to start acupuncture, and (3) electroacupuncture. The project also compares acupuncture with and without electrical stimulation in stroke treatment. The aim of the study is to use rigorous research methods to determine: (1) whether acupuncture has a beneficial effect on activities of daily living, motor and cognitive functioning, and quality of life in post-stroke survivors, above and beyond standard rehabilitation; and (2) if so, whether the length of time after stroke, before acupuncture is begun, affects the extent to which acupuncture is effective, and what the optimal time to begin acupuncture therapy would be. In addition, it is important to determine whether there is any benefit to initiating acupuncture treatment in stroke survivors who are well past the subacute stage, and who have apparently reached a plateau in their recovery.

22. **Title:** The Impact of Managed Care on Rehabilitation Services and Outcomes for Persons with Spinal Cord Injury.
   **Address:** Mount Sinai School of Medicine.
   **Principal Investigator:** Marcel Dijkers, PhD

   **Abstract:** This project examines the impact of managed care on rehabilitation services and outcomes for people with spinal cord injury (SCI). The study analyzes demographic, medical, functional, community integration, life satisfaction, and service delivery data collected from Model Systems projects to determine how managed care is altering the acute and rehabilitative management of SCI and how it affects short- and long-term outcomes, such as functional status and community integration. Objectives include: (1) describing the pathways of newly injured people with SCI through the health care system, from injury to stable community residence: acute care, rehabilitation care (including inpatient-acute, subacute, day hospital, and outpatient), home care, and readmissions for complications; (2) assessing the impact of managed care on these pathways: determining whether managed care patients differ from those with more traditional health insurance in terms of services received (providers, services, durations); and (3) assessing the effect of various pathways on the outcomes for this patient population at one and two years after injury in functional, medical, psychological, and health services utilization. The project team disseminates findings to consumers, managed care and other payer organizations, policy-makers, and SCI professionals using a variety of mechanisms. Findings are expected to contribute to the redesign of the SCI Model Systems National Database to make it correspond optimally to the organization of health and rehabilitative services in the 21st century.

23. **Title:** Interventions to Improve Memory in Patients with Multiple Sclerosis.
    **Address:** State University at Stony Brook.
    **Principal Investigator:** Lauren B. Krupp, MD

    **Abstract:** This project: (1) tests the efficacy of interventions, specifically targeting cognitive functioning, in patients with Multiple Sclerosis (MS); and (2) uses a novel outcome measurement that may be more sensitive and ecologically valid than existing measurements. The experiments determine the efficacy of donepezil therapy and glucose administration for enhancing memory functioning, two interventions that are extremely well-tolerated and have been demonstrated to be effective for improving memory and other aspects of cognitive functioning in several populations. Verbal memory is the most common area of impairment in people with MS, and therefore a verbal memory task is the primary outcome measure. Secondary outcome measures assessing other aspects of cognitive function (i.e., nonverbal memory, conceptual thinking, processing speed) may also be improved with intervention.
Title: Health Promotion for Women Aging with Disability.
Address: Baylor College of Medicine.
Principal Investigator: Margaret A. Nosek, PhD.

Abstract: This project studies whether an intervention to improve self-efficacy and connectedness improves health-promoting behaviors, which is related to improved physical and psychological health. The research is based on two hypotheses: First, regarding the effectiveness of the intervention: women aging with physical disabilities who participate in a health promotion workshop intervention report higher levels of connectedness and self-efficacy in disability management after the intervention and at a three-month follow-up, than women aging with physical disabilities who do not participate in the intervention; and second, regarding predictors of health outcomes and the mediating effect of health promoting behaviors: connectedness in social and intimate relationships and self-efficacy in disability management significantly predict health promoting behaviors, which predict physical and psychological health outcomes among women aging with physical disabilities, when severity of disability and socioeconomic status are controlled.

Technology for Access and Function

Rehabilitation, biomedical engineering, and assistive technology research has produced results that have helped people with disabilities to achieve and maintain maximum physical function, live in their own homes, attain gainful employment, and participate in and contribute to society. NIDRR’s research addresses a broad range of technology, including systems of public technology, such as telecommunications and the built environment and orphan technology for individuals. The research program also encourages universal design practices.

1. Title: Rehabilitation Engineering Research Center in Prosthetics and Orthotics
Address: Northwestern University
Principal Investigator: Dudley S. Childress, PhD

Abstract: This Center designs improved prosthesis and orthosis components or systems using knowledge from research and engineering areas. Research activities include: (1) studying several issues of human walking; (2) creating a three-dimensional instrument, based on the Direct Ultrasound Ranging System, that is able to provide estimates of walking efficiencies and quality of walking, and that provides clinicians with many parameters in a simple way; (3) delivering data-gathering instruments and a validated prototype database for collection, storage, and processing short- and long-term information concerning outcomes of prosthetic and orthotic (P&O) fittings; (4) creating a prototype computer-based system to select the most appropriate P&O device for specific individuals; (5) developing a computer-based visualization aid that allows display of a person and their proposed prosthetic arms before the limbs are fabricated to assist with decision-making and fitting; (6) performing a number of "proof-of-concept" investigations and advancing the design of several P&O components and systems to technology transfer and utilization stages; (7) maintaining a high international profile, through a newsletter and through participation in the development of international standards in P&O; (8) providing educational and research opportunities for engineers, practitioners, and scientists in P&O; (9) creating an advisory board that assists with research and development efforts and with the organization of the State-of-the-Science P&O conference. Information is disseminated through a Web site, the "Capabilities" newsletters, presentations, and journal articles.
2. **Title:** Rehabilitation Engineering Research Center on Assistive Technology for Older Persons with Disabilities  
   **Address:** State University of New York (SUNY) at Buffalo  
   **Principal Investigator:** William C. Mann, PhD  
   **Abstract:** Activities of the RERC focus on research, assistive device development, education, and information relating to assistive technology for older people in the home and beyond the home. The projects of the RERC fall into four major areas: (1) research: ten projects address assessments in the home and community, issues for minority elders, highly problematic device categories, clinical trials of effectiveness, and managed care work issues; (2) device development: six projects address automobiles, obesity, mobility, balance, stairs, and public seating; (3) education: four projects address professional students, graduate students, and rehabilitation and aging service professionals; and (4) information: ten projects include a "Helpful Products" series of videos and booklets, training manuals, resources for hotel and motel guests, product information, national conferences, newsletter inserts, a World Wide Web site, monograph series, resource sourcebook, and a resource phone line.

3. **Title:** Rehabilitation Engineering and Research Center (RERC) on Universal Design and the Built Environment at Buffalo  
   **Address:** State University of New York (SUNY) at Buffalo  
   **Principal Investigator:** Edward Steinfeld, ArchD  
   **Abstract:** The RERC on Universal Design and the Built Environment promotes the adoption of universal design. The research program includes The Prototype Anthropometric Database Project, a research database on anthropometrics of wheelchair users and use of that database in ergonomic modeling software, and The Buildings in Use Project, that demonstrates the benefits of universal design by comparing the impact of buildings and elements with universal designs to buildings and elements that are not designed to be universally accessible. Product development efforts include development of prototypes for innovative universally designed products, evaluation & testing of these prototypes, and a Commercialization Package for each prototype to help bring it market. The Visitability Initiative, a training and action-research in 5 cities to develop visitability demonstration projects, is a collaboration with Concrete Change, a consumer advocacy organization focusing on making housing visitable for people with disabilities. The RERC's research program also include training, curriculum development, publication, technical assistance, and dissemination of universal design resources.

4. **Title:** Rehabilitation Engineering Research Center on Hearing Enhancement and Assistive Devices  
   **Address:** The Lexington School for the Deaf/Center for the Deaf  
   **Principal Investigator:** Matthew H. Bakke, PhD  
   **Abstract:** This RERC develops and evaluates technology to accommodate the needs of people with hearing loss, and disseminates related information in a form that is understandable to consumers, service providers, employers, and community leaders. These goals are accomplished by: (1) developing and evaluating improved, cost-effective technological aids for each of the target populations identified; (2) developing and evaluating instrumentation for detecting hearing loss at an early age; (3) providing improved access to modern telecommunications; (4) developing and evaluating specialized technology for community, home,
and work environments; and (5) pursuing an active program of dissemination and training to ensure effective utilization of assistive technology.

5. Title: Rehabilitation Engineering Research Center on Communication Enhancement in the New Millennium
   Address: Duke University

   Principal Investigator: Frank DeRuyter, PhD

   Abstract: This project uses innovative communications technologies to benefit researchers, engineers, rehabilitation service providers, developers, and users of Alternative and Augmentative Communication (AAC) technologies. The project: (1) investigates attitudinal barriers toward technology use by elderly people with communication disorders, their listeners, and service providers; (2) studies the organizational strategies of adult AAC users to determine if preferences are predictive of performance using AAC; (3) studies how to improve AAC technologies for young children with significant communication disorders by evaluating learning demands and functional performance (also involves development of design specifications); (4) evaluates and enhances communication rate efficiency and effectiveness through the development of procedures and software technology that simulates and measures the performance of AAC technologies; (5) identifies barriers to employment, describes strategies to overcome them, documents design specifications for AAC technologies, and describes action plans to achieve successful employment outcomes; (6) increases employment opportunities for graduates of an employment and AAC program; and (7) develops a coordinated program that monitors and seeks out technology developments in both commercial form and prerelease development stages that affect the engineering and clinical AAC field.

6. Title: Rehabilitation Engineering Research Center (RERC) on Universal Design and the Built Environment
   Address: North Carolina State University

   Principal Investigator: Molly Story

   Abstract: The purpose of the Rehabilitation Engineering Research Center (RERC) on Universal Design and the Built Environment is to improve the accessibility and usability of the built environment, and advance the field of universal design. The goals of the project are to: (1) increase knowledge of the complex and dynamic relationship between the individual and the environment, including knowledge of what design features, details and arrangements optimize the accessibility and usability of the built environment for the widest diversity of users; (2) increase the adoption and improve the practice of universal design by the building and product manufacturing industries; (3) increase inclusion of the universal design approach in post-secondary design curricula, and increase the number of designers and researchers trained in universal design practices; and (4) increase awareness of and stimulate demand for universal design among builders, manufacturers, designers, human service professionals, and individuals with disabilities and their families.

7. Title: Rehabilitation Engineering Research Center on Wheeled Mobility
   Address: University of Pittsburgh

   Principal Investigator: Douglas A. Hobson, PhD
Abstract: The RERC on Wheeled Mobility investigates the use of dynamic seating for reducing spasticity, and enhancing seating comfort; investigates the biomechanical characteristics of soft tissue related to the risk of developing pressure ulcers, and the relationship between pressure measurements and pressure ulcer incidence; develops and validates the use of outcomes measures for seating and mobility intervention; and investigates the use of the World Wide Web as a seating decision support tool for consumers. This project also develops and evaluates a comparative data source for use in decision support of wheelchair selection; an interface for integrating external devices with powered wheelchairs; wheelchair seating standards; standardized postural measures; injury prevention wheelchair technologies; and enhanced controls for powered wheelchairs.

8. Title: Rehabilitation Engineering Research Center on Information Technology Access
   Address: University of Wisconsin/Madison

   Principal Investigator: Gregg C. Vanderheiden, PhD

   Abstract: This RERC improves access by individuals with all types, degrees, and combinations of disabilities to a wide range of technologies, including computers, ATMs, kiosks, point-of-sale devices and smartcards, home and pocket information appliances, Internet technologies (XML, XSL, CSS, SMIL, etc.), intranets, and 3-D and immersive environments. As one component in a larger system of consumers, researchers, industry, and policy and public agencies, the Trace Center's program is designed to work within the existing structure, supporting other components, and coordinating its efforts to address the functioning of the whole. The program identifies strategies that can be used by industry to broaden the user base for their standard products, so individuals with as broad a range of abilities as possible are able to use standard products directly. Further, the Center targets specific compatibility and interconnection standards work to ensure that people who cannot use products directly are able to operate them using assistive technologies. The Center focuses on the use of targeted projects and collaboration, both national and international, to carry out the research, development, information dissemination, training, and standard-setting activities required. The approach is intended to be flexible, forward-looking, and broad in scope, yet focused on key access issues as defined by its consumer constituency and its research programs.

9. Title: The Effect of Ankle-Foot Orthotic Design on Hemiplegic Gait.
   Address: Los Amigos Research and Education Institute, Inc. (LAREI).

   Principal Investigator: Sara J. Mulroy, PhD

   Abstract: This project defines the clinical criteria for optimal orthotic prescription in persons who have had a stroke. The study originates from the identification of significant lower extremity weakness in a recent study of recovery of walking in patients after stroke. A pilot survey of 10 patients who had been prescribed an ankle foot orthosis (AFO) after discharge from inpatient rehabilitation found 40 percent of the respondents were no longer using their orthosis. Reasons for the abandonment included improved walking capability, inability to don the AFO independently, and lack of improvement in walking. The results of this pilot indicate that the orthoses are not fully meeting the needs of this patient population. There is a need to develop criteria for orthotic prescription based on the patient's lower extremity strength and muscle tone. In concert with the development of definitive prescription criteria, patients need to be provided with information as to the purpose of the orthosis and what changes in their walking are realistically expected.
10. Title: Optimizing the Conditions for Reading with the Periphery of the Visual Field
   Address: The Smith-Kettlewell Eye Research Institute

   Principal Investigator: Manfred MacKeben, PhD
   Abstract: This project studies the parameters for optimal letter and word recognition using the periphery
   instead of the center of the retina, in people with central (foveal) vision loss. The results are used to develop
   a computer program that optimizes reading off a screen after foveal vision loss. The project uses computer
   displays for presentation because they allow changing the display mode and typeface instantaneously. Font
   creation software is used to modify characteristics of often-confused letters, using an objective measure of
   salience, and the effect can be tested immediately. This optimizes typefaces for viewing with the peripheral
   retina. If it improves peripheral reading from a screen, the product is made available for printing on
   paper.

11. Title: The Influence of Real-Time Frequency Transposition on the Recognition and
    Understanding of Speech by Adults Who Are Hearing Impaired.
    Address: Wichita State University.

   Principal Investigator: Raymond Hull, PhD.
   Abstract: This project tests a new generation of real-time frequency transposition hearing aids. The purpose
   is to compare the influence of the new devices with that of conventional hearing aids on the recognition and
   understanding of speech by adults who possess the most common type of hearing loss among adults with
   hearing impairments: precipitous high frequency sensorineural hearing loss. Performance in speech
   recognition and speech understanding in adults who possess significant hearing loss is compared with the
   performance of conventional hearing aids. The project is based on the premise that adults who possess
   sensorineural hearing loss in the moderate-to-severe range generally possess their best hearing in the lower
   frequencies. Audiologists attempt to take advantage of that usable hearing when fitting them with hearing
   aids in order to provide the person with the greatest advantage for the recognition and understanding of
   speech. However, in spite of current technology, it becomes difficult to amplify the better low frequency
   hearing and also amplify sound in the middle-to-high frequencies with enough gain to enhance the person's
   hearing in that range without discomfort or overamplification in the lower frequencies.

12. Title: Development and Commercial Transfer of a Tactile Image Printer (TIP)
    Address: International Braille Research Center

   Principal Investigator: T. V. Cranmer, PhD
   Abstract: The project designs a product that allows students, educators, and other professionals who are
   blind to access a variety of graphic material such as computer screens, maps, schematics, geometry tables,
   organizational charts, flow charts, and line drawings. Researchers develop a device that produces sharper,
   better-defined tactile images and includes lines and filled-in areas of varying dimensions and textures.
   Colors can also be produced as needed or as appropriate. Developers include the inventor, engineers,
   educators, publishers, and grassroots advocacy organizations, with support from three Rehabilitation
   Research Engineering Centers, those on Information Access (Trace), Blindness and Visual Impairment
   (Smith-Kettlewell), and Technology Transfer (SUNY/Buffalo). The device should help people
who are blind or who have visual impairments to become active participants in the new global economy. Phases of the project include firmware development, experimentation and testing, creation and testing of graphic material, and product and information dissemination.

13. Title: Closed Captioning and Audio Description: Development and Testing for Access to Digital Television
   Address: WGBH Educational Foundation

   Principal Investigator: Larry R. Goldberg

   Abstract: This project addresses the urgent, time-sensitive need to improve the effectiveness of Digital Television (DTV) to deliver high-quality captioning and description services to people with hearing or visual impairments. Digital Television (DTV) is a complete redesign of North America's television service, featuring a digital signal, a sharper picture, an aspect ratio resembling that of a wide-screen movie, multiple CD-quality audio channels, and ancillary data services. This project uses knowledge and understanding gained from research and development previously undertaken by the WGBH Educational Foundation (among others) to design and develop prototype DTV captioning and description processes. Project objectives are: (1) to develop and disseminate a standard data file that tests DTV systems for quality and accuracy in handling DTV captions and descriptions as they are encoded, transmitted, and decoded in accordance with accepted standards and official minimum requirements; (2) to develop and disseminate an advanced-features data file that tests DTV systems for quality and accuracy in handling DTV captions and descriptions as they are encoded, transmitted, and decoded in accordance with accepted standards and with a full range of advanced features; and (3) to evaluate the effectiveness of DTV receivers in decoding DTV captions and descriptions and to measure implementation of advanced features.

14. Title: Promoting the Practice of Universal Design
   Address: North Carolina State University School of Design

   Principal Investigator: Molly Story

   Abstract: This project promotes the practice of universal design by developing and implementing a self-supporting product design evaluation and marketing program that responds to consumer and industry needs. Universal design is the design of products and environments that are usable, to the greatest extent possible, by everyone regardless of their age or ability. The critical next step toward increasing the practice of universal design is adoption and application of its principles both by consumers and by industry. The three objectives of this project are to improve consumers' ability to recognize universal design, to improve designers' ability to meet the needs of a diverse consumer base, and to recognize and support industry efforts to market universal design successfully. Ways these objectives are achieved through this project include: (1) developing a set of performance measures that reflect the Principles of Universal Design, (2) confirming the reliability of these measures and piloting the evaluation program, (3) developing a plan of self-support for the universal design evaluation program, and (4) disseminating the results to appropriate audiences. The project develops a sound universal design program based on information gathered directly from future users—consumers, designers, and marketers—as well as the universal design research community.

15. Title: A Computerized Worker-Job Assessment to Access Assistive Technology Information for the Workplace.
   Address: Lifease, Inc.
Principal Investigator: Barbara A. Larson.

Abstract: WORKEASE software helps to identify and solve work-site problems due to limitations resulting from aging in the workforce, disability, or hazard. The completed program gives decisionmakers, whether they are workers, employers, or others, an efficient and effective checklist-type instrument for creating and implementing state-of-the-art workplace adaptations. The project defines appropriate ability and demand characteristics and builds a demonstration database of job-adapting assistive technology. For each identified job requirement that exceeds worker capacity, the program retrieves a solution from its database that enables assistive technology to adapt the job to the individual.

16. Title: Writing Rehabilitation System with Dynamic Analysis Tools.
Address: CyBotic Technologies, Inc.
Principal Investigator: Charles Pfeiffer.

Abstract: This project helps people reacquire handwriting skills while reducing the work of occupational therapists by developing a “writing trainer” assistive technology for home and professional settings. The task of handwriting has always been linked to psychological and educational well-being, and recent research professes that the lessons of handwriting have such a beneficial impact that such learning is paramount to healthy mental development. The loss of handwriting skills due to a stroke or other debilitation is immeasurably distressing; occupational therapists spend many hours helping individuals reacquire some if not all of them. The envisioned handwriting trainer would allow occupational therapists to preprogram or select routines for users to perform on their own. It would physically help individuals perform handwriting motions and use sensory interfaces to monitor performance.

17. Title: Automated PC-Based Speech-to-Sign-Language Interpreter
Address: Seamless Solutions, Inc.
Principal Investigator: Edward M. Sims, PhD

Abstract: This project integrates speech recognition and natural language processing software with Seamless Solutions, Inc.’s PC-based Signing Avatars(tm) 3D character animations of sign language communication to provide a prototype PC-based speech-to-sign language and text-to-sign-language interpreter. The new development in this project is the addition of Natural Language Processing (NLP), using a sign lexicon and translation rules that analyze English sentences to provide not only correct translations of each sign, but also correct and realistic facial expression, timing, and emphasis. The result is the synthesis of high quality, realistic sign language translation of spoken or textual English language input.

Independent Living and Community Integration

Independent living recognizes that each person has the right to independence through maximum control over his or her life, based on an ability and opportunity to make choices in performing everyday activities. These activities include: managing one’s personal life; participating in community life; fulfilling social roles, such as marriage, parenthood, employment, and citizenship; sustaining self-determination; and minimizing physical or psychological dependence on others. Community integration incorporates ideas of both place and participation, so that a person is physically located in a community setting, and participates in community activities. Issues of consumer direction and control also are integral to concepts of community integration. NIDRR’s research program encourages independent living and community
integration to achieve more successful outcomes for people with disabilities, and it fosters the development of innovative methods to achieve these outcomes and to measure achievement.

1. **Title:** Rehabilitation Research and Training Center on Personal Assistance Services (PAS)
   **Address:** World Institute on Disability
   
   **Principal Investigator:** Deborah Kaplan, JD
   
   **Abstract:** This project furthers the understanding that Personal Assistance Service (PAS) systems design can better promote the economic self-sufficiency, independent living, and full integration of people of all ages and disabilities into society. The project explores the models, policies, access to, and outcomes of, personal assistance services, through: (1) gathering perspectives of consumers, program administrators, policy makers, and personal assistants using a State of the States survey and database development; (2) a policy study; (3) a cost-effectiveness study; (4) a study of workplace PAS; and (5) a study on the conditions to improve the quality and quantity of the Personal Assistant workforce.

2. **Title:** Rehabilitation Research and Training Center on the Community Integration of Individuals with Traumatic Brain Injury
   **Address:** Mount Sinai School of Medicine
   
   **Principal Investigator:** Wayne A. Gordon, PhD
   
   **Abstract:** This program includes seven projects: (1) evaluate a measure of community integration that assesses an individual's level of participation, and the experience of that participation, in home and community; (2) evaluate replications of The Program Without Walls, a pioneering, consumer-oriented program for the delivery of vocational rehabilitation services developed in Rochester, New York; (3) respond to the needs of families by providing peer mentoring by an individual or family member who has successfully coped with the challenges of a TBI; (4) implement and evaluate the Consumer Advocacy Model (CAM) of substance use prevention within an outpatient TBI day-treatment program; (5) study the emergence and resolution of post-TBI behavioral and emotional challenges to determine those at risk, and factors in the environment help in overcoming challenges such as substance abuse, depression, and anxiety disorders; (6) conduct a longitudinal study of older individuals with TBI and their counterparts without disabilities, to explore the factors associated with successful post-TBI aging; and (7) validate a brain injury screening effort within a high school in New York City. Both academic performance and behavioral challenges of children identified as having had a brain injury are documented.

3. **Title:** Effectiveness of a System that Includes Computer-Based Monitoring in Promoting Care Among Older Persons with Physical Disabilities
   **Address:** State University of New York (SUNY) at Buffalo
   
   **Principal Investigator:** William C. Mann, OTR, PhD
   
   **Abstract:** This study determines the effectiveness of using a computer-based system of services between live-alone older people with physical disabilities and health care professionals. The system, which includes Internet-based communication (including audio and video), is used to: (1) monitor daily self-care needs, (2) identify the need for a home health care visit, (3) suggest self-administered interventions, and (4) provide information and training to enhance daily functional performance. The study employs a Randomized Clinical Trial (RCT) design with 100 older people with physical disabilities from Western
New York, an Evaluation of Assistive Device Use Among Older Rehabilitation Patients, an Evaluation of Assistive Device Use Among Older Renters, and an Environmental Skill-Building Program for Family Caregivers of Dementia Patients. Secondarily, the study determines: (1) the costs associated with placement of computer technology and Internet capacity in the homes of frail elders and instruction in the self-care monitoring program, (2) the reliability of self-report functional assessment using computer technology in comparison to in-home observation of self-care performance, and (3) the acceptability of computer monitoring and utilization of intervention components.

4. Title: Women's Personal Assistance Services (PAS) Abuse Research Project
Address: Oregon Health Sciences University

Principal Investigator: Laurie Powers, PhD

Abstract: This project increases the identification, assessment, and response to abuse by formal and informal personal assistance service (PAS) providers of women with physical and/or cognitive disabilities living independently in the community. The aims of the project are to: (1) develop culturally sensitive screening approaches to identify PAS abuse, (2) develop a culturally appropriate PAS abuse assessment protocol, and (3) develop culturally appropriate response strategies to prevent and manage PAS abuse. Culturally diverse participants assist in the development of these three aims. The study includes three phases, beginning with a focus group study of culturally diverse women with physical and cognitive disabilities. Phase II involves the use of findings from Phase I to develop and disseminate a survey of 260 culturally diverse females with disabilities drawn from four national organizations. Phase III involves the development and field testing of the effectiveness of the screening, assessment, and support protocols, the final product being a comprehensive package of PAS abuse prevention materials. The project plans to disseminate these materials on a national basis.

Associated Disability Research Areas

Related disability research emphasizes knowledge areas that are cross-cutting and essential to the support and refinement of disability research generally. The common theme linking disability statistics, outcome measures, and the emerging fields of disability studies, rehabilitation science, and disability policy research is that they all provide essential frameworks and building blocks for the research and address important issues in a meaningful way.

1. Title: Disability Statistics Rehabilitation Research and Training Center
Address: University of California/San Francisco

Principal Investigator: Mitchell P. LaPlante, PhD

Abstract: The Center conducts research in the demography and epidemiology of disability 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, 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, policymakers, and other consumers, and assist them in interpreting statistical information. A National Disability Statistics and Policy Forum is conducted periodically to foster dialogue between people with disabilities and representative organizations, researchers, and policymakers.
2. Title: Center on Emergent Disability: A National Study on the Changing Impact of Major Demographic, Health, Social, and Economic Trends on the Manifestation of Disability
Address: University of Illinois/Chicago

Principal Investigator: Glenn T. Fujiura, PhD

Abstract: The Center on Emergent Disability at the University of Illinois/Chicago is a national research effort that seeks to characterize the changing impact of major demographic, health, social, and economic trends on the manifestation of disability in America. Core activities of the Center include: (1) state level analysis of changes in the etiology of disability through a systematic canvass and analysis of state public health surveillance systems; (2) evaluation of the implications of change from the perspective of implications for service delivery at the local level in conjunction with statewide disability planning councils in Florida, Illinois, New Jersey and Texas; (3) study of political identity and coalition building with these constituencies and their relationships to the development of policies in state human services infrastructure; (4) a series of secondary analyses of national health and economic data sets to profile the character of changes in the population of Americans with disability; and (5) an integrated framework for monitoring and reporting medical and diagnostic research on "newly emergent" conditions. The goal is to develop a model of evolving risk and its impact on population change, state-wide agenda formation, planning, policy choice, and implementation against the backdrop of emergent conceptions of disability.

Knowledge Dissemination and Utilization

Dissemination and utilization are the tools through which to ensure that people with disabilities become fully integrated and participating members of society. NIDRR's dissemination and utilization efforts ensure the widespread distribution, in usable formats, of practical scientific and technological information generated by research, demonstration, and related activities. NIDRR's challenge is to reach diverse and changing populations, to present research results in many different and accessible formats, and to use technology appropriately.

1. Title: ABLEDATA Database Program
Address: Macro International, Inc.

Principal Investigator: Katherine Belknap

Abstract: This project maintains and expands the ABLEDATA database, develops information and referral services that are responsive to the special technology product needs of consumers and professionals, and provides the data to major dissemination points to ensure wide distribution and availability of the information to all who need it. The ABLEDATA database contains information on more than 26,000 assistive devices, both commercially produced and custom made. Requests for information are answered via telephone, mail, electronic communications, or in person.

2. Title: National Rehabilitation Information Center (NARIC)
Address: KRA Corporation
Principal Investigator: Mark X. Odum

Abstract: The National Rehabilitation Information Center (NARIC) maintains a research library of more than 60,000 documents and responds to a wide range of information requests, providing facts and referral, database searches, and document delivery. Through telephone information referral and the Internet, NARIC disseminates information gathered from NIDRR-funded projects, other federal programs, and from journals, periodicals, newsletters, films, and videotapes. NARIC maintains REHABDATA, a bibliographic database on rehabilitation and disability issues, both in-house and on the Internet. Users are served by telephone, mail, electronic communications, or in person. NARIC also prepares and publishes the annual "NIDRR Program Directory" and its companion "Compendium of Products by NIDRR Grantees and Contractors". Both are available in database format from NARIC's Website.

3. Title: National Center for the Dissemination of Disability Research (NCDDR)
Address: Southwest Educational Development Laboratory

Principal Investigator: John Westbrook, PhD

Abstract: The National Center for the Dissemination of Disability Research (NCDDR) helps close the gap between the production of disability research and its use by addressing four objectives: (1) to increase the use of effective dissemination and utilization strategies among NIDRR-funded research projects; by identifying and evaluating effective D&U methodologies that grantees can use; (2) to assure access to NIDRR-funded research findings among diverse public audiences, by developing, implementing, and evaluating a range of access strategies; (3) to improve the effectiveness and efficiency of NIDRR grantees' dissemination efforts, by developing, implementing, and evaluating plans for collaboration among NIDRR-funded research projects; (4) to strengthen the capacity of NIDRR-funded research projects to address the needs of their intended audiences, by providing technical assistance in the design and implementation of D&U methodologies. Research includes data collection to clarify information needs among people with disabilities and their families, describe barriers that prevent access to research outcomes, and obtain descriptions of researchers' approaches to setting research priorities and disseminating results. D&U activities include a variety of supports for dissemination to people with disabilities, service and community-based agencies, advocacy organizations, and disability and mainstream media. The project focuses extensively on innovative approaches to electronic media, but also addresses the needs of consumers, service agencies, and others who lack electronic access. NCDDR staff provide information, training, and consultations in response to technical assistance requests from NIDRR grantees via toll-free telephone, electronic mail, the World Wide Web, and print media.

4. Title: Trails Web Site with Universal Access Information
Address: Beneficial Designs, Inc.

Principal Investigator: Peter W. Axelson; Denise A. Chesney

Abstract: This project develops the Trails Web site to provide universal access information for trails throughout the United States, making the site useful to all hikers, regardless of their ability. The Universal Trails Assessment Process enables trail managers to assess specific trails objectively with regard to grade, cross slope, width, surface characteristics, and obstacles. The collected trail data is processed to create Trail Access Information in a format similar to a Nutrition Facts food label. The Trails Web site contains Trail Access Information on numerous hiking trails and allows users to search for trails that meet their specific access needs.
Capacity-Building for Rehabilitation Research and Training

NIDRR funding for capacity building supports efforts to improve the rigor of rehabilitation research and its relevance to the consumer community. This research training will emphasize cross-disciplinary efforts and participatory research that take into account trends in science and society. This training must contextualize disability and rehabilitation in society. Capacity building targets all participants in the disability research field, including scientists, service providers, and consumers. For scientists, emphasis is placed on training to increase the number of researchers with knowledge of advanced research methods. For providers, training will focus on applying new knowledge generated by research efforts. For consumers, the goal is training to facilitate the use of research findings as well as participation in research activities. Other goals of NIDRR's capacity building efforts include increasing the number of rehabilitation researchers with disabilities and from underserved populations.

1. Title: Advanced Rehabilitation Research Training Project in Rehabilitation Services Research
   Address: Northwestern University
   Principal Investigator: Allen W. Heinemann, PhD

   Abstract: This project develops a five-year fellowship program in rehabilitation services research at Northwestern University's Institute for Health Service Research and Policy and the Department of Physical Medicine and Rehabilitation. It uses available expertise and collaborators to train postdoctoral fellows in rehabilitation health services research. Over two years the program includes course work, a practicum, original research, and grant writing. Fellows new to health services research have six core courses, as well as the two additional courses for all fellows. The first year concentrates on beginning Masters in Public Health (MPH) courses. The second year includes intermediate MPH course work plus electives. Each fellow is expected to develop an individual research project by the end of the first training year and a publishable article by the end of the second year in addition to submitting at least one grant application related to the research activity.

2. Title: Interdisciplinary Rehabilitation Research Training Program
   Address: University of Texas Medical Branch
   Principal Investigator: Kenneth J. Ottenbacher, PhD

   Abstract: This project provides postdoctoral research opportunities to qualified individuals interested in clinical and academic careers related to rehabilitation research. Three postdoctoral fellows plan, conduct, and disseminate research in one of the following areas: Cognitive/Neurological Rehabilitation, Applied Biomechanics/Physiology of Rehabilitation, and Geriatric Rehabilitation. Each rehabilitation research fellow selects one of the three research areas and conducts clinical investigations for up to three years. Outcomes include published research studies, presentations at national scientific meetings, submission of grant proposals, completion of research-related courses, training in techniques of dissemination, and the development of interdisciplinary research networks. In addition to participating in clinical research
activities, each fellow completes a series of core courses and directed study related to interdisciplinary research and the ethics associated with scientific inquiry in rehabilitation. The activities of each postdoctoral fellow are directed and monitored by a fellowship supervisor with a demonstrated ability to implement, conduct, and disseminate the results of research investigations important to the advancement of rehabilitation science.

**State Technology Assistance**

This program, funded under Title I of the The Assistive Technology Act of 1998, supports consumer-driven grants to States. Currently there are 56 projects that provide statewide, comprehensive, technology-related assistance for individuals with disabilities of all ages. The purpose of the program is to increase and improve access to assistive technology devices and services through public awareness and information, advocacy, outreach, technical assistance and training and interagency coordination.

1. **Title:** North Dakota Interagency Program for Assistive Technology (IPAT)
   **Address:** North Dakota Department of Human Services

   **Principal Investigator:** Judith A. Lee

   **Abstract:** The Interagency Program for Assistive Technology is dedicated to supporting the assistive technology (AT) needs of all people with disabilities in North Dakota, including those individuals experiencing the effects of aging. The vision of this project is increased access to assistive technology devices and services for the citizens of North Dakota. This goal is realized through: (1) interagency coordination that develops and promotes policies that improve access to assistive technology devices and services for individuals with disabilities of all ages; (2) a public awareness program designed to provide information to targeted individuals relating to the availability and benefits of assistive technology devices and services; (3) technical assistance and training that provides support to public and private entities to increase consumer access to appropriate assessments, training, equipment, and funding for assistive technology; and (4) outreach activities to all regions of this rural and sparsely populated state, including a focus on Native Americans and older individuals living below the poverty level, the two population groups identified as underrepresented in North Dakota.
ITEM 5—DEPARTMENT OF ENERGY

INTRODUCTION

The Department of Energy (DOE) is a leading science and technology agency whose research supports our nation's energy security, national security, and environmental quality and contributes to a better quality of life for all Americans. DOE owns and manages more than 50 major installations located in 35 states, employing approximately 10,000 federal workers and 100,000 contract workers.

Science is at the center of DOE's work, performed in its 27 laboratories and other scientific user facilities and in the nation's universities. DOE supports breakthrough research in energy sciences and technology, high energy physics, global climate change, genome mapping and the bio-sciences, superconducting materials, accelerator technologies, environmental sciences, and super-computing. DOE also supports science and mathematics education from the K–12 level through post-doctoral work.

In support of the nation's energy security, DOE promotes development of clean, secure, sustainable energy resources, works to increase the diversity of energy supplies and fuel choices, and maintains the Strategic Petroleum Reserve.

In fulfilling its national security mission, DOE assures the safety and reliability of the U.S. nuclear weapons stockpile without underground testing and supports U.S. non-proliferation, arms control, and nuclear safety objectives world-wide.

In meeting its environmental quality mission, DOE is responsible for cleaning up the environmental legacy left at sites where, for some 50 years, the nation's nuclear weapons were designed and manufactured.

ENERGY EFFICIENCY PROGRAMS

Weatherization Assistance Program—The program's mission is to make energy more affordable and improve health and safety in homes occupied by low-income families, particularly those with elderly residents, children, or persons with disabilities. Elderly residents make up approximately 40 percent of the low-income households served by this program. As of September 30, 2000 about 4.9 million homes had been weatherized with federal, state, and utility funds; of these, an estimated 2.0 million were occupied by elderly persons.

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

The program has become increasingly effective due to improvements in air-leakage control, insulation, water heater systems, windows and doors, and space heating systems. At current prices, a weatherized low-income household now saves approximately $250 per year, about one-third of its space heating costs. Program benefits are further described in the Progress Report of the National Weatherization Assistance Program, available through the National Technical Information Service, 703/487-4650, 5285 Port Royal Road, Springfield, VA 22161.

States implement the program through community-based organizations. DOE and its state and community partners weatherize approximately 70,000 single- and multi-family dwellings each year. The program awarded $133 million in Fiscal Year 1999 and $135 million in Fiscal Year 2000 for grants to the 50 states, the District of Columbia, and six Native American tribal organizations. In addition to DOE appropriations, state and local programs receive funding from the Department of Health and Human Services' Low Income Home Energy Assistance Program, from utilities, and from states.

**State Energy Program**—The program provides grants to State Energy Offices to encourage the use of energy efficiency and renewable energy technologies and practices in states and communities through technical and financial assistance. In Fiscal Year 1999, $32 million was appropriated for the program and in Fiscal Year 2000, $33 million. States have broad discretion in designing their projects. Typical project activities include: public education to promote energy efficiency; transportation efficiency and accelerated use of alternative transportation fuels for vehicles; financial incentives for energy conservation/renewable projects including loans, rebates, and grants; energy audits of buildings and industrial processes; development and adoption of integrated energy plans; promotion of energy efficient residences; and deployment of newly developed energy efficiency and renewable energy technologies.

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

**INFORMATION COLLECTION AND DISTRIBUTION**

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

The results of the RECS are analyzed and published by the Energy Information Administration. The most recent survey data are from the 1997 RECS and are published on the Internet at http://www.eia.doe.gov/emeu/recs. The 1997 RECS public use data files are also available at this site. These files will include demographic characteristics of the elderly such as age, marital status and household income, as well as estimates of consumption and expenditures for electricity, natural gas, fuel oil, kerosene, and liquefied petroleum gas used in elderly households.

In the 1997 RECS, 28.5 million, or 28 percent of all U.S. households, were headed by a person 60 years of age or older. Of these elderly households, 44 percent were one-member households (12.4 million people living alone) and 44 percent contained two people. In 19 percent of the two-member elderly households both members were under the age of 65; in 21 percent of these households, only one member was younger than 65; and in 60 percent, both members were over the age of 65. Comparisons of elderly versus non-elderly households reveal that:

- The 1997 household income of elderly households was generally lower than that of non-elderly households. Nearly a quarter, 23 percent, of elderly households had incomes of less than $10,000, compared to 9 percent of the non-elderly households. Only 12 percent of the elderly households had incomes of $50,000 or more, compared to 34 percent of the non-elderly households. Of the 14.7 million U.S. households whose income was below the poverty line, 37 percent were headed by a person 60 years of age or older.

- Despite having lower household incomes, the elderly households were more likely to own their housing unit, 80 percent, than were non-elderly households, 63 percent. The elderly were also more likely to live in a single-family house, 76 percent, than were non-elderly households, 71 percent.

- Elderly households are less likely to have a personal computer or a modem connecting that computer to the Internet or e-mail networks than are households headed by persons less than 60 years of age. Among elderly households, 14 percent have a personal computer compared to 43 percent of the non-elderly households. Only 7 percent of elderly households have a modem connection compared to 26 percent of the non-elderly households.

- Elderly households are only marginally less likely to have a microwave oven, 79 percent, than are non-elderly households, 85 percent.

Analysis of the 1997 RECS data shows that consumption patterns differed between the elderly and non-elderly for some uses of energy. The elderly used more energy to heat their homes but used less energy for air conditioning, water heating, and appliances. Expenditures followed the same pattern. Specifically,

- The average expenditures per household member in elderly households in 1997 was $708. This amount was higher than
the comparable amount for all other households, due to the fact that households headed by persons 60 years or more of age tend to be smaller than those headed by persons under 60 years of age.

- About 58 percent of total energy consumption and about 37 percent of total energy expenditures in elderly households were for space heating. On the other hand, appliances accounted for 23 percent of consumption and 45 percent of total expenditures in elderly households. Energy costs for appliances are much higher relative to consumption than are energy costs for space heating because virtually all appliances are powered by electricity, the most expensive energy source, whereas space heating is largely provided by other, less expensive, energy sources.

**Research Related to Aging**

Through fiscal year (FY) 2000, the Office of Environment, Safety and Health (EH) sponsored research to further understanding of the human health effects of radiation. As part of this research program, DOE sponsored epidemiologic studies concerned with understanding health changes over time. Lifetime studies of humans constitute a significant part of EH's research; and because the risks of various health effects vary with age, these studies take age into consideration. EH supports research to characterize late-appearing effects induced by chronic exposure to low levels of physical agents, as well as some basic research on certain diseases that occur more frequently with increasing age.

Because health effects resulting from chronic low-level exposure to energy-related toxic agents may develop over a lifetime, they must be distinguished from normal aging processes. To distinguish between induced and spontaneous changes, information is collected from both exposed and non-exposed groups on changes that occur throughout the life span. These data help characterize normal aging processes and distinguish them from the toxicity of energy-related agents. Summarized below are specific research projects that the Department sponsored in FY 2000.

**Long Term Studies of Human Populations**—Through EH, DOE supports epidemiologic studies of health effects in humans who may have been exposed to chemicals and radiation associated with energy production or national defense activities. Information on life span in human populations is obtained as part of these studies. Because long-term studies of human populations are difficult and expensive, they are initiated on a highly selective basis.

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

Multiple epidemiologic studies involving about 400,000 contract employees at DOE facilities are being managed by the Department
of Health and Human Services through a Memorandum of Understanding between the two agencies. These studies include assessments of health effects at older ages due to ionizing radiation and other industrial toxicants. Several of the studies will look closely at workers who were first exposed at age 45 or older, assessing the impact of these late exposures in relation to the burden of chronic diseases that are common among older people. The average age of workers included in these studies is greater than 50 years.

A recent study indicated that workers who were occupationally exposed to radiation for the first time at age 45 or older might be more sensitive to health effects than workers who were exposed at younger ages. However, very few workers at DOE fit this profile. This finding is very preliminary and further research and analyses are being conducted to see if these results can be duplicated.

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

In response to the Defense Authorization Act of 1993, EH has established a program involving a number of ongoing projects across the DOE weapons complex to identify former workers whose health may have been placed at risk as a result of occupational exposures that occurred from the 1940's through the 1960's. The projects provide medical screening and monitoring for former workers to identify those at high risk for occupationally related diseases and to identify workers with diseases that may be reduced in severity by timely interventions.

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

**OTHER DOE-FUNDED RESEARCH RELATED TO AGING**

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

The Aging Research involves study of a brain chemical, dopamine (DA), and its function in humans as they age. It has long been recognized that age brings a significant decline in the function of the brain DA system, but the functional significance of this loss is not known. Medical imaging studies, using radiotracers and positron emission tomography, are designed to investigate the consequences of age-related losses in brain DA activity in cerebral
function and to investigate mechanisms involved with the loss of DA function in normal aging. The results of these studies to date have shown that healthy volunteers with no evidence of neurological dysfunction do experience a decline in parameters of DA function, which are associated with a decline in performance of motor and cognitive functions. The results of these studies also indicate that changes in life style, such as exercise, may be beneficial in promoting the health of the dopamine system in the elderly.
ITEM 6—DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 (Public Law 97–35) amended Title XX to establish the SSBG program under which formula grants are made directly to the 50 States, the District of Columbia, and the 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 ten (10) percent of their block grant funds to other block grant programs for support of health services, health promotions and disease prevention activities, and low-income home energy assistance. In the welfare reform legislation, Section 103 of Title I of Public Law 104–193 gives states the authority to transfer up to 30 percent of their Temporary Assistance to Needy Families (TANF) grant to SSBG and the Child Care Development Block Grant programs. The Balanced Budget Act of 1997 (Public Law 105–33) provided that the TANF transfer to SSBG would be up to 10 percent of a State's TANF grant. The Transportation Equity Act of 1998 (Public Law 105–178) reduced the amount available for transfer from TANF to SSBG to 4.25 percent beginning in Fiscal Year 2001.

Under the SSBG, Federal funds are available without a matching requirement. In fiscal year 2000, a total of $1.775 billion was allotted to States. Of that amount, $425 million was delayed for funding until September 29, 2000. $1.909 billion was appropriated for these activities in fiscal year 1998. Within the specific limitations in the law, each State has the flexibility to determine what services will be provided, who is eligible to receive services, and how funds are distributed among the various services within the State. State and/or local Title XX agencies (i.e., county, city, regional offices) may provide these services directly or purchase them from qualified agencies and individuals.

A variety of social services directed at assisting aged persons to obtain or maintain a maximum level of self-care and independence may be provided under the SSBG. Such services include, but are not limited to adult day care, adult foster care, protective services, health-related services, homemaker services, housing and home maintenance services, transportation, preparation and delivery of
meals, senior centers, and other services that assist elderly persons to remain in their own homes or in community living situations. Services may also be offered which facilitate admission for institutional care when other forms of care are not appropriate. Under the SSBG, States are not required to submit data that indicate the number of elderly recipients or the amount of expenditures provided to support specific services for the elderly. States are required, prior to the expenditures of funds under the SSBG, to prepare a report on the intended use of the funds including information on the type of activities to be supported and the categories or characteristics of individuals to be served. States also are required to report annually on activities carried out under the SSBG. Beginning with fiscal year 1989, the annual report must include specific information on the numbers of children and adults receiving services, the amount spent in providing each service, the method by which services were provided, i.e., public or private agencies, and the criteria used in determining eligibility for each service.

Based on an analysis of post-expenditure reports submitted by the States for fiscal year 1998, the list below indicates the number of States providing certain types of services to the aged under the SSBG.

**Services:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home-Based Services</td>
<td>36</td>
</tr>
<tr>
<td>Adult Protective Services</td>
<td>31</td>
</tr>
<tr>
<td>Transportation Services</td>
<td>19</td>
</tr>
<tr>
<td>Adult Day Care</td>
<td>19</td>
</tr>
<tr>
<td>Health Related Services</td>
<td>14</td>
</tr>
<tr>
<td>Information and Referral</td>
<td>16</td>
</tr>
<tr>
<td>Home Delivered</td>
<td>17</td>
</tr>
<tr>
<td>Congregate Meals</td>
<td>9</td>
</tr>
<tr>
<td>Adult Foster Care</td>
<td>13</td>
</tr>
<tr>
<td>Housing</td>
<td>9</td>
</tr>
</tbody>
</table>

1 Includes 50 States, the District of Columbia, and the five eligible territories and insular areas.

In enabling the elderly to maintain independent living, most States provide Home-Based Services which frequently includes homemaker services, companion and/or chore services. Homemaker services may include assisting with food shopping, light housekeeping, and personal laundry. Companion services can be personal aid to, and/or supervision of aged persons who are unable to care for themselves without assistance. Chore services frequently involve performing home maintenance tasks and heavy housecleaning for the aged person who cannot perform these tasks. States also provide Adult Protective Services to persons generally sixty years of age and over. These services may consist of the identification, receipt, and investigation of complaints and reports of adult abuse. In addition, this service may involve providing counseling and assistance to stabilize a living arrangement. If appropriate, Adult Protective Services may include the provision of, or arranging for, home based care, day care, meal service, legal assistance, and other activities to protect the elderly.
The Low Income Home Energy Assistance Program (LIHEAP) is a Department of Health and Human Services block grant program administered by the Office of Community Services (OCS) in the Administration for Children and Families (ACF).

LIHEAP helps low-income households meet the cost of home energy. The program is authorized by the Omnibus Budget Reconciliation Act of 1981, as amended most recently by the Community Opportunities, Accountability, and Training and Educational Services Act of 1998, the NIH Revitalization Act of 1993 (P.L. 103–43), and the Human Services Amendments of 1994 (P.L. 103–252). In fiscal year 1999, all 50 states, the District of Columbia, five territories, and 130 tribes and tribal organizations received grants amounting to approximately $1.2775 billion, including $175 million in emergency contingency funds, and $2.2 million in re-allotted funds from FY 1998.

In FY 2000, $1.1 billion is available. In addition, $300 million in emergency contingency funds are available if the President decides to release some or all of the funds because of weather, supply shortages, or other energy emergencies. Federally-recognized and state-recognized Indian tribes, including Alaska native villages, may apply for direct LIHEAP funding. The amount to be reserved from a state's allotment for a direct grant to a tribe will be based on the ratio of eligible tribal households to total eligible households in the state, or a larger allotment amount agreed on by the tribe and state. Of the $1.1 billion appropriated for FY 2000, $27.5 million is earmarked for leveraging incentive awards, to reward grantees that add non-Federal resources to help low income households meet their home heating and cooling needs. Up to 25 percent of the leveraging incentive awards, or $6,875,000, will be used to fund grants to LIHEAP grantees under the Residential Energy Assistance Challenge Option Program (REACH) to develop innovative programs to reduce the energy vulnerability of LIHEAP-eligible households.

LIHEAP block grants are made to States, territories, and eligible applicant Indian Tribes. Grantees may provide heating assistance, cooling assistance, energy crisis interventions, and low-cost residential weatherization or other energy-related home repair to eligible households. Grantees can make payments to households with incomes not exceeding the greater of 150 percent of the poverty level or 60 percent of the State's median income. Most households in which one or more persons are receiving benefits from the Temporary Assistance to Needy Families (TANF) block grant, Supplemental Security Income, Food Stamps or need-tested veterans' benefits, may be regarded as categorically eligible for LIHEAP.

Low-income elderly households are a major target group for energy assistance. They spend, on average, a greater portion of their income for heating costs than other low-income households. Grantees are required to target outreach activities to elderly or handicapped households eligible for energy assistance. In their crisis intervention programs, grantees must provide physically infirm in-

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3 Beginning with fiscal year 1986, States are prohibited from setting income eligibility levels lower than 110 percent of the poverty level.
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 1998, about 34 percent of households receiving assistance with heating costs included at least one person age 60 or over, as estimated by the March 1998 Current Population Survey.

OCS is a member of the National Energy and Aging Consortium, which focuses on helping older Americans cope with the impact of high energy costs and related energy concerns.

The 1998 reauthorization retains legislation from the 1994 reauthorization that specifically allows grantees to target funds to vulnerable populations, mentioning by name "frail older individuals" and "individual with disabilities". No new initiatives commenced in 1999 or 2000 that impacted 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 (Title VI, Subtitle B, Public Law 97-35 as amended; and the Coats Human Services Reauthorization Act of 1998 105-285) is authorized through fiscal year 2003. 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 elderly, or the numbers of elderly persons served.

II. Major Activities or Research Projects Related to Older Citizens in 1997 and 1998—The Human Services Reauthorization Act of 1986 contained the following language: “each such evaluation shall include identifying the impact that assistance . . . has on . . . the elderly poor.” The reauthorization act of 1998 requires that states assure a portion of the grant funds will be used to support activities for elderly low-income individuals as part of their State Application and Plan submitted to OCS. Following the 1994 reauthorization, local community action agencies began to include a description of how linkages will be developed to fill identified gaps in services through information, referral, case management, and follow-up consultations as well as a description of outcome measures to be used to monitor success in promoting self sufficiency, family stability and community revitalization. As a result, the CSBG Task Force on Monitoring and Assessment, a representative body of eligible entities, established a goal which states, “Low-income people, especially vulnerable populations, achieve their potential by strengthening family and other support systems”. This goal assists local, state and federal agencies to focus jointly on vulnerable populations, particularly the frail elderly.

III. Funding Levels—Funding levels under the CSBG program for States and Indian Tribes or tribal organizations amounted to $491.9 million in fiscal year 1999. For fiscal year 2000, $521.5 million was appropriated. Of this amount, $3.3 million is available for federally and state-recognized tribes. A total of $8.4 million is available for training and technical assistance.

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: 7/97–6/30/2002; FY ’97—$82,680

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: 7/97–6/30/2002; FY ’97—$82,680  
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  
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.

**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  
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.

**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: 7/92–6/30/1999; FY ’97—$82,680  
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.

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: 7/97–6/30/2002; FY ’97—$82,680

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: 7/97–6/30/2002; FY ’97—$82,680

The project provides pre-service training including practical experience on best practices in serving the older population with developmental disabilities to three (3) graduate and to three (3) undergraduate students from different disciplines per year (from the second funding year on); provides culturally adapted in-service 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 Developmental Disabilities throughout Puerto Rico.

CREATIVE CHOICES FOR HEALTHY LIVING

Grantee: University-Affiliated Program Department of Pediatrics, Univ. of Arkansas for Medical Sciences.
Project Director: Judith Holt, Ph.D ((501) 682–9900

The UAP of Arkansas’ Training Initiative Project, Creative Choices for Healthy Living, will focus on persons who are aging with developmental disabilities, their access to appropriate services and supports within the community. Specifically, it will enhance the health and well-being of older persons with developmental disabilities and other members of the aging community; enhance the skill and competencies of community trainers to provide the training identified by the community action plan; expand the project into new communities; develop and disseminate preserve training
modules for undergraduate and graduate courses; disseminate project training modules for use in other settings state- and nation-wide; and evaluate the project’s effects.

MEETING THE NEEDS OF A CULTURALLY-DIVERSE POPULATION

Grantee: Department of Pediatrics, Children's Hospital Los Angeles
Project Director: Irma Castaneda, Ph.D (213) 669-2300-9900
Project Period: 7/1/97-6/30/2002, FY '97—$82,680

Develop and implement an interdisciplinary training program with a special emphasis on the multicultural aspects of aging and developmental disabilities which is integrated into Department's curriculum for a minimum of one primary or secondary consumer, and two graduate students per year. Will integrate material on multicultural aging and developmental disabilities into existing gerontology certificate programs. Provide training and consultation on the integration of content related to multicultural aging and developmental disabilities to four university departments. Provide training to a total of 100 health care providers, community support personnel, and family members on the changing health and social needs of aging individuals with developmental disabilities from ethnic minority groups.

ADMINISTRATION ON AGING

SECTION I.

1. REAUTHORIZATION

On November 13, 2000, President Clinton signed into law legislation (P.L. 106-501) to reauthorize the Older Americans Act. The amended Act, last reauthorized in 1992, will provide essential home and community-based services to millions of older Americans across the United States. In addition, for the first time ever, it will provide under the National Family Caregiver Support Program much needed support to families who are caring for their loved ones who are ill or who have disabilities.

2. NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

In 1999, President Clinton announced the Administration on Aging proposal to create the National Family Caregiver Support Program (NFCSP). The NFCSP is one of four LTC initiatives proposed in the FY 2000 Administration budget to help families sustain their efforts to care for an older relative who has serious chronic illness or disability. Under this Older Americans Act program, State Units or Offices on Aging, working in partnership with local Area Agencies on Aging, community service providers, and consumer organizations, will be expected to put in place at least five program components:

- Individualized information on available resources to support caregivers;
- Assistance to families in locating services from a variety of private and voluntary agencies;
- Caregiver counseling, training, and peer support to help them better cope with the emotional and physical stress of
dealing with the disabling effects of a family member's chronic condition;
- Respite care provided in the home, at an adult day care center, or over a weekend in a nursing home or residential setting such as an assisted living facility; and
- Limited supplemental services to fill a service gap that cannot be filled in any other manner.

The NFSCP program was enacted as part of the Older Americans Act Amendments of 2000 (P.L. 106-501) signed into law on November 13, 2000. Full start-up funding for the program, as proposed at $125 million, has been provided for FY 2001.

The basis underlying the program is simple: family caregivers need help. Families, not social service agencies or government programs, are the mainstay underpinning long term care (LTC) for older persons in the United States. According to the most recent National Long Term Care Survey (1994), more than seven million persons are informal caregivers providing unpaid help to older persons who live in the community and have at least one limitation in their activities of daily living. These caregivers include spouses, adult children, and other relatives and friends. Of the older persons receiving paid and unpaid assistance, 95 percent have family and friends involved in their care. Paid home care is the exception, not the rule, for the great majority of older persons with disabilities.

The degree of caregiver involvement has remained fairly constant for more than a decade, bearing witness to the remarkable resilience of the American family in taking care of its older persons. This is despite increased geographic separation, greater numbers of women in the workforce, and other changes in family life. Thus, family caregiving has been a blessing in many respects. It has been a budget-saver to governments faced annually with the challenge of covering the health and LTC expenses of persons who are ill and have chronic disabilities. If the work of caregivers had to be replaced by paid home care staff, the estimated cost would be $45–95 billion per year.

3. LONGEVITY SYMPOSIUM

The 21st century presents many opportunities and challenges for the Aging Network—medical and technological advances, home and community-based care options, the need to prepare for a long life, and the need to implement evidence-based and culturally-responsive services to ensure that American elders receive the most effective assistance. The Administration on Aging convened a symposia series which highlighted the agency’s commitment to helping the Aging Network prepare for the myriad of issues that come along with the gift of longevity.

The first symposium, Longevity in the New American Century, convened in March 1999, was designed to identify the most potent, most promising research findings on issues important to older Americans and their families. Based upon these research findings, the Administration on Aging and other agencies and organizations will be able to make strategic decisions and build outcome-oriented programs for older Americans. The speakers invited to share information at this symposium were asked to provide specific ideas for an evidence-based, outcomes agenda in relation to the issues of
caregiving, information and technology, diversity, consumer protection, economic security, and health.

The second symposium, Building the Network on Aging Toolkit, convened in May 2000, focused on the presentation of evidence-based, outcomes-oriented strategies that can directly be used to develop and strengthen policies, programs and services. The primary purpose of this second symposium was to bridge the gap between research and practice. The speakers presented tools and methods that are essential components of programs for family caregiver support, cultural competent service delivery, the elimination of health disparities, life course planning, the application of new technologies, and for the measurement of program outcomes.

4. PRIORITY INITIATIVES

Cultural Competence

The Administration on Aging (AoA) recognizes that minority Americans often are at greater risk of poor health, social isolation, and poverty. Currently, minority elders comprise over 16.1 percent of all older Americans (65 years of age and older). In the future, this number is expected to increase dramatically. As a result, AoA has focused on educating the public and the aging network on cultural competence.

Cultural competence is a set of congruent behaviors, attitudes, knowledge, and policies that come together in a practice and a service system that enables professionals to serve diverse clients. During calendar years 1999 and 2000, AoA has initiated the following activities to increase culturally competent practice:

- AoA's Longevity Symposia series, entitled Longevity in the New American Century included a few workshops focusing on cultural competence and the minority aging experience. Included in the workshops were new research, policy development ideas, and suggestions for programs that promote equality in the aging experience for minority elders;
- Collaboration with the Office of Minority Health (OMH) on the May 2000 edition of Closing the Gap, which focused on health issues and concerns for minority older Americans;
- A Guide for Culturally Competent Practice was developed for dissemination to providers of aging services;
- Grants for applied research and demonstration projects seeking to provide culturally and linguistically competent services to Alzheimer's Disease patients and their families in New York City, Los Angeles, and San Francisco;
- Grants for a legal services hotline project serving northern California;
- Grants for a resource center that disseminates educational and best practice materials to better equip minority and non-English speaking consumers to combat waste and fraud in the Medicare and Medicaid programs;
- Presentations by AoA staff at national conferences and meetings on how to develop culturally appropriate services to serve minority elders;
• AoA's website addition "The Many Faces of Aging: Resources to Effectively Serve Minority Older Persons" provides information on cultural competence.

Eldertech—Technologies for Successful Aging:

The number of older persons in the U.S. is estimated to increase from over 33 million today to 53 million in 2020. By 2030, the demographic profile for the whole nation will be similar to the profile in the state of Florida today. Technologies that help to meet the challenges of aging, both for individual Americans as well as for the entire nation, will be increasingly valuable as the shift in demographics continues this century.

In October 2000, the White House Office of Science and Technology Policy held a Forum on Technologies for Successful Aging. The Administration on Aging, as part of the cross-Cabinet Steering Committee for this forum, played a key role in developing the agenda for the forum whose goal was to identify collaborative, technology transfer, and technology development and deployment opportunities for government, industry and academic communities that help to improve the independence, mobility, security, and health of aging Americans.

In support of this goal, the 100 participants of the Conference began work to identify current and prospective barriers to those opportunities, mechanisms of support, and areas where additional research is needed. Specific topic areas included Health Care and Assistive Devices, Regulatory and Technology transfer, Information and Technology, Mobility, Housing and the Workplace, and Consumer Protection, Security and Privacy issues. The Forum's overarching mission was to identify and prioritize recommendations that can be articulated as a set of near-term opportunities as well as long-term challenges to federal policymakers. The Intergovernmental Steering Committee continues to meet to follow up and formalize the steps that need to be taken in the coming months and years, and recommendations will be made to the incoming Administration to continue the work that has begun.

Mental Health Initiatives

Companion Report to Surgeon General's Report on Mental Health

AoA has authored a report that expands on the discussion of older adults and mental health contained in the 1999 Surgeon General's report. The AoA report focuses on challenges in the delivery of mental health services to older Americans, and highlights a number of supportive services that can provide vital assistance to older adults with mental health problems and their families. Release of this report is planned for January 2001.

The report includes background information about the demographic characteristics of older Americans, the common stressors and adaptations that older persons face, and a brief summary of the findings from the Surgeon General's report. The report describes community mental health services, delivery of mental health services in primary and long-term care, and Medicare and Medicaid financing of mental health care. Supportive services dis-
cussed in the report include respite care, adult day services, support groups and peer counseling programs, wellness and health promotion programs, mental health outreach services, and caregiver programs. The discussion of each service includes its purpose, implementation models and examples, and research regarding effectiveness.

Lastly, the report sets forth the challenges that must be addressed in order to provide effective community-based care to older persons with mental illnesses. Identified needs include: expanding prevention and early intervention services; increasing the number of professionals and paraprofessionals trained in geriatric mental health; providing adequate financing for mental health services; enhancing collaboration among delivery systems; improving access to mental health care; educating the public about mental illness and mental health treatment; expanding research on mental health issues in older adults; addressing the mental health needs of special populations; and encouraging consumer involvement.

ALZHEIMER'S DISEASE DEMONSTRATION GRANTS TO STATES

The Alzheimer's Disease Demonstration Grants to States Program (ADDGS) was established under Section 398 of the Public Health Service Act (P.L. 78-410) as amended by Public Law 101-157 and by Public Law 105-379, the Health Professions Education Partnerships Act of 1998. Beginning in fiscal year (FY) 1999, the program was transferred within the Department of Health and Human Services from the Health Resources and Services Administration (HRSA) to the Administration on Aging (AoA).

The ADDGS program's mission is to expand the availability of diagnostic and support services for persons with Alzheimer's disease, their families, and their caregivers. The Administration on Aging provides an added focus of reaching hard-to-serve and underserved people with Alzheimer's disease or related disorders (ADRDs).

In general, the ADDGS projects demonstrate how existing public and private resources within States may be more effectively identified, utilized, and coordinated to enhance the educational and service delivery systems for persons with Alzheimer's disease, their families and caregivers. Under the Program, state grantees:

- Link public and non-profit agencies that develop and operate respite care, and other support, educational, and diagnostic services within the State to people who need services;
- Deliver services such as primary health care physician education and support services including respite care, home health care, personal care, day care, companion services, short-term respite care, and other forms of respite and supportive services to persons with ADRDs (at least 50 percent of the total grant must be spent on these activities);
- Improve access to home and community-based long-term care services for persons with Alzheimer's disease & their families;
- Provide individualized and public information, education, and referrals about 1) diagnostic, treatment and related services that are available; 2) sources of assistance to obtain such services, including entitlement programs; 3) legal rights of individuals and families affected by ADRD.
In FY2000, AoA held a competitive grant award process, resulting in the issuance of grants to 16 states. Each grant has a 3-year project period and requires local match in the amounts of 25 percent (year 1), 35 percent (year 2), and 45 percent (year 3). The general programmatic foci of the program are to:

- develop models of care for persons with Alzheimer’s disease, and
- improve the responsiveness of the home and community based care system for persons with dementia.

Projects are targeted to hard-to-reach populations including ethnic minorities, low income and rural families with Alzheimer’s disease. The 16 states with ADDGS grants are Alaska, Arizona, Arkansas, California, Iowa, Maine, Minnesota, Nebraska, Nevada, New Hampshire, New Mexico, Rhode Island, Texas, Vermont, Virginia, and Wisconsin.

MANAGED CARE INITIATIVE

In addition to the 16 new projects, 5 states have grants of $80,000 to fund services provided under the ADDGS Managed Care Initiative, an effort started in 1997 by HRSA. The Managed Care Initiative is designed to test the impact of community-based service interventions on primary care physician utilization rates by persons with Alzheimer’s disease in a managed care environment.

Organizations with FY 2000 ADDGS Managed Care Initiative Grants are:

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

5. REINVENTING THE ADMINISTRATION ON AGING

Performance Measurement

AoA and the Aging Network have forged a partnership to utilize the tools provided by the Government Performance and Results Act (GPRA) to demonstrate to the Congress and the public the value of the programs administered under the Older Americans Act (OAA). GPRA has provided the Network the opportunity to use performance measurement to continuously document the results that service providers, Area agencies on Aging, State agencies on Aging, and AoA produce for older Americans. The reauthorized Older Americans Act reinforces the importance of measuring results, and directs AoA to develop performance outcome measures for Older Americans Act programs by December 2001. AoA and the Network have launched the Performance Outcomes Measures Project (POMP) to serve as a mechanism to identify and institutionalize indicators of results that will serve the long-term program improvement needs of the Network and Older Americans Act programs.

Early in its second year of operation, the POMP is building on the consensus achieved by AoA’s initiative to pull together selected network participants to identify a set of core areas and methods of performance measurement that can serve the aging community. With the assistance of accomplished researchers in the fields of
gerontology and statistics, State and area partners from 16 States developed and tested performance measurement instruments that center on the needs and characteristics of the people they serve. Consistent with the best quality management practices in the field, POMP focuses primarily on customer assessment measures for core service areas, such as home care, transportation, and caregiver services. Pilot test users have found a high degree of satisfaction with services, and have also identified customer-based recommendations for service improvement. For example, test findings for pilot areas indicate that transportation services are used most for doctor's appointments, and that expanded hours of service would be the most helpful change. State and area partners also tested nutrition assessment instruments for new clients and found that the nutritional risk of these individuals was very high. This indicates for test locations that nutrition services are targeted to the elderly who need the service most. Follow-up surveys of these same individuals will provide an indicator of the effects of Aging Network nutrition services on the nutritional status of these high-risk individuals after six months of program participation.

Statistical methodologies that are useful to program administrators in the field are an added and promising feature of the AoA sponsored performance outcome measurement effort. The POMP survey methods and instruments have been designed to allow real people, working area agency staff and others, to conduct valid sample surveys of clients across an assortment of service areas. The materials and experiences of pilot agencies are being documented and have been proven to be replicable for a variety of agencies and programs.

To support and enhance the indicators of program results that the performance outcome measurement partners are working to define, AoA is making use of ongoing administrative data to more fully illustrate and define the success of the Network in the service of elderly Americans. Ongoing administrative data from State and area agencies will be useful for demonstrating the effectiveness of these program entities in targeting services to those most vulnerable and in need. Existing administrative data will be useful for demonstrating the effectiveness of the Network in coordinating services and leveraging resources in support of the program objectives of the Older Americans Act.

AoA and its program partners are committed to use performance measures to inform decision making that improves programs for older Americans. As AoA's performance measures mature, and trends in program performance emerge, AoA and the Network believe that these indicators of results, along with program evaluation and other management assessment tools, will be critical to program development in support of older Americans.

**Policy Analysis**

For the first 30 years after enactment of the Older Americans Act (OAA) the major thrust of efforts undertaken by the Administration on Aging (AoA) was to support the development of a nationwide infrastructure with a capability to promote more comprehensive and coordinated home and community-based services to vulnerable older individuals. A network of State and Area Agencies on
Aging, as well as providers of supportive and nutrition services, has developed which leverages other sources of funds and coordinates with other agencies in addressing the needs of older individuals in greatest economic or social need, including older individuals with physical or mental impairments, living alone, with low income, minority status, or rural residence. The statutory basis for these efforts may be found in Titles III, VI, and VII of the OAA.

More recently the focus has shifted to the responsibilities of the AoA to "serve as the effective and visible advocate for older individuals within the Department of Health and Human Services and with other departments, agencies, and instrumentalities of the Federal Government by maintaining active review and commenting responsibilities over all Federal policies affecting older individuals" (OAA Section 202(a)(1)). The OAA requires that the Assistant Secretary for Aging "shall coordinate, advise, consult with, and cooperate with the head of each department, agency, or instrumentality of the Federal Government proposing or administering programs or services substantially related to the objectives of this Act, with respect to such programs or services" (OAA Section 203(a)(1)). Additionally the OAA provides that "The head of each department, agency, or instrumentality of the Federal Government proposing to establish programs and services substantially related to the objectives of this Act shall consult with the Assistant Secretary prior to the establishment of such programs and services." (OAA Section 203(a)(2)).

To implement these statutory requirements, recently a policy unit has been established in areas defined in the Declaration of Objectives for Older Americans (OAA Section 101 (1) "An adequate income..."), (2) "The best possible physical and mental health......"), (3) "Obtaining and maintaining suitable housing......"). In the Economic Security policy area there will be review and analysis of legislation and regulations covering programs administered by the Social Security Administration, the U.S. Department of Labor, and other agencies; in the Housing policy area of programs administered by the U.S. Department of Housing and Urban Development and other agencies; in the Health policy area of programs administered by the Health Care Financing Administration, the Veterans Administration, the Substance Abuse and Mental Health Services Administration and other agencies. The policy analysts represent AoA at meetings with representatives of these departments and agencies and participate actively on work groups. They prepare analyses of reports, develop policy briefs, and advise senior officials on developments in their policy areas.

**International Activities**

The AoA responds to requests for information from international organizations such as the United Nations, foreign governments, and agencies. It hosts international scholars, officials and practitioners who come to the U. S. to learn firsthand about America's response to population aging. In 1999 and 2000, AoA staff briefed delegations from over 25 countries.

The AoA participates in a number of collaborative efforts with other countries and with international organizations, such as the World Health Organization, to enhance aging programs and poli-
cies worldwide. The AoA has a signed agreement with the China National Committee on Aging of the People’s Republic of China to share information and to develop collaborative activities.

The Aging Core Group of the Health Working Group, U.S.-Mexico Binational Commission.—The Commission promotes exchanges at the Cabinet level on a wide range of issues critical to U.S.-Mexico relations. The Aging Core Group is one of five areas of collaboration between the U.S. Department of Health and Human Services and the Mexican Ministry of Health. The U.S. side of the Core Group is led by the Assistant Secretary for Aging. A number of ongoing exchanges of information, training and technical assistance have taken place to help both countries better address the special health needs of older people. In 1999 and 2000, in collaboration with the AoA, the Mexican Ministry of Health hosted invitational conferences to share models of care for the elderly; nutrition and the elderly; and prevention and control of chronic disease in the elderly.

The International Year of Older Persons 1999.—The AoA coordinated the U.S. government’s activities for the International Year of Older Persons (IYOP). A Federal Committee for the IYOP (the “Committee”) was created and chaired by the Assistant Secretary for Aging. The Committee consisted of over 40 governmental agencies and departments.

The IYOP was formally launched by the reading of a message from President Clinton by HHS Secretary Donna E. Shalala on October 19, 1999, at a gathering at the U.S. Department of Agriculture. Guests included Cabinet heads and representatives, international delegates and senior advocates in Washington, D.C. A special video message was delivered from US Senator John Glenn (D-OH) upon his return to space on October 29 as a NASA researcher. Gubernatorial proclamations of the IYOP within their states were displayed.

• In June 1999, the AoA and the Committee convened the invitational symposium Coming of Age: Federal Agencies and the Longevity Revolution. The symposium brought together some 300 senior administrators from across the Executive Branch to examine and address the policy and program implications of our rapidly aging American society. The goal of the symposium was to establish a foundation for the advancement of the federal policy and program agenda related to older Americans and their families in the 21st century. Discussions were organized around the major themes of economic security, aging in place, older people as a resource, health promotion and care, and disability and long-term care.

• An IYOP website was established on the AoA home page and became a major international source of information on the IYOP.

• The IYOP culminated with an event entitled “Positive Aging: A Goal for the Next Millennium”—A Day Celebrating the Culmination of The United Nations International Year of Older Persons. The event was hosted by the Committee and the US Committee (representing non-governmental aging associations). The program included a federal and a business panel
and an award ceremony for communities that have celebrated the IYOP.

The Federal Committee on Aging Issues.—With the close of the IYOP, the Committee continues its work as the Federal Committee on Aging Issues. The Assistant Secretary for Aging continues to chair the Committee. The Committee continues to share information among members and to examine ways of implementing recommendations from the 1999 symposium, Coming of Age: Federal Agencies and the Longevity Revolution.

International Plan of Action on Aging, 2nd World Assembly on Aging.—Working together with the Committee, AoA is coordinating the federal government’s input to the revised International Plan of Action. The revised Plan will be presented for discussion at the 2nd World Assembly on Aging, to be held under the UN auspices in 2002.

International Conference on Rural Aging.—Under Title IV of the Older Americans Act, the Administration on Aging funded West Virginia University to put on the first international conference on rural aging: Rural Aging: A Global Challenge. The West Virginia University Center on Aging is now a UN Programme on Aging Advisory Site on Rural Aging. Representatives of 40 nations attended the five-day conference held in June 2000 in Charleston, West Virginia. Policy recommendations on worldwide rural aging were adopted. They will become the basis of a Rural Aging Plan of Action to be included in the revised UN International Plan of Action on Aging.

Work Force Plan of the Administration on Aging

AoA’s workforce planning initiative was completed here at headquarters in December, 1999 and in our regional offices in November, 2000. The plan highlights the Administration on Aging’s vision of itself to be actualized by the year 2005, identifies competencies of its present workforce and areas for staff development, and focuses on organizational competency gaps to be addressed in the recruitment of staff in the future.

In the last few months AoA has recruited approximately twenty new employees, following the indicators, conclusions, and recommendations contained in our workforce plan, and we will continue to use the workforce plan as the basis for our recruitment and staff development efforts in the future. The workforce plan indicates that the agency’s present allocation of staff to the organizations support functions or infrastructures (i.e. grants, budget and finance, personnel, and training, IRM, and general administrative functions) are adequate for the size of the agency. The staffs performing these functions also are younger, with less seniority within the agency, and tend to have received technical training specific to their particular jobs. On the other hand AoA’s workforce plan highlights the fact that an overwhelming number of the almost one hundred employees the agency has lost since 1993 have been program staff. That trend will continue unabated over the next five years, when a 60 percent turnover in staff is anticipated because of retirements.

AoA has recently filled a vacant management position which oversees our regional operations and a planning and evaluation of-
ficer position, but the vast majority of the new recruits are policy analysts and program analysts with extensive experience in applying research methodologies, evidence-based principles and qualitative and quantitative approaches to policy formulation and development and to the design, implementation, and evaluation of programs and services. AoA has recruited policy analysts with a thorough, in-depth knowledge of the following public policy areas, as they relate to older people: home and community based long term care, healthcare, housing, economic security, and mental health. The newly hired program analysts will concentrate on program design, technical assistance, and implementation in the following program areas: home and community based long term care/housing, elder rights/legal services, public health promotion, and consumer protection.

A few of these analysts have been assigned the task of serving as mentors to the two Presidential Management Interns (PMI) recruited by the agency this summer. Next year and in subsequent years, AoA will be in a position to concentrate on recruitment of staff at the GS 9 entry level of the PMI program, the Outstanding Student program, and the Student Co-op program and anticipate being able to employ each year at least four to six staff from these programs to replace program staff retiring.

Regional Teams

As part of the new vision for the Administration on Aging, The Assistant Secretary on Aging directed the Regional Offices in 1999 to establish teams, including multi-regional teams, to help advance AoA's priorities in the areas of public/private partnerships, diversity, customer service and financial management. The teams made significant progress during 1999 and 2000.

The Boston (Region I) and New York (Region II) Offices worked together on a team to foster public/private partnerships. As it’s first project, the team established a partnership with the Federal Deposit Insurance Corporation (FDIC) and the Women’s Institute for a Secure Retirement (WISER) to help mid-life and elderly women, especially low-income and minorities, understand and prepare to meet their everyday economic and financial needs at progressive states of aging. The partnership has produced a financial literacy program known as Power 2000 Take Control of Your Financial Future. The program includes a training manual with a suggested curriculum, materials that can be duplicated, resource guides and information on how to conduct a local workshop. To promote the program, AoA, FDIC and WISER identify and stimulate opportunities for presentations to the Aging Network, the banking network and other community-based groups, all of whom are asked to serve as catalysts in promoting the financial literacy program in their localities. Local partnerships are then formed among the partners and other federal, state and local organizations to serve as facilitators, resources and/or faculty in conducting Power 2000 presentations locally. The program was successfully piloted during 2000 in New York City and in one rural community in Upstate New York. Based on the results of the pilot, the partnership plans to roll out the program in 2001 to AoA regions nationwide.
The San Francisco Office (Region IX) team is focused on policy issues related to diversity and aging. The team has developed a new section of the AoA web site, www.aoa.gov, “The Many Faces of Aging: Resources to Effectively Serve Minority Older Persons,” to help increase access to programs and services for older minority Americans and their caregivers. The site was launched in December, 2000 and includes a range of health and aging resources for and about minorities and diverse aging populations; demographic snapshots and statistics; and laws and executive orders related to ensuring improved access and culturally appropriate services. The site highlights various approaches to develop culturally and linguistically responsive services for minority older persons. The Dallas-Atlanta (Regions IV and VI) team has been building a diversity website that will offer state-specific data on minority populations. These two initiatives were developed response to the growing diversity of the aging population. Currently, minority elders comprise over 16.1 percent of all older Americans (65 years of age and older). In the future, their numbers are expected to increase dramatically. Between 1999 and 2030, the older minority population 65+ is projected to increase by 217 percent, compared with 81 percent for older white population.

The Denver Office (Region VIII) team is focused on customer service, including the establishment of internal performance outcome measures for employee participation and performance. The Denver team has developed a comprehensive orientation manual for all new AoA employees. The manual provides background information on the Department of Health and Human Services, AoA, the Older Americans Act and the Aging Network, as well as information on internal operating policies and procedures. The manual will be issued in January 2001.

The Denver team also has developed several tools for AoA’s external customers. The “Compendium of Grant Resources for Native American Elders Programs” was developed in partnership with the Community Resource Center in Denver and the National Committee to Preserve Social Security and Medicare. The Compendium contains resources on funding, publications, resource agencies, profiles of funders and internet resources targeted to Native Americans. The Compendium project was initiated in Region VIII when Tribal Elders Programs requested additional funding information from the regional office to augment moneys received under Titles VI and III of the Older Americans Act. “Cyberspace Resources on Retirement” is a publication that identifies internet links on retirement and financial planning, health, quality of life and other baby boomer issues. The publication was a result of a creative partnership among the Develop Denver Office, the Community College of Denver, American Association for Retired Persons, and the National Committee to Preserve Social Security and Medicare.

The Chicago (Region V) and Kansas City (Region VII) Offices have collaborated on establishing a fiscal management team comprised of representatives from all the regional offices and the AoA central office in Washington. The team serves as the focal point within AoA on all grantee related fiscal matters. The team ensures the provision of timely, consistent, uniform and accurate fiscal policy and technical assistance to the state units on aging, Native
American programs, and the area agencies on aging. During 2000, the team developed a manual for AoA project officers, and drafted several technical assistance documents that will be used to implement the 2000 Amendments to the Older Americans Act, including the National Family Caregiver Support Program.

The Seattle (Region X) Office team is looking at the issue of active aging, including the opportunities and challenges associated with creating meaningful roles for older people. There is a growing body of research which suggests that both the individual and the nation as a whole can benefit from older people being actively engaged in activities which allow them to make meaningful contributions to their families, their communities and the larger society. This issue will take on great significance as the baby boom generation ages. As a first step in exploring this issue, the Seattle team is reviewing the literature to identify what we know about the key factors and dynamics associated with active aging.

SECTION II

1. SUMMARY OF REPORTS

State Program Report

Each year, the Administration on Aging (AoA) awards Older Americans Act (OAA) funds to every state based primarily on the relative size of the state's elderly population.

Each State Unit on Aging (SUA), in turn, relies upon Area Agencies on Aging (AAAs) to partner with a diverse set of home and community service providers in getting supportive, nutrition, and related services to older persons. (Several states with relatively small populations combine the SUA and AAA functions into a single agency). The following is summary information on the clients, services, expenditures and staffing of OAA programs for fiscal year 1998 (most recent data available).

Clients

Older Americans Act programs served nearly 6.5 million persons 60 years of age and older in FY 1998. While services are open to all older Americans, efforts are made to focus on those with the greatest economic and social need. Thus, OAA program participants have incomes below the poverty level at a rate nearly four times that of the total population in this age group. Nearly one-third of these individuals live in rural areas, compared to less than one-quarter of the total population age 60 and above. Participants in OAA service programs were members of racial or ethnic minority groups at a level nearly one-third higher than the total elderly population. OAA minority clients had incomes below the poverty level at a rate more than twice that of the minority elderly population overall.

Services

Older Americans Act programs provided nearly 20 million units of personal care, homemaker and chore services in FY 1998. During the same period, OAA programs provided almost 130 million home delivered meals and 114 million congregate meals. Older persons
received over 45.7 million trips to medical services, grocery stores, and other community services through OAA transportation programs. Over 13 million units of information and assistance services were provided to older persons and those acting on their behalf.

**Expenditures and Staffing**

State Units on Aging and Area Agencies on Aging generated nearly $2 billion in state and local funds to supplement the $678 million in OAA dollars they received from AoA in FY 1998. Many SUAs also administered other programs for the elderly such as Medicaid home and community based waivers and state funded support services. There were 3,285 SUA staff and another 37,174 staff at the AAA level working together to administer the much needed services provided through OAA funds. These figures include over 16,000 volunteers.

**Ombudsman Program Report**

State Long Term Care Ombudsmen are advocates for residents of nursing homes, board and care homes, assisted living facilities and similar adult care facilities. They work to resolve problems of individual residents and to bring about changes at the local, state and national levels to improve care. While most residents receive good care in long-term care facilities, far too many are neglected, and other unfortunate incidents of psychological, physical and other kinds of abuse do occur. Thus, thousands of trained volunteer ombudsmen regularly visit long-term care facilities, monitor conditions and care, and provide a voice for those unable to speak for themselves.

Begun in 1972 as a demonstration program, the Ombudsman Program today is established in all states under the Older Americans Act, which is administered by the Administration on Aging (AoA). Local ombudsmen work on behalf of residents in hundreds of communities throughout the country. Detailed information on the program for 1998 (the latest year for which reports are available) follows.

**Cases and Complaints**

In FY 1998, ombudsmen nationwide opened 136,424 cases and closed 121,686 cases involving 201,053 individual complaints, most of which were filed by residents or friends and relatives of residents. Eighty-two percent of cases were in nursing home settings; 17 percent involved board and care, assisted living and similar facilities; and one percent were in non-facility settings. The top five nursing home complaints were in categories involving poor resident care, lack of respect for residents and physical abuse. Seventy-two percent of nursing home complaints and 67 percent of board and care complaints were resolved or partially resolved to the resident’s or complainant’s satisfaction.

**Program Funding**

FY 1998 program funding totaled $47,404,557, $4.35 million more than in FY 1997. While program funding rose in FY 1998, it was relatively level for the period FY 1995 to 1998. Resources are still inadequate to meet the need for ombudsman services and vol-
unteer coverage in all facilities covered by the program. About 58 percent of the program funding was from federal sources, especially Title III of the OAA; states provided about 28 percent of funding; 14 percent was from private sources.

Local Programs, Staffing and Volunteers

There were 587 local and regional ombudsman programs in FY 1998, essentially the same as in FY 1997; most of these programs were located in area agencies on aging. The number of paid ombudsman staff increased from 887 full-time equivalents (FTEs) in FY 1997 to 927 FTEs in FY 1998, with 679 paid staff working full-time on the program. The number of volunteers who are trained and certified to investigate complaints increased from 6,795 in FY 1997 to 7,359 in FY 1998. Most state ombudsman programs are located in state agencies on aging, but programs in 15 states are located in other types of organizational settings, a slight increase since FY 1997.

Report on the American Indian, Alaskan Native and Native Hawaiian Program

The Office for American Indian, Alaskan Native and Native Hawaiian programs serves as the focal point within the AoA for the operation and assessment of Native American programs authorized under Title VI and oversight of the Native American Elders Resource Centers authorized under Title IV. The Office Director continues to serve as the effective and visible advocate on behalf of older Native Americans, coordinates activities with other Federal departments and agencies, collects and disseminates information related to the problems of older Native Americans, and promotes coordination between the administration of Title III and Title VI.

Title VI—Grants for Native Americans

Under Title VI of the OAA, the AoA annually awards grants to provide supportive and nutritional services for older American Indians, Alaska Natives and Native Hawaiians.

Title VI, Grants to Indian Tribes, was added to the OAA in the 1978 amendments and was expanded by the 1987 Amendments to include Native Hawaiians.

In Fiscal Year 2000 grants totaling $18,457,000 were awarded to 225 American Indian and Alaska Native Tribal Organizations, and two organizations serving Native Hawaiians, to provide congregate and home-delivered meals and a variety of supportive services. As required by the OAA, 90 percent of the funds went to the Tribal organizations and 10 percent went to the Native Hawaiian organizations.

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

In addition to providing meals, nutrition education, screening, and counseling, Title VI programs are important resources for social interaction and supportive services. For example, congregate meal programs provide Native elders with important opportunities to meet with friends, participate in recreation and other activities, and take trips to other elder programs or state and national meetings. Other vital supportive services can include outreach, family support, legal assistance, and transportation to meal sites, doctor’s appointments, and grocery shopping. Most programs offer health-related services, such as podiatry screening and blood pressure monitoring.

*Tribal Listening Session*

President Clinton signed an Executive Memorandum on April 29, 1994 affirming that the United States government maintains the unique relationship with Indian Tribes founded on the principle of government-to-government relations. Consistent with this relationship, the AoA hosted a Tribal Listening Session on August 8, 2000 in Washington, DC with Tribal leaders throughout the country. The Session focused on issues affecting the lives of Indian elders. There were over 100 participants representing Tribes nationally. The Listening Session allowed for an open dialogue addressing four priority areas: 1) policy directions; 2) capacity building; 3) health care; and 4) long-term care. Recommendations were made by the participants in these four areas and are currently being reviewed and addressed.

*National Resource Centers*

Since 1994, AoA has awarded grants to two universities to establish National Resource Centers for Older American Indians, Alaska Natives, and Native Hawaiians. The University of Colorado at Denver and the University of North Dakota at Grand Forks provide culturally competent health care resources, community-based long term care information, and related services. They serve as the focal points for developing and sharing technical information and expertise for American Indian organizations, Native American communities, educational institutions, and professionals and others working with Native elders.

*Interagency Task Force on Older Indians*

The 1987 Amendments in Section 134(d) directed the Commissioner on Aging to establish a permanent Interagency Task Force on Older Indians, with representative of federal departments and agencies who work to improve services to older American Indians. This Task Force was established in Fiscal Year 1990. Task Force members focus on three areas of concern: health, transportation, and data. The Task Force recommends ways to improve interagency collaboration, enhance services, and identify problems or barriers that prevent or diminish collaboration.
Discretionary Grants Program

The Administration on Aging supports a number of demonstration programs, national resource centers, and related discretionary grant projects under the authority of Title IV of the Older Americans Act, the Health Insurance Portability and Accountability Act, and the Public Health Services Act. The principal AoA discretionary grants program efforts are summarized below:

Health Care Fraud and Abuse Control Program Activities

The General Accounting Office estimates that billions of Medicare and Medicaid dollars are lost each year to waste, fraud and abuse. The AoA has played an active role in the ongoing effort to address this serious national problem through the enactment of P.L. 104–209, the Omnibus Consolidated Appropriations Act of 1997. Language contained in Title IV of the Older Americans Act directs the AoA to establish community-based projects that utilize the skills and expertise of retired professionals in identifying and reporting waste, fraud and abuse. The projects are designed to recruit and train retired professionals, such as doctors, nurses, teachers, lawyers, accountants, and others to work in their communities and in local senior centers to help identify deceptive health care practices, such as over billing, overcharging, or providing unnecessary or inappropriate services. These senior volunteers undergo several days of training reviewing health care benefit statements and outlining steps individuals can take to protect themselves.

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

Working in partnership with partners at the federal, state, and local levels, the Medicare error rate has been reduced by more than 40 percent over the past three years, and billions of dollars of improper payments have been returned to the Medicare and Medicaid programs.

Over the past three years, the AoA’s projects supported by Title IV of the Older Americans Act and the Health Insurance Portability and Accountability Act have a commendable track record:

- They have trained more than 40,000 volunteers and aging service professionals to serve as community resources and educators.
- These volunteers and professionals in turn have conducted more than 25,000 community education events and one-on-one
counseling sessions, directly educating more than one million beneficiaries.

- The projects also held more than 2,500 media events, reaching more than an estimated 45 million people.
- During this time period, more than 2,300 complaints have been referred to health care providers, Medicare contractors, the Office of Inspector General, or other appropriate entities for follow-up investigation and correction.
- While it has not been possible to document the results of all the cases referred by the AoA's grantees, nearly $58 million in savings have been documented as being directly related to the efforts of the projects.
- The heightened awareness of beneficiaries checking their Medicare Summary Notices and Explanation of Medicare Benefit statements has contributed to a 42 percent reduction in the Medicare error rate since the projects have been in operation.

**Pension Information and Counseling Program**

Now located in 14 states (Arizona; California; Connecticut; Illinois; Maine; Massachusetts; Michigan; Minnesota, Missouri; New Hampshire; New York; Rhode Island; Vermont; and Virginia), the pension counseling demonstration projects supported by AoA since 1993 have assisted over 10,000 older Americans with pension problems. The projects have been instrumental in recouping over $30 million in pension claims. Each of the pension counseling projects brings its own unique model to the program. Some projects operate with full-time lawyers, others rely on highly trained volunteers to provide assistance. The projects provide a range of services, from answering pension questions to providing legal assistance to obtain promised pension benefits.

Each of the demonstration projects offers several basic services:
- Counseling and assistance to older individuals and their families who need help in determining their rights and in following the process for filing claims or complaints related to pension and other retirement benefits;
- Information on sources of pension and other retirement benefits;
- Referrals to attorneys, actuaries, legal services and other advocacy programs;
- Outreach programs to provide information, counseling, assistance and referral regarding pension and other retirement benefits with special emphasis on outreach to women; minority; rural, and low-income retirees.

The Pension Rights Center in Washington, DC, with financial assistance from the Administration on Aging, provides technical assistance to individual pension projects, state and area agencies on aging, and legal services providers on pension issues, and encourages these groups to coordinate their activities with other federal agencies. The Center also provides training for staff and volunteers working in pension demonstration projects.

**Elder Rights and Legal Assistance Program**

AoA support for model projects and resource centers under its Elder Rights and Legal Assistance Program is summarized below:
(1) Statewide Senior Legal Hotlines

Model legal hotlines, utilizing paid, specially-trained, and experienced lawyers, are designed to provide unlimited free legal advice to all state residents age 60 and older, regardless of their level of income or resources. The hotlines also provide legal briefs and related assistance such as document reviews and calls/letters to third parties, but only when there is a likelihood that this would resolve the problem. Services are provided statewide by means of toll-free telephone lines. Currently, AoA is supporting senior legal hotlines in northern California, Georgia, Hawaii, Indiana, Iowa, Kentucky, Maine, Maryland, Michigan, New Hampshire, Tennessee, Washington, and West Virginia.

(2) National Legal Assistance Support Projects

The Older Americans Act mandates the support, under Title IV, of a national system of legal assistance support activities to State and Area Agencies on Aging which will assist them in developing an elder rights system and in providing, developing and supporting legal assistance for older people. In the 1992 amendments to the Older Americans Act, legal assistance was made an integral part of the new Title VII, Vulnerable Elder Rights Protection program. As a result, AoA expanded the role of the national system to encompass elder rights systems development. Five (5) national level providers of legal support and assistance are now being funded by AoA through 2001.

(3) National Resource Centers to Protect Elder Rights

Two centers active nationwide (the National Center on Elder Abuse and the National Long Term Care Ombudsman Resource Center) have been funded by AoA since 1993 to provide findings, products, information, training, and technical assistance that would help to safeguard the rights of older persons living in residential and institutional settings.

Reach 2010 for the Elderly

In FY 2000, the AoA joined with the Centers for Disease Control and Prevention to strengthen the scope of the departmental initiative to eliminate health disparities among racial and ethnic minority populations by mounting REACH 2010 for the Elderly. This major collaborative effort has the goal of improving the health status of older racial and/or ethnic minority persons. Four projects were funded to support community coalitions in their groundbreaking initiatives to reduce health care disparities in the areas of heart disease, diabetes, and immunization. The Reach 2010 grantees are as follows:

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

Other Significant Discretionary Program Efforts

Other noteworthy AoA-supported discretionary programs and projects include the Alzheimer’s Disease Demonstration Grants to
States Program, the Family Friends/Volunteer Senior Aides program, the National Eldercare Locator, minority aging model projects, and home and community based long term care demonstration projects.

2. PROGRAM DIRECTION

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<tr>
<th>FY 1999</th>
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<th>FY 2001</th>
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<td>Supportive Services &amp; Centers</td>
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FY 1999

In FY 1999, AoA programs were funded at a total of $881.7 million, an increase of almost $11 million over FY 1998. The majority of this money was allotted by statutory formula to states and territories. Funding for the major supportive services and nutrition programs remained unchanged; increases were provided for several smaller AoA programs. Vulnerable Older Americans did receive an additional $3 million (+33%) to increase Ombudsman activities. AoA's sole discretionary grant program, State and Local Innovations and Projects of National Significance received $18 million, the largest increase, +$8 million (+80%). In FY 1999 the number of projects funded under this discretionary authority increased from approximately 61 to 105 and included the Eldercare Locator, Senior legal hotlines, pension counseling, and evaluation activities.

FY 2000

In FY 2000, AoA programs were funded at a total of $932.7 million, an increase of $51 million. Home-Delivered meals, one of AoA's two formula grant nutrition programs, received an additional $35 million, a +31 percent increase. Funding for AoA's other formula grant programs again remained static. The increase for Home-Delivered meals allowed grantees to provide nearly 166,000,000 meals to frail, home-bound elders. Vulnerable Older Americans also received a $1 million increase, again for the Ombudsman program. And once again, State and Local Innovations and Projects of National Significance received a large increase (73%) bringing the program level to over $31 million and funding approximately 70 new projects, 120 projects total. Program Administration also received a nearly $2 million increase to fund staff increases and increased costs of facilities rental, automated systems support, travel, supplies and equipment.

THE FUTURE

In FY 2001, the start of which covers the final three months in calendar year 2000, funding for Aging programs has increased sig-
nificantly, to a total of $1.1 billion or $169 million over the FY 2000 level. This includes $125 million for a new National Family Caregiver Support Program to provide support to the 7 million informal caregivers of older Americans. In addition, the FY 2001 budget includes increases for each of its core services and programs, including home-delivered and congregate meals; preventive health; grants to Native Americans, programs which protect the rights of the vulnerable, as well as an increase for the Alzheimer's Disease Demonstration Project Grants to States.

ACCOMPLISHMENTS OF THE ADMINISTRATION ON AGING: 1999–2000

Administration/Departmental Initiatives

Since 1995, the Administration on Aging has been a partner in the Administration's Operation Restore Trust initiative, along with HCFA, the Office of the Inspector General, and the Department of Justice to combat waste, fraud and abuse in Medicare and Medicaid. AoA has trained state and local ombudsmen and volunteers, aging network personnel, including staff and volunteers of State and Area Agencies on Aging, health insurance counselors and other service providers to identify and report suspected fraud and abuse. In FY 2000, $10 million in grants was awarded to 48 “Senior Medicare Patrol Projects” operating in 43 states plus the District of Columbia and Puerto Rico. These projects have trained approximately 30,000 senior volunteers and aging network staff and educated 650,000 beneficiaries to identify and report suspected cases of fraud and abuse.

Reauthorization of the Older Americans Act (OAA) with inclusion of the National Family Caregiver Support Program, part of the Administration's Long Term Care Initiative unveiled in 1999, which will help hundreds of thousands of family members care for their older family members by providing respite care and supplemental services, information, assistance, training, support and counseling. FY 2001 funding for the National Family Caregiver Support Program is $125 million.

Public Information/Customer Service

Launching of AoA’s web site in 1995, a major source of timely and useful information to older people, the national aging network, policymakers. AoA’s web site has been expanded to include limited access web sites for the Federal Coordinating Committee of the International Year of Older Persons (1999); a limited Spanish web site containing resource and referral information to those interested in Hispanic aging and health issues, and an independent web site dedicated to providing and sharing information about the Administration on Aging’s role in the Administration’s effort to fight fraud, waste and abuse in Medicare and Medicaid. In FY 2000, a minority/aging issues limited access web site and an on-line caregivers guide called “Because We Care” was added.

Institution in 1999 of a limited access list serve specifically devoted to national aging network of state and area agencies on aging responsible for the collection and reporting program performance data to the Administration on Aging. Through NAPISNEWS, cus-
tomized information and technical assistance can be quickly disseminated and provided to appropriate staff throughout the country.

Creation of a Congressional mandated National Aging Information Center to provide convenient access to a wide range of resources for those interested in aging issues and information. The Center serves the aging network, educators, researchers, practitioners and the general public.

Establishment of AoA's national disaster assistance program to assist older persons and representatives of the aging network in recovery efforts from Presidentially declared disasters. Since 1993, the Administration on Aging in collaboration with its state and area agencies on aging, FEMA, and the Red Cross has provided approximately $17.5 million in disaster relief to thousands of older persons in immediate need of assistance.

**MEDICARE+CHOICE**

Since 1998, AoA has worked in partnership with the Health Care Financing Administration (HCFA) to support Medicare+Choice (M+C) implementation. Through the Information and Referral for Medicare Beneficiaries Projects, AoA was able to provide funds to State Units on Aging (SUAs) to strengthen the capability of information and referral providers at the State, Area Agency and local levels to respond to inquiries regarding M+C. In addition, AoA worked in collaboration with it's National Information and Referral Support Center and HCFA to develop the Medicare+Choice Training Manual for Older Americans Act Information Referral & Assistance Programs. The manual was provided to State Units on Aging and Area Agencies on Aging to assist them in developing Medicare+Choice training and outreach activities. Over 15,000 information and referral specialists and other Aging Network staff have received training as a result of this collaborative effort.

**NATIONAL SYMPOSIA ON LONGEVITY**

The Administration on Aging convened two symposia during 1999 and 2000 which focused on the implications of a long living society. The symposia were designed to increase public awareness of longevity, provide a forum for dialogue about the implications for research, policy, programs and services, and foster the development of partnerships and collaborations between a variety of organizations. The first symposium focused on the most potent and promising research findings related to caregiving, economic security, health, population diversity, consumer protection, information and technology and media relations. The second symposium bridged the gap between research and practice by providing the participants evidenced-based, outcomes-oriented methods and tools that could be used to plan, develop and modernize services and programs for America's diverse and growing older population.

**Programs and Services for Older Americans**

The Older Americans Act continues to provide essential home and community services for older persons, and their family members such as nutrition, transportation, and legal assistance,
through a national aging network of 57 State offices on aging, 655 area agencies on aging, 225 Tribal Organizations, service providers and volunteers.

**Nutrition**

Release of a Congressionally mandated evaluation of the Elderly Nutrition Program under the Older Americans Act (OAA) to determine the effectiveness of the Elderly Nutrition Program in meeting the nutritional needs of older persons as well as meeting unmet needs. Key findings include determination that the highly successful OAA Elderly Nutrition program provides an average of one million meals per day to older Americans; between 80 and 90 percent of participants have incomes below 200 percent of the DHHS poverty level, and more twice as many of the participants live alone.

Establishment of the National Policy and Resource Center on Nutrition and Aging which focuses on providing information dissemination, training and technical assistance and policy analysis on issues related to nutrition and older persons.

The Morning Meals on Wheels Program Initiative was launched in 20 communities across the United States. This is a partnership with General Mills Food service and the Administration on Aging to provide at-risk older Americans with additional food and nutrition security. Morning Meals on Wheels provides home elders with a morning meal delivered to their door in addition to their regularly scheduled noon meal.

Alzheimer’s Disease Demonstration Grants program was transferred from HRSA to AoA. Sixteen new ADDGS grants were funded in 2000, to expand support efforts for persons with Alzheimer’s Disease and their caregivers. The program emphasizes outreach to under served populations and regions, program development, service delivery systems and information dissemination.

AoA convened its first Tribal Listening Session to Native American elder issues. The session gave American Indians, Alaska Natives, and Native Hawaiian representatives the opportunity to discuss policy directions and capacity building in areas such as long term care, health promotion, and support services needed in the future. Greater numbers of Native Americans are living well into their 80’s and 90’s. AoA funds 225 tribal organizations representing more than 300 American Indian and Alaska Native tribes and two organizations serving Native Hawaiians, through Title VI of the Older Americans Act.

**Consumer Protection**

Release of the National Elder Abuse Incidence Study which found that more than one half million older Americans, mostly older women, suffered some form of abuse and neglect in 1996, most at the hands of their family members.

Entered into Interagency Agreement with the Department of Justice to address the public safety and security needs of older Americans. Activities have included promotion of local and state TRIAD programs, which are efforts to increase cooperation between law enforcement and aging and social services providers to reduce criminal victimization.
Funding a new National Center on Elder Abuse to be operated by the National Association of State Units on Aging in partnership with the other advocacy organizations to facilitate training and technical assistance between state and local service providers, including older Americans, working to prevent elder abuse.

Establishment of Pension Counseling and Counseling program including 10 AoA-funded pension demonstration projects serving 14 states and one technical assistance Project for a total of $3.3 million dollars. These projects have assisted 30,000 retirees, older employees and their spouses or widows/widowers to determine whether or not they are receiving the amount of retirement benefits to which they are entitled. The project has recouped at least $21 million in pension benefits on behalf of their clients returning $7 for every $1 spent to older Americans. AoA also released results of a two-year Congressional study of the Pension Counseling Program, which found that basic pension counseling for older workers and retirees is needed, can be easily provided at a moderate cost by training volunteers, and can yield substantial individual and collective savings.

Design and Implementation of the National Ombudsman Reporting System (NORS) to obtain needed detailed ombudsman complaint and program information in an effort to design policy and serve as a baseline against which to measure program outcomes in future years. Funding of the National Long Term Care Ombudsman Resource Center, which provides training and technical assistance to state and local ombudsmen across the country.

Partnership with the Federal Deposit Insurance Corporation in the Financial Literacy, Y2K and Banking Campaign, a public awareness campaign to promote financial literacy in particular between women and low income and minority populations.

Promoting Health and Quality of Care

AoA has awarded four demonstration grants to expand the Centers for Disease Control’s Reach 2010 (Racial and Ethnic Approaches to Community Health 2010) initiative. This grants will permit four communities to develop science based, community demonstration projects to address health disparities in older, racial and ethnic minority populations.

AoA and HCFA joined forces to improve the quality of care in nursing homes. Nearly one half million dollars has been dedicated to support 4 demonstration projects to educate and empower communities and families to improve nutrition and hydration, and prevent abuse of nursing home residents.

Management

To develop the national core set of performance outcome measures for aging services required by the Government Results and Performance Act, AoA is building on performance outcome measures currently in use by state and area agencies. Seventeen State and Area Agency partners are working to address the elements of data collection; analysis and recommendations; pilot testing, and dissemination, utilization and mentoring activities.
The Administration on Aging was one of the first in HHS to undertake a workforce planning process. In early 1999, it completed a workforce plan to identify requisite knowledge, skills, and abilities for management and staff to be able to formulate, implement and assess programs and policies related to older persons and their families. The workforce plan serves as a guide for the recruitment and hiring of new managers and staff.

The Administration on Aging embarked upon the reorientation of its Central and Regional Office program and policy foci in order to respond more effectively to the growing numbers and the increasing diversity of older Americans and their families, baby boomers anticipating their older years, and of populations at greater risk of chronic illness, disability and economic security.

International Activities

AoA chaired and led national federal activities for the International Year of Older Persons, designated by the UN for 1999. As head of the Federal Committee for the International Year for Older Persons, AoA convened the first ever federal symposium “Coming of Age: Federal Agencies and the Longevity Revolution.” As part of the IYOP activities, the Assistant Secretary for Aging addressed the 54th Session of the United Nations General Assembly on the aging challenges of a longer living U.S. society.

Joined as a partner with Sister Cities International, Inc. which joins aging professionals and volunteers in the US with their counterparts in other countries to provide technical assistance in meeting the needs of any population.

The Administration on Aging is a principal partner in the US-Mexico Bilateral Commission Health Working Group convened as part of the 1996 Annual Meeting of the US-Mexico Bilateral Commission. AoA assists in the identification of public health issues that effect both countries including aging, migrant health, prevention of tobacco abuse, women's health, immunization, and substance abuse.

AoA was a member of the 1999 World Health Day Advisory Committee. “Healthy Aging” was designated by the World Health Organization as the topic of World Health Day 1999. In the US, the theme “Healthy Aging, Healthy Living - Start NOW! was selected by the American Association for World Health and the advisory committee as fitting since 1999 was IYOP.

Network Security/Y2K

AoA was the first in the Department of Health and Human Services to achieve Y2K compliancy, and worked for two years with its national aging network of state and area agencies on aging to ensure they were ready for the year 2000.

Security of AoA’s computer network has been improved in response to the President's Decision Directive 63 concerning anticipated cyberterrorism.
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 ongoing and completed HHS evaluations. In addition, the PIC data base includes reports on ASPE policy research studies, the Inspector General's program inspections and investigations done by the General Accounting Office and the Congressional Budget Office. Copies of final reports of the studies described in this report are available from PIC.

During 2000, ASPE undertook or participated in the following analytic and research activities which had a major focus on the elderly.

1. POLICY DEVELOPMENT—AGING

*Federal Interagency Forum on Aging-Related Statistics*

ASPE is a member of the Federal Interagency Forum on Aging-Related Statistics. The 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 the agencies through joint problem-solving, identification of data gaps, and improvement of the statistical information bases on the older population. The primary goals of the Federal Forum were to provide federal agencies a venue for discussing aging-related data issues and concerns that cut across agency boundaries, facilitate the improvement of existing aging data bases and the development of new sources of information, improve the dissemination of information on aging-related research and data, and encourage cross-national research and data collection on population aging. The Federal Forum was instrumental in gathering support for several important surveys of the aging U.S. population (e.g., the Health and Retirement Survey, the survey of Assets and Health Dynamics Among the Oldest-Old, and the Second Longitudinal Study of Aging) and produced several stand-alone reports including *Trends in the Health of Older Americans and 65+ in the United States.*
2. RESEARCH AND DEMONSTRATION PROJECTS

Panel Study of Income Dynamics

University of Michigan, Institute for Social Research
Principal Investigators: James N. Morgan, Greg J. Duncan, Martha S. Hill

Through an interagency consortium coordinated by the National Science Foundation, 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 (OEO). The PSID has gathered information on family composition, employment, sources of income, housing, mobility, health and functioning, and other subjects. The current sample size is over 7,000 persons, and an increasing number of them are elderly. The data files have been disseminated widely and are used by hundreds of researchers in this and other countries to get an accurate picture of changes in the well-being of different demographic groups, including the elderly.

Funding: ASPE and HHS precursors: FY67 through FY79—$10,559,498; FY80—$698,952; FY81—$600,000; FY82—$200,000; FY83—$251,000; FY84—$550,000; FY85—$300,000; FY86—$225,000; FY87—$250,000; FY88—$250,000; FY89—$250,000; FY90—$300,000; FY91—$300,000; FY92—$800,000; FY93—$225,000; FY94—$205,000; FY95—$100,000; FY96—$200,000

End Date: Ongoing

1999 NLTCS/ICS: File Preparation and Preliminary Data Analysis

MEDSTAT Group

The purpose of this project is to prepare the 1999 NLTCS/ICS data file for analysis and to perform some preliminary descriptive analyses. This is a necessary prerequisite for more detailed analyses, which will be used to update the ASPE booklet “Informal Caregiving: Compassion in Action” (published in 1998, based on 1995 NLTCS data).

Funding: $49,452 (FY00)

End Date: September 30, 2001

A Comparative Study of the Outcomes and Costs Associated with Medicare Post-Acute Services in Skilled Nursing Facilities, Rehabilitation Hospitals/Units, and Home Health Settings

University of Colorado

Using the outcome measurement instrument developed for patients suffering from a stroke (i.e., developed under the project Medicare Post-Acute Care: Quality Measurement), two projects have been combined to study the outcome and costs of Medicare post acute care services for Medicare beneficiaries who have suffered a stroke and are discharged from acute care hospitals to skilled nursing facilities (SNFs), rehabilitation hospitals/units (RFs), home health agencies (HHAs), or use multiple post-acute care settings. These studies will examine in a post-prospective payment system environment the: (1) demographic and health related characteristics of and assess the extent of overlap in stroke patients treated in each of the post-acute care settings; (2) patterns
of service use and costs associated with the treatment of similar patients in each setting and across episodes of care; (3) outcomes across an episode of care for similar Medicare beneficiaries treated by each post acute provider type and those treated by multiple providers; (4) the relationship between outcomes for similar patients and differences in the mix and intensity of services provided, and level of reimbursement across post acute care providers and episodes of care; and (5) core measures that are most useful to incorporate into on-going reporting requirements to monitor outcomes in each post-acute care setting and across episodes of care.

Funding: Total Award $1,593,536 (FY99 $898,956; FY00 $694,580)
End Date: August 28, 2003

Analyses of Changes in Elderly Disability Rates: Implications for Health Care Utilization and Costs

The Urban Institute

The purpose of this project is to conduct analyses using the 1984 to 1999 National Long-Term Care Survey (NLTCS) and the Medicare Current Beneficiary Survey (MCBS) to understand the nature of recent declines in elderly disability rates and their implications for health care utilization and costs. Specifically, researchers at The Urban Institute are (1) decomposing changes in elderly disability rates using the 1984 to 1999 NLTCS and exploring possible reasons for the decline, and (2) linking changes in elderly disability rates to the use of specific medical procedures (e.g., cataract surgery, coronary and joint replacement surgeries) and/or assistive technology. The MCBS is the primary data set for the latter analyses.

Understanding the structure of the decline will give us our first clues as to the reasons for the overall decline, the likelihood that disability rates will continue to fall in the future, and its potential impact on health care spending. Current hypotheses for the decline include improvements in nutrition (including advances in food preparation and storage over the century), healthier life-styles (higher levels of physical activity, lower levels of drinking and smoking), better treatment of chronic diseases through medical procedures and pharmaceuticals, and use of assistive devices and technology. It is likely that future improvements in disability and changes in health care utilization and spending will be heavily dependent on which of these hypotheses is correct. For example, if declines in disability rates are due primarily to improvements in IADLs or equipment use and reflect environmental changes rather than improvements in the intrinsic health of the elderly population, then the declines observed over the last decade may not continue into the next century and may have limited impact on acute health care spending. This project is a first step in understanding the policy implications of the changes that we are observing in elderly disability rates.

Funding: $254,409 (FY99 $179,409; FY00 $75,000)
End Date: December 31, 2001

Analyses of Residential Transition of Older Americans.

Urban Institute
There are four main questions to be addressed in this project: (1) How do characteristics (both individual and environmental) of elderly persons residing in institutional settings differ from those residing in community-based settings? (2) How do these characteristics vary over time? (3) Are there differences in these characteristics between subgroups of institutionalized and non-institutionalized elderly? (4) What is the relationship between selected individual and environmental factors and the transition of the elderly between community and institutional residential settings? Data from six years of the Medicare Current Beneficiary Survey will be used to answer these questions. Understanding residential transitions will help staff in the Department improve surveys that monitor acute health and long-term care use in different settings (e.g., the Medical Expenditure Panel Survey) and address outstanding long-term care policy issues (e.g., allocation of resources between community and institutional settings).

Funding: Total Award $153,494 (FY00 $153,494)
End Date: March 31, 2002

Assessment of Home Care Benefits Used by Holders of Private Long-Term Care Insurance
Life Plans, Inc.
Most experts agree that long-term care insurance products must include both nursing home and home care benefits if they are to be commercially acceptable. Yet private insurers as well as public payers are concerned about their ability to control home care claims, particularly given the potential substitution of formal home care services for care provided by families. The purpose of this study was to collect detailed information on the experience of long-term care policy holders who have filed insurance claims to receive home care benefits and how their formal and informal service use compares to a comparable population of elderly persons without private insurance. Primary data collection involved face-to-face interviews with approximately 1,000 persons (500 disabled insurance claimants and 500 next-of-kin of those claimants) to collect information on functional and medical characteristics of claimants as well as formal and informal services use. The sample of claimants was drawn from the files of insurance companies that account for the majority of private long-term care policies now in force.

Funding: $50,000
End Date: March 1, 2000

Case Studies of Nursing Home Transition Programs
Medstat Group
The purpose of this project is to conduct case studies of Nursing Home Transition Programs in up to eight states (with possible additions depending on future grant awards). The programs being evaluated were developed and implemented with funding from an ongoing grant initiative sponsored by the Health Care Financing Administration (HCFA) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). A case study approach is proposed for two reasons: (1) the vast differences in state Medicaid programs, state long-term care infrastructures, and proposed nursing home transition programs; and, (2) the small number of nurs-
ing home residents expected to participate in the transition programs.

Each case study will attempt to determine the most significant barriers faced by nursing home residents in returning to the community, and, to glean the relative success or failure of the strategies used by grantees to overcome these barriers. As HCFA and ASPE intend to continue making additional grants in this area, an evaluation of grantee activity will assist federal policy makers in further grant making, and state policy makers in developing transition programs.

Funding: Total Award $300,006 (FY00 $300,006)
End Date: February 1, 2002

**Characteristics of Nursing Home Residents**

Hebrew Rehabilitation Center for Aging

Caring for persons with disabilities in the least restrictive setting is a major long-term care policy objective. It is important to identify nursing home residents who could be discharged to the community if appropriate home and community-based services were available. This project will analyze data from a new source—the Minimum Data Set (MDS)—in nine states. The MDS consists of assessments which have been conducted on all nursing home residents in selected States as part of a HCFA demonstration (and starting in the summer of 1998, the data will be collected in electronic form in all 50 States). We will learn much more about the medical conditions, functional needs, and specific services used by nursing home residents than was possible with previous data sets. We will also be able to study important subpopulations, especially the non-elderly. The policy implications of the findings will be assessed.

Funding: Total Award $150,000 (FY98 $150,000)
End Date: September 30, 2001

**Evaluation of Practice in Care (EPIC)**

University of Colorado

From 1989 to 1992, there was a 210 percent increase in Medicare expenditures for home health services. This increase in utilization has generated widespread policy interest in appropriate measures to control expenditures without compromising quality. Medicare home health has been the subject of considerable research, but the actual practice of home health care has not been extensively examined. This study will analyze “episodes” of care under the Medicare home health benefit, assess the actual practice of care, the extent to which there is variation in practice between acute and long-term patients, and the factors that account for that variation. This study will also examine decision-making processes between patients, providers and physicians. What takes place during a visit and between visits as “actual practice” has never been measured. Furthermore, the function of decision-making by various parties has not been observed in “actual practice.” This effort to understand issues surrounding regional and practice variations of home health care delivery will aid the Department and the industry in combating fraud and abuse, as well as contribute valuable data to a future prospective payment system.

Funding: Total Award $1,400,000 (FY97 $200,000)
Informal Caregivers Supplement to the 1999 National Long-Term Care Survey.

Duke University

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has been involved in the past in designing a modest respite benefit for Medicare beneficiaries with Alzheimer’s disease for inclusion in the President’s budget. In 1998, there is renewed interest in having proposals for respite services and other caregiver supports, on a broader scale, incorporated into the President’s long-term care budget initiative. We are currently working with White House, OMB, and Treasury staff to explore the use of tax incentives to help informal caregivers be able to afford paid home care services as a supplement to their own informal efforts. In order to respond to these kinds of policy analysis requests, it is important for ASPE to look ahead and anticipate future data needs. In this case, the need is to have data collection mechanisms in place to track, over time, changes in the characteristics of informal caregivers of the disabled elderly, as we have to follow changes in the population of disabled elders themselves. ASPE supported the first and second Informal Caregiver’s Supplement to the National Long-Term Care Survey in 1982 and 1989 respectively. A third round of data collection on informal caregivers is now needed in order to remain up-to-date.

Family members typically initiate the process of nursing home placement for disabled elders when they feel that the disabled elder needs more help than can be provided in a home setting. Often families come to such a decision when one or more family caregivers have been providing upwards of 60 hours per week of unpaid assistance. This project will enable in-depth analysis of the conflicts informal caregivers experience between employment and eldercare as well as provide information about the health status of caregivers and measures of caregiver stress and burden. These data can then be used in crafting policy initiatives to support caregivers and prevent “caregiver burnout” which could result in premature institutionalization. It will help determine whether and to what extent caregivers’ age, marital status, relationship to the care recipient, household income, employment, health status, and various measures of caregiver stress and burden are associated with greater or lesser use of supplemental formal care. We will also be able to measure the extent to which caregivers as well as the disabled elders themselves experience out-of-pocket spending for supplemental home care.

Funding: Total Award $300,000 (FY98 $300,000)
End Date: March 1, 2000

Long-Term Care Microsimulation Model

Lewin Group

This project will update and expand the capability of the Brookings/ICF Long-Term Care Financing Model, which currently takes a national sample of persons, ages them over time, and estimates their long-term care use and financing when they become elderly. It will incorporate results from recent surveys of nursing homes
and home care utilization; e.g., the 1989 and 1994 National Long-Term Care Surveys. The model will also be expanded to include acute care use and expenditures, and the period of simulation will be extended to 2030. The economic assumptions will be updated.

The model will continue to be used to project future trends and to perform policy simulations, including expanded coverage for nursing home and home care, changes in Medicaid eligibility and services, and expanded enrollment in private long-term care insurance plans. It will also be used to estimate the impact of changing trends in disability and the combined burden of acute and long term care services on the elderly.

Funding: $1,304,820 (FY97 $232,266; FY98 $211,709)
End Date: December 31, 2000

Managed Delivery Systems for Medicare Beneficiaries with Disabilities and Chronic Illnesses

Mathematica Policy Research

The last decade has brought tremendous changes in the health care system as payers and providers struggle to bring health care expenditures under control. The momentum to achieve a reformed, more managed U.S. health care system, one which seeks to bring costs under control while improving access to, continuity and coordination of care, appears unstoppable. However, it remains unknown how this transforming health care system will affect the health and well-being of people with significant disabilities and chronic illnesses. The Medicare program has lagged behind the private insurance market and even the Medicaid program in the proportion of its beneficiaries participating in managed care plans. In 1995, about 2.3 million older persons out of a total Medicare beneficiary population of 25 million were enrolled in the Medicare Risk Program implemented under TEFRA. There is little information on the experience of older persons with disabilities in these and other managed care plans.

The purpose of this study is to: (1) address the characteristics of elderly persons with chronic illnesses and disabilities that need to be accommodated in designing and operating managed delivery systems (MDS); (2) examine the issues that health care policy makers, plan administrators and providers need to consider in designing, operating, and monitoring MDS for the elderly with disabilities and chronic illness; (3) examine how MDS actually perform in meeting the needs of the elderly disabled; and (4) identify the factors that influence the success of MDS in meeting the needs of this population.

Funding: Total Award $349,450 (FY97 $244,450; FY00 $105,000)
End Date: May 31, 2001

Medical Expenditure Panel Survey (MEPS) Nursing Home Component

Medstat Group

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Agency for Health Care Policy and Research (AHCPR) entered into this Interagency Agreement for the purpose of allowing ASPE and an ASPE contractor (The MEDSTAT Group) access to the Nursing Home Component of the 1996 Medical Ex-
penditure Panel Survey (MEPS) including the Community Caregiver Supplement. Through its contractor, ASPE will edit and prepare data files and analyze data from the MEPS Nursing Home Component and the Community Caregiver Supplement. The purpose of the ASPE-supported analyses is to better understand how to promote and improve home and community-based services as opposed to institutional services for persons with significant functional disabilities.

End Date: July 1, 2000

Medicare Post-Acute Care: Quality Measurement

Urban Institute

This project developed four outcome measurement instruments and methods of data collection that could be used in future research to examine outcomes and costs associated with Medicare post-acute care (PAC) services for patients who have suffered a stroke, congestive heart failure (CHF), pneumonia, and back and neck conditions. These conditions were selected because of their prevalence within and across PAC settings. The instruments and the data collection methodology will be revised based on two field tests and technical expert input. The outcome measurement instrument developed for stroke patients will be used in other ASPE funded studies (i.e., A Comparative Study of the Outcomes and Costs Associated with Medicare Post-Acute Services).

Funding: Total Award $482,943 (FY97 $321,035; FY99 $161,908)
End Date: December 31, 2000

Monitoring the Health Outcomes for Disabled Medicare Beneficiaries

Laguna Research Associates

The Balanced Budget Act (BBA) of 1997 mandated major changes in home health payment requiring the implementation of a Prospective Payment System (PPS) by October 1999 (later delayed until October 2000) and an Interim Payment System (IPS) prior to the implementation of PPS. It also contained changes in eligibility and coverage for home health services. These changes, while intended to reduce Medicare home health costs, run the risk of reducing beneficiaries' access to appropriate care and adversely affecting health outcomes, especially for beneficiaries needing the most care (Komisar and Feder 1998, Smith and Rosenbaum 1998, MedPAC 1999, GAO 1998, Gage, 1998). Disabled Medicare beneficiaries are especially vulnerable.

The purpose of this project is to study the impact of recent payment policy changes on disabled Medicare beneficiaries' satisfaction and quality of life with a view toward formulating inferences that will inform national home health care policy for the disabled. The study will build on a research project recently funded by the Home Care Research Initiative of The Robert Wood Johnson Foundation that examines the direct and indirect effects of the BBA changes. The project's main focus is to examine BBA impacts on Medicare beneficiaries' access to care, costs, satisfaction, and quality of care. Also examined will be the effects on agencies and on the overall health system.

Funding: Total Award $150,000 (FY99 $150,000)
National Study of Assisted Living for the Frail Elderly

"Assisted living" refers to residential settings for people with disabilities which combine both housing and personal assistance services within a homelike or noninstitutional environment. The number of assisted facilities nationally is not known; estimates range from 8,000 to 30,000. Similarly, estimates for the number of frail elderly and other persons residing in such facilities range from 350,000 to 1,000,000. This study will, among other things, generate a more reliable estimate of the number of these facilities and their residents. As assisted living options multiply, a challenge facing the Federal and State governments is how to regulate such arrangements, balancing consumer protection concerns (especially if public funds reimburse costs) with resident rights for self-direction, taking risks and maintaining accustomed lifestyles.

The major purpose of this project is to analyze the role of assisted living within the current long-term care system from the perspective of consumers, owners/operators, workers, regulators, investors and other stakeholders, and to issue a report on its current status and future directions. The study will address several broad policy-relevant issues, including supply and demand trends; barriers; how closely practice parallels philosophy; the impact of key features on outcomes; and quality and accountability. The contractor will assist HHS and other Federal agencies in the formulation of regulatory and financing policy options for assisted living. A Technical Advisory Group has been established to provide guidance to the contractor.

Funding: Total Award $2,025,000 (FY98 $350,000; FY99 $75,000)

"Cash and Counseling" Demonstration/Evaluation.

University of Maryland, Center on Aging

This project, which is being done in collaboration with the Robert Wood Johnson Foundation, will employ a classical experimental research design (i.e., random assignment of participants to treatment and control groups) to test the effects of "cashing out" Medicaid-funded personal assistance services for the disabled. The demonstration will include elderly as well as younger disabled consumers. Two States are expected to participate in the demonstration. In these States, control group members will receive "traditional" benefits—i.e., case managed home and community-based services, where payments for services are made to vendors—while treatment group members receive a monthly cash payment in an amount roughly equal to the cash value of the services they would have received under the traditional program.

It is hypothesized that cash payments will foster greater client autonomy and that, as a result, consumer satisfaction will be greater. Consumers are expected to purchase a somewhat different mix of disability-related services and/or assistive technologies when they make the decisions and payments themselves than when case managers contract with vendors on their behalf. It is also hypothesized that States will save Medicaid monies (mostly in administrative expenses) from cashing out benefits. The analysis will consider
care. The model is proposed as a fully voluntary enrollment model for 1,200 beneficiaries. All Medicare and Medicaid covered benefits are offered under full capitation for eligible participants who elect to enroll. Partnership sites for the frail elderly are the existing PACE sites in Milwaukee and Madison. The Partnership model for people with disabilities will utilize Centers for Independent Living in Madison and Eau Claire. The model for people with disabilities is believed to be the first site in the nation for fully capitated Medicare and Medicaid services for people with physical disabilities. Partnership sites for the frail elderly are the existing PACE sites in Milwaukee and Madison.

Status: The four sites became operational in early 1999 and by the end of the year had a combined enrollment of over 700. An evaluation of the Partnership, under separate contract, began in mid-1999.

Continuing Care Network Demonstration, Technical Assistance and Third Party Assessments
Prj #: 18-C-91101/2
Start Date: 09/30/1999
End Date: 03/05/2005
Funding: $437,994
Vehicle: Cooperative Agreement
PI: Helena Temkin-Greener, PhD
Awardee: Community Coalition for Long Term Care
PO: Noemi V. Rudolph
Description: This initial award is part of a multi-year technical assistance and third party assessment for the Continuing Care Network (CCN) demonstration project in Monroe County. Specific objectives include: (1) to analyze and compare the proposed HCFA Medicare+Choice capitation methodology with the CCN demonstration risk-adjusted payment model, (2) to assure the collection of assessment data and administer a subcontract with the independent assessor, (3) to design and empirically test a Medicare and Medicaid risk/savings sharing model, and (4) to examine CCN strategies for outreach/education, marketing, and enrollment especially as it pertains to the frail and dual eligibles. Data sources will include: the Monroe County Medicare and Medicaid Database and the CCN demonstration database, surveys, assessments conducted by the independent assessor and by care plan nurses, interviews, and focus groups.

Status: In progress.

Continuing Care Network Demonstration
Prj #: 11-W-00126/2
Start Date: 09/30/1999
End Date:
Funding: $0
Vehicle: Waiver-only Project
PI: Linda Gowdy
Awardee: New York State Department of Health, Bureau of Continuing Care Initiatives
PO: Noemi V. Rudolph
Description: Medicare waivers were approved for this demonstration on September 1999. The CCN project, a 5-year demonstration, is designed to test the efficiency and the effectiveness of financing
Description: This evaluation is designed to assess the impact of dual eligible demonstrations in the States of Minnesota, Colorado, Wisconsin and New York. Analyses will be conducted for each State and across States. The quasi-experimental design will utilize surveys, case studies, and Medicare and Medicaid data for analysis. Major issues to be examined include the use of a capitated payment strategy to expand services while reducing/controlling costs, the use of case management techniques and utilization management to coordinate care and improve outcomes and the goal of responding to consumer preferences while encouraging the use of noninstitutional care. A universal theme to be developed is the difference between managing and integration.

Status: Beneficiary surveys have been completed in the Minnesota demonstration. Beneficiary surveys for the Wisconsin demonstration are planned to be conducted in early 2000. Two case study reports and the First Annual Report have been submitted to HCFA. The New York demonstration received its waivers in September 1999 and increased evaluation activities will soon be underway.

Wisconsin Partnership Program
Prj #:11-W-00123/05
Start Date: 10/16/1998
End Date: 12/31/2004
Funding: $0
Vehicle: Waiver-only Project
PI: Steve Landkamer
Awardee: Wisconsin Division of Health and Family Services, Department of Health and Family Services
PO: James Hawthorne

Description: The State submitted an application in February 1996 for Medicare and Medicaid demonstration waivers to establish a “Partnership” model of care for dually-entitled nursing home-certifiable beneficiaries who are either under age 65 with physical disabilities or frail elders. This project is utilizing Centers for Independent Living in Madison and Eau Claire. This is believed to be the first site in the nation offering fully capitated Medicare and Medicaid services for people with physical disabilities. Waivers were approved on October 16, 1998 and one site (Elder Care—Madison) became operational on January 1, 1999. Community Care for the Elderly—Milwaukee expected to become operational on March 1, 1999. Community Living Alliance—Madison and Community Health Partnership—Eau Claire expected to become operational in the spring of 1999. The “Partnership” model is similar to the Program for All-inclusive Care for the Elderly (PACE) model in the use of multidisciplinary care teams, prepaid capitation, and sponsorship by community-based service providers. Rather than the physician being co-located with the multi-disciplinary team, the Partnership program will enable participants to use a physician of their choice in the community who agrees to participate as a contractor with the Partnership plan. This model utilizes nurse practitioners and other multidisciplinary team members to provide continuity and coordination with the physicians who elect to participate. The Partnership also will rely less on adult day care centers than do PACE sites as the organizing focus for the provision of
to be a significant rate of continued medical non-compliance. This appears to be the case even where patients demonstrate a basic understanding of the medical basis and management strategy of their illness. Simple, straightforward medical information and instruction are not, it seems, sufficient as behavior motivators to effect long-standing behavioral change in the Native Hawaiian population. It is this underlying behavioral motivation that the Waimanalo Health Center proposes to address in an integrated and comprehensive outreach and preventive health demonstration project. The Center proposes to significantly increase the number and intensity of personal and culturally relevant motivators to effect positive lifestyle changes. The Center would provide culturally relevant and medically sound outreach, screening, educational, and preventive health services for its entire service area.

Status: This project is underway.

*State of Minnesota "Senior Health Options (MSHO) Project*
  Prj #:11-W-00024/5
  Start Date: 04/01/1995
  End Date: 12/01/2000
  Funding: $0
  Vehicle: Waiver-only Project
  PI: Pamela Parker
  Awardee: Minnesota, Department of Human Services
  PO: Linda Frisch
  Description: In April 1995, the State of Minnesota was awarded Medicare and Medicaid waivers for a 5-year demonstration designed to test delivery systems that integrate long-term care and acute-care services for elderly dual eligibles. The State targeted the elderly dually-entitled population that resides in the seven-county metro area and St. Louis county. Elderly Medicaid eligibles now required to enroll in the State's current section 1115 Prepaid Medical Assistance Program (PMAP) Demonstration are being given the option to enroll in the State's current section 1115 Prepaid Medical Assistance Program (PMAP) Demonstration and additional Medicare benefits to basic PMAP benefits. Under this demonstration, the State is being treated as a health plan that contracts with HCFA to provide services, and provides those services through subcontracts with various appropriate providers. The State is continuing its current administration of the Medicaid-managed care program while incorporating some Medicare requirements that apply directly to the health plans with which the State would subcontract for SHO. HCFA’s direct oversight functions will continue to apply to the overall demonstration and managing entity, which will be the State.
  Status: The State implemented the project in March 1997. It is currently ongoing.

*Multi-state Evaluation of Dual Eligibles Demonstrations*
  Prj #:500–96–0008/03
  Start Date: 09/30/1997
  End Date: 09/29/2002
  Funding: $2,155,854
  Vehicle: Task Order
  PI: Robert L. Kane, M.D.
  Awardee: University of Minnesota
  PO: Noemi V. Rudolph
to care and quality of care provided to Medicaid eligibles in these facility types. A Report to Congress must be submitted by August 7, 2001. To partially fulfill this statutory requirement, HCFA entered into a collaborative arrangement with The Commonwealth Fund and Brandeis University to study the relationship between state Medicaid reimbursement policy and access to care and quality of care for Medicaid eligibles in NFs. The Commonwealth Fund provided financial support through a grant to Brandeis. HCFA's contribution has been technical guidance and data, and in exchange was promised a report that would have provided the basis for the Report to Congress. The research plan of the Brandeis/Commonwealth project relies on a number of strategies. First, survey data collected under a HCFA contract by Wichita State University and the University of California, San Francisco are used to track changes in states NF reimbursement policies in the aftermath of Boren Amendment repeal. Data from other sources—HCFA's OSCAR and Medicare SNF cost reports databases—are used to construct other variables that measure the relevant policy outcomes: access to NF services and quality of care in those facilities. Statistical methods are then used to determine what relationships exist (if any) between the outcome variables and state Medicaid reimbursement policy variables. Finally, additional qualitative information on state responses to Boren Amendment repeal is drawn from parallel research conducted by an independent researcher also working under a Commonwealth Fund grant and the Urban Institute through their Assessing the New Federalism Project. Phase I of the project (November 1998 to December 2000) consists of a cross-sectional study of the relationship between state payment policy and the relevant outcome variables using data from 1996 (prior to Boren Amendment repeal). Phase II (January through December 2001) will expand the analysis to include data from 1999, allowing a study of changes since the repeal of the Boren Amendment. In November 1998, The Commonwealth Fund approved grant funding for Phase I, and Brandeis University researchers began work shortly thereafter. In January 1999 a Memorandum of Understanding was signed formalizing the collaborative relationship between HCFA and Brandeis University. On June 12, 2000, however, The Commonwealth Fund informed HCFA that they would not provide financial support for Phase II of the research. In order for the Report to Congress can be submitted in a timely fashion HCFA must now bring the research to completion.

Mauli Ola (Spirit of Life) Project
Prj #:18-C-91142/9
Start Date: 09/28/2000
End Date: 09/27/2005
Funding: $704,055
Vehicle: Cooperative Agreement
PI: Charman Akina
Awardee: Waimanalo Health Center
PO: Stephanie Monroe
Description: A significant number of Native Hawaiians do not access medical services on a timely basis, even when such services are made available and affordable. Of those who do, their continues
percent to 19 percent (between the financial and beneficiary-level impacts of the program) in over a decade. The aim of this task order is to gain a better understanding of the broader HCBS waiver program and determine what programmatic mechanisms have been successful.

Status: The project is ongoing.

Study of the Impact of Boren Amendment Repeal on Medicaid Skilled Nursing Facilities
Prj #: Other/CF–1999–1
Start Date: 01/01/1999
End Date: 12/31/2000
Funding: $280,000
Vehicle: Grant
PI: Christine Bishop, Ph.D.
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
PO: Paul J. Boben, Ph.D.

Description: This project examines the impact of the repeal of the Boren Amendment through a study of the relationship between States' Medicaid payments to nursing homes and quality and access to care for Medicaid recipients. The results of this research will assist HCFA in preparing a report to Congress on the effects of Boren Amendment repeal, as mandated by the Balanced Budget Act of 1997. HCFA's participation in this project is primarily to supply the needed data and to supervise its use.

Status: The research team has just begun looking at data from the Online Survey Certification and Reporting system and Skilled Nursing Facility Cost Report data bases maintained by HCFA. A report examining the relationship between State Medicaid reimbursements for skilled nursing facilities and access and quality of care for Medicaid eligibles is expected soon.

Study of the Impact of Boren Amendment Repeal on Nursing Facility Services for Medicaid Eligibles
Prj #: 500–95–0060/03
Start Date: 09/29/2000
End Date: 10/10/2001
Funding: $268,875
Vehicle: Task Order
PI: Christine Bishop
Awardee: Brandeis University
PO: Paul J. Boben, Ph.D.

Description: The purpose of this project is to study the impact of repeal of the Boren Amendment on Medicaid eligibles' access to Nursing Facility (NF) services and the quality of care available to them in those facilities. The results of the study will enable HCFA to submit the required Report to Congress. The Balanced Budget Act of 1997 (BBA) effected the repeal of a provision of Medicaid commonly known as the ABoren Amendment. The Boren Amendment provided lower limits on the amounts states could pay three types of institutional providers: hospitals, nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR). State payments had to be sufficient to cover the cost of efficiently and economically operated facilities. The BBA also required HCFA to study the effect of this repeal of the Boren Amendment on access
vide feedback for monitoring and continuous quality improvement of NMEP informational materials directed to the Medicare population over time.

Status: The project is in the first of two phases. An analysis plan has been approved for Phase I, MCBS data user agreements executed, and MCBS Access to Care files for 1995-1997 and associated supplemental files have been received. Phase I data analyses have begun and several working measures of knowledge constructed. A report entitled "A Knowledge Index Technical Note" using Phase I data has been received and is under review. Phase II will extend Phase I analyses using MCBS 1998 Access to Care files including special supplements—Round-23 (beneficiary knowledge) and Round-24 (beneficiary needs).

Survey and Evaluation of New Medicare Members of Medicare+Choice Plans
Prj #:500–95–0047/07
Start Date: 09/08/1999
End Date: 09/07/2001
Funding: $657,583
Vehicle: Task Order
PI: Merrile Sing, Ph.D.
Awardee: Mathematica Policy Research, Inc
PO: Peri Iz, Ph.D.
Description: The purpose of this project is to design a survey for and collect data from Medicare beneficiaries who are new members of Medicare+Choice (M+C) plans and to evaluate the effectiveness of the National Medicare Education Program (NMEP) for these beneficiaries. The objective is to understand the special information needs of new Medicare members, their sources of information (who/where), their preferred distribution channels (how), their understanding of the basic (standard) Medicare program, their understanding of their particular M+C plan, and the impact NMEP activities may have on new members' decision to choose an M+C plan or change their plan. This project does not include the disenrollee population. The project will support HCFA strategic plan initiatives, contribute to Government Performance and Results Act program performance reporting, and provide feedback for monitoring and quality improvement to NMEP informational materials directed to the M+C population over time.

Status: This project is in the start-up phase.

Evaluation of the Home & Community-based Services Waiver Program
Prj #:500–96–0005/03
Start Date: 09/30/1998
End Date: 03/29/2002
Funding: $2,308,371
Vehicle: Task Order
PI: Lisa Maria Alecxih
Awardee: Lewin Group, The
PO: Renee Mentnech
Description: The Home and Community-Based Services (HCBS) Waiver Program has been operating since 1981 and has experienced tremendous growth in recent years. The percent of Medicaid long-term care spending devoted to HCBS has increased from 10
agencies, and the overall medical and long-term care system. Analysis based on the data HCFA supplies under this award, taken together, will help understand the overall pattern of impacts and be useful in formation of future reimbursement policy. The special study for HCFA looks at beneficiary access. This will analyze pattern of Medicare home health use before and after the implementation of the BBA. There is a focus on assessing whether changes occurred in the skill mix of types of visits received by home health users. It will examine whether differential effects have occurred for different categories of home health users and in different geographic areas.

Status: The data have been accessed and the analysis are being prepared.

Assessing Readiness of Medicare Beneficiaries to Participate in Informed Health Care Choices

Prj #: 17-C-90950/1
Start Date: 08/17/1998
End Date: 06/16/2000
Funding: $63,192
Vehicle: Cooperative Agreement
PI: James O. Prochaska, Ph.D.
Awardee: Pro-Change Behavior Systems
PO: Sherry A. Terrell, Ph.D.

Description: This study will adapt the investigator's transtheoretical model of health behavior change using the Medicare Current Beneficiary Survey (MCBS) data to predict a Medicare beneficiary's readiness to make an informed decision about his/her Medicare health insurance plan choice. The model is a mathematical algorithm that assigns/classifies a case to a stage of readiness to make a decision.

Status: The research team has received MCBS data for 1995-1997 from HCFA and prepared related analytic files. Once 1998 MCBS files are available, the transtheoretical model can be applied.

Analysis of Medicare Beneficiary Baseline Knowledge Data Using MCBS

Prj #: 500-95-0061/04
Start Date: 06/16/1999
End Date: 06/15/2002
Funding: $229,123
Vehicle: Task Order
PI: James M. Robinson, Ph.D.
Awardee: University of Wisconsin—Madison/Research Triangle Institute
PO: Sherry A. Terrell, Ph.D.

Description: The purpose of this project is to analyze Medicare beneficiary baseline knowledge data which have been previously collected through the Medicare Current Beneficiary Survey (MCBS). The program objective is to evaluate National Medicare Education Program (NMEP) print material (Handbook: 1999 and Bulletin) and selected information distribution channels (print, Internet, 1-800-MEDICARE). The policy objective is to support HCFA strategic plan initiatives, contribute to Government Performance and Results Act program performance reporting, and pro-
ment of regulatory standards, work-force problems, organizational capacity for quality improvement, and quality measurement/information strategies in long-term care situations.

In 1986, IOM issued the report, Improving the Quality of Care in Nursing Homes, which was to serve as a foundation for the Nursing Home Reform Act of 1987. Since then, much has changed including attitudes about those using long-term care, ways of providing care, and strategies for assessing and improving the quality of care. In 1997, with primary funding from the Robert Wood Johnson Foundation, the IOM appointed an expert committee to examine a broader range of long-term care services, recipients, and quality improvement strategies than those considered in the 1986 report. Questions being investigated include:

What are the demographic, health, and other characteristics of individuals requiring long-term care and how are they changing?

What are the roles of the various long-term care settings, and how do they relate to other components of community care systems?

What are the strengths and limitations of existing methods and tools to measure, oversee, and improve quality of care and the outcomes of long-term care?

How can these methods and tools be improved?

What is known about the current quality of long-term care in different settings and the extent to which care has improved or deteriorated in the last 10–15 years?

What is known about the impact of long-term care regulation, especially the Nursing Home Reform Act of 1987?

After working for over a year, the IOM committee concluded that an additional meeting was needed given the complexity of the topics being considered and a number of recent developments in long-term care, including various initiatives by the Department of Health and Human Services. In particular, the committee directed that additional report text be drafted related to payment issues and research directions. This HCFA project provides the support to make this last portion of the work possible.

Status: The final report is completed.

Direct and Indirect Effects of the Changes in Home Health Policy and an Analysis of the Skill Mix of Medicare Home Health Services Before and After the Balanced Budget Act of 1997

Prj #: HCFA–00–0108
Start Date: 03/16/2000
End Date: 03/23/2001
Funding: $24,298
Vehicle: Simplified Procurement
PI: Nelda McCall
Awardee: Laguna Research Associates
PO: Sydney P. Galloway
Description: This project provides partial support for a project primarily funded by the Robert Wood Johnson Foundation (RWJ). As part of this larger project, HCFA supplies needed data and receives the results of a special study. The major (RWJ) project examines three areas where impacts of the Balanced Budget Act (BBA) might fall on the Medicare beneficiary, home health care
the true burden of diabetes is actually not known, because diabetes frequently goes undiagnosed. The Centers for Disease Control and Prevention (CDC) estimate that the number of persons with undiagnosed diabetes to be over 5 million. At the present time, it has been estimated that 10.3 million people have been diagnosed with diabetes in the United States. HCFA's Women's Health Workgroup developed an initiative on diabetes in response to the Department's interest in proposals for the Women's Living Long, Living Well and the Prevention Initiatives. Diabetes was identified as a disease that affected our beneficiaries across the life span and scope of all HCFA's programs (Medicare, Medicaid, and the State Children's Health Insurance Program). This project is designed to provide a mechanism for on-going analyses from the Medicare Current Beneficiary Survey (MCBS) and the Medicare administrative files that are linked for these survey participants. Through creating a database and analytic files, studies on Medicare beneficiaries with diabetes can be conducted using several years of data from the MCBS. Important issues related to health, health status, co-morbid conditions, functional status, disability, quality of life as well as costs and utilization of health care services can be examined. We plan to study at a minimum:

- Demographic characteristics of beneficiaries who report a diagnosis of diabetes (age; gender; race/ethnicity; income; education; marital status; etc.)
- Health and functional status (activities of daily living; instrumental activities of daily living)
- Health care services variables (usual source of care; doctor and emergency room visits)
- Co-morbid health conditions (heart disease; stroke; blindness; amputations; etc.)
- Utilization of services from the link to the Medicare administrative files for outpatient services; inpatient hospitalizations; etc.
- Use of preventive services appropriate for diabetics (immunizations; eye exams; foot care; etc.)
- Costs associated with preventive care and treatment of Medicare beneficiaries with diabetes.
- Changes in coverage policies for diabetic treatment and care.

Status: In developmental phase.

Improving Quality in Long-term Care
Prj #:HCFA-99-0100
Start Date: 04/01/1999
End Date: 03/31/2001
Funding: $50,000
Vehicle: Purchase Order
PI: Janet Corrigan, Ph.D.
Awardee: National Academy of Sciences, Institute of Medicine, Board on Health Care Services
PO: Sydney P. Galloway

Description: HCFA provided funds to support a portion of an ongoing project in the National Academy of Sciences/Institute of Medicine (IOM). Our funding would sponsor an additional meeting of the project committee to further explore and deliberate on its findings and recommendations related to the definition and enforce-
cial origin. However, for women, cardiovascular disease is responsible for more deaths than almost all of the leading causes of death, including cancer. The general category of cardiovascular diseases (CVD) includes not only heart diseases such as coronary heart disease, but also hypertension or high blood pressure and stroke. Until recently, death rates for coronary heart disease had declined. However, with the growing aged population, the slope of this decline has begun to level off.

Another cardiovascular disease with a major impact on the aged population is stroke. Stroke is the third leading cause of death. Recent studies have identified disparities in treatment for heart disease both by gender and race/ethnicity. There are a growing number of racial and ethnic groups in this country who appear to be disproportionately sharing the burden of these chronic diseases. Just as cardiovascular disease can result in disabilities, arthritis and osteoporosis are also diseases that cause disability and lost work days. As the population ages, the impact of this disease may have major ramifications for society as more and more persons become disabled. Osteoporosis is a potential cause of disabilities because this disease increases the risk of fracture. Data from the Medicare Current Beneficiary Survey (MCBS) showed that the percentage of Medicare beneficiaries reporting osteoporosis increased with increasing age. The study also found that a higher percentage of whites reported having had a hip fracture than nonwhites. A final category of diseases are the respiratory diseases. Asthma and COPD are among the 10 leading chronic conditions. It has been found that deaths due to asthma are more likely to occur in African Americans and Hispanics than among whites. In summary, chronic diseases are quite prevalent in the aged population. Little is known about the gender and racial differences in patterns of utilization and health outcomes for the Medicare population. Findings from this project will assist HCFA in targeting policies, programmatic changes, education, outreach, research and demonstration projects to achieve improved health outcomes for our female Medicare beneficiaries.

Status: In progress.

Health status and Quality of Life for Women with Diabetes: Data from the Medicare Current Beneficiary

Prj #: 500-96-0516/13
Start Date: 09/30/2000
End Date: 09/29/2001
Funding: $92,490
Vehicle: Task Order
PI: Celia H. Dahlman [Fu Assoc's, Sub]
PO: Marsha G. Davenport, M.D., M.P.H.

Description: This task order will develop a database, create analytic files, and provide programming and analytic support for studies on beneficiaries with diabetes from the Medicare Current Beneficiary Survey (MCBS). These studies will focus on gender and racial/ethnic differences for respondents in the MCBS who reported having had a diagnosis of diabetes. Chronic diseases contribute significantly to the morbidity and mortality of older Americans. Diabetes is the seventh leading cause of death in this country. However,
economic status, and geographic areas. The advantage of a longitudinal database is that it provides data at multiple time points during a person's life. Due to recent expansions in the race/ethnic coding in the Medicare enrollment database (EDB), it is now possible to examine health care access, utilization, and outcomes among minority groups.

Patterns of Injury in Medicare and Medicaid Beneficiaries

Project #: 500-95-0060/04
Start Date: 09/29/2000
End Date: 09/30/2001
Funding: $715,991
Vehicle: Task Order
PI: Deborah Garnick
Awardee: Brandeis University
PO: Rosemary Hakim, Ph.D.

Description: This project is a descriptive study of the extent and impact of injuries in the Medicare and Medicaid populations, and to conduct in depth analyses on specific types of injuries. Unintentional injuries accounted for more than 90,000 deaths in the US in 1997, making this the fifth leading cause of death overall. Intentional injuries, suicide and homicide, have resulted in more than 50,000 deaths annually since 1985. The impact on health care costs, income and productivity is significant. Injuries may be an even more important cause of mortality and morbidity among persons in vulnerable populations, which include the populations served by Medicare and Medicaid. While mortality data for injuries are available, data addressing the prevalence of morbidity due to injuries and the expenditures for related care are not available. The Medicare and Medicaid data are particularly well suited to assess morbidity due to injuries that are severe enough to come to medical attention.

Status: In progress.

Examining Gender and Racial Disparities Among Medicare Beneficiaries with Chronic Diseases

Project #: 500-95-0058/15
Start Date: 09/29/2000
End Date: 09/28/2001
Funding: $177,442
Vehicle: Task Order
PI: Deborah Dayhoff
Awardee: Health Economics Research, Inc.
PO: Marsha G. Davenport, M.D., M.P.H.

Description: The purpose of this task order is to develop and complete an analytic study using the Medicare administrative claims files to expand HCFA's knowledge base in the area of women's health and chronic diseases. Chronic diseases contribute significantly to the morbidity and mortality of older Americans. Diseases such as arthritis, asthma, chronic obstructive pulmonary disease (COPD) and other respiratory conditions, cancers, diabetes, heart disease, hypertension, osteoporosis, and stroke comprise the major categories of chronic conditions affecting persons age 65 and older. Cardiovascular diseases (CVD), primarily heart disease and stroke, are the leading cause of death irrespective of gender or ra-
prospects for continuation of this coverage and possible implications for the restructuring of the Medicare fee-for-service and Medicare+Choice (M+C) programs. Although approximately one-third of aged Medicare beneficiaries have coverage under an existing employer-sponsored health insurance policy, the prevalence of coverage has declined and retiree cost-sharing requirements have increased in recent years. If current trends continue, the future of employer-sponsored coverage of Medicare eligible retirees is not encouraging. Declining employer-sponsored coverage could result in more Medicare beneficiaries purchasing individual Medigap policies, joining Medicare+Choice plans or going without supplemental coverage. As Medicare beneficiaries face paying more for services previously covered by retiree health insurance, the Medicare Program may come under increasing pressure to offer additional benefits, most notably outpatient prescription drugs.

The project will consist of two parts. The first part will analyze existing secondary data to describe the types of coverage offered to Medicare-eligible retirees, the funding for this coverage and recent trends in coverage. The second part will be comprised of interviews aimed at understanding the prospects for future employer-sponsored coverage of this population, possible impacts of Medicare reform initiatives on this coverage and how the Medicare Program, both fee-for-service and managed care, might be restructured to encourage continued coverage. Interviewees would, at a minimum, include employers, unions, business coalition/purchasing groups and outside consultants (insurance agents/brokers, third party administrators and professional benefits consultants).

Status: Research Triangle Institute will perform this project under a subcontract

Health Disparities: Longitudinal Study of Ischemic Heart Disease Among Aged Medicare Beneficiaries

Prj #: 500-95-0058/12
Start Date: 09/22/2000
End Date: 01/21/2002
Funding: $282,157
Vehicle: Task Order
PI: Jerry Cromwell
Awardee: Health Economics Research, Inc.
PO: Linda Greenberg, Ph.D.

Description: The purpose of this task order contract is to assess the use of Medicare covered services among Medicare beneficiaries with ischemic heart disease based on sociodemographic characteristics (e.g., race/ethnicity, sex, age, socioeconomic status). During the past few years, the Health Care Financing Administration (HCFA) has undertaken several efforts to strengthen the base of knowledge of health disparities among racial/ethnic groups. This project is one part of a larger HCFA and Department of Health and Human Services effort to address health disparities among Medicare beneficiaries. This will be done using a longitudinal database that links Medicare enrollment and claims data with small-area geographic data on income (e.g., U.S. Census data or other private data sources). Such information will be useful to compare the incidence of disease and the outcomes of diagnostic and surgical procedures for ischemic heart disease (IHD) across racial/ethnic groups, socio-
Diseases most likely to affect the elderly's future health expenditures.

Past efforts to model health care expenditures.

The first TEP—consisting primarily of physicians knowledgeable about treatments for the elderly—will identify conditions likely to affect expenditures by the future elderly. For each condition, the TEP will identify the emerging technologies and estimate likely consequences on mortality and morbidity. The second TEP—consisting primarily of social scientists and modelers—will help determine appropriate health status measures, methodologies, and data sets for estimating model parameters, and the best modeling techniques.

RAND will use a microsimulation model to estimate future Medicare expenditures. The modeling efforts will consist of three components: a “basic” model, a “health status” model, and a “what if” model. The “basic” model will categorize the future elderly population by age and sex, then iteratively apply a transition matrix to calculate the status of the population at later time periods. This will serve as a useful benchmark for subsequent modeling efforts. The “health status” model will augment the basic model to explicitly include health status so that RAND can explore the possibility that changes may occur in the health status of the elderly and the treatment of particular health conditions among the elderly. RAND will use longitudinal datasets to estimate the transition rates—the probability that a person (or persons) with certain demographic characteristics and known health status will transition to another category with a different demographic and health status description over some time period. RAND will estimate the direct costs of health expenditures by fitting parametric models of the distribution of expenditures using existing data that link health status to spending. Finally, the “what if” model will explore changing the parameters of the health status model to reflect possible changes to the health care environment, including medical breakthroughs.

Status: The project is well underway. In September 1999, a final design report was accepted. In the fall of 1999, project staff consulted with nationally-recognized geriatricians to discuss which disease groups and specific medical conditions should be covered by the medical TEPs. Members have been appointed to the medical and social science TEPs. Preliminary reviews of the literature are expected prior to the TEP meetings. Work on devising a microsimulation model to estimate future Medicare expenditures is underway. Final project results are expected by December 2001.

Retiree Health Benefits
Prj #:500–95–0061/08
Start Date: 09/30/2000
End Date: 06/30/2002
Funding: $249,971
Vehicle: Task Order
PI: Lauren McCormack
Awardee: University of Wisconsin—Madison/Research Triangle Institute
PO: Brigid Goody, Sc.D.
Description: This project examines current employer-based health insurance coverage for Medicare-eligible retirees, the
ucts, questionable marketing and sales practices, sales of overlapping and duplicative coverage, and low loss ratios prompted Congress in 1980 to establish Federal standards for Medigap plans. Most States adopted the standards, which were developed by the National Association of Insurance Commissioners. Continued concern regarding marketing abuses and confusion among beneficiaries eventually prompted Congress to mandate Medigap policy standards. As a result of the Omnibus Budget Reconciliation Act of 1990, effective in 1992, newly issued Medigap policies have been required to conform to one of ten standardized benefit packages. The law also mandated other standards, including minimum loss ratios and a guaranteed open enrollment period for new Medicare enrollees. Despite many changes in the Medicare program since the early 1990s, the basic benefit structure of Medicare supplemental insurance has remained unchanged. This project will examine possible updated Medigap benefit structures, and compare these alternatives to the premiums and benefit structures of currently available supplementary coverage, as well as Medicare+Choice options.

**Status:** In progress.

**Health status and Medical Treatment of the Future Elderly: Implications for Medicare Program Expenditures**

**Prj #:** 500-95-0056/09  
**Start Date:** 06/30/1999  
**End Date:** 06/15/2001  
**Funding:** $1,582,650  
**Vehicle:** Task Order  
**PI:** Dana Goldman, Ph.D., and Michael Hurd, Ph.D.  
**Awardee:** RAND Corporation, The  
**PO:** Linda Greenberg, Ph.D.

**Description:** This project is designed to develop demographic-economic models to project how changes in health status, disease, and disability among the next generation of the elderly will affect future Medicare spending. The goal of this task order is to enable HCFA actuaries and policymakers to simulate the impact of changes in health and functional status, as well as changes in medical technology, on future costs to the Medicare program. The first aim of the model will be to answer the question: "If the current trends in demographics continue, and if the future generation of the elderly face the same health status and health care environment as today's elderly, what will future health care costs be?" The second aim of the model will be to serve as the simulation vehicle for evaluating "what if" scenarios to explore how various assumptions about changes in the health status of the elderly and the health care environment will affect Medicare and non-Medicare costs.

The models will focus on two key determinants of health spending: diseases (and the medical technology to treat them) and health status. RAND will use literature reviews and technical expert panels (TEPs) to guide the model development effort. The literature review effort will focus on five areas:

- Health and disability trends.
- New medical treatments.
- Effects of new technologies on morbidity and mortality.
The first is an internal analysis of the randomized clinical trial to be conducted by the Columbia University consortium analysts. The clinical trial analysis is primarily focused on the impact of the telemedicine intervention on health outcomes and clinical care of the participants. The second evaluation, which is this project, is to assess the financial impact of the demonstration. This evaluation is independent of Columbia's internal analysis. This financial impact evaluation will focus on whether the home telemedicine intervention can increase access to care for Medicare beneficiaries in medically underserved areas; whether the use of the intervention would reduce health care costs; and whether the physicians who are part of demonstration are representative of the physician population serving Medicare beneficiaries. More specifically, the questions to be addressed are:

What is the impact of the use of telemedicine and medical informatics on:
- access of Medicare beneficiaries to health care services?
- reducing the costs of health care services to Medicare beneficiaries?
- improving the quality of life of Medicare beneficiaries?

In addition, issues to be addressed may include:
- costs of the telemedicine intervention, with attention to both technology and service costs of the intervention
- estimation of the cost-effectiveness of the telemedicine intervention
- differences in the physicians who participate in the demonstration from those who do not participate.

Status: This project is subcontracted to Mathematica Policy Research.

*Design and Simulation of Alternative Medigap Structure*

**Prj #:** 500-95-0059/07  
**Start Date:** 09/30/1999  
**End Date:** 07/29/2001  
**Funding:** $588,984  
**Vehicle:** Task Order  
**PI:** Lisa Maria Alecxih  
**Awardee:** Lewin Group, The  
**PO:** John Robst

Description: While Medicare benefits are extensive, like many insurance products, the program has deductible and co-insurance requirements as well as limitations on payments to providers. On average, basic Medicare benefits alone cover about half the personal health care expenditures of aged beneficiaries (Laschober and Olin, 1996). Because of these “gaps” in coverage, many beneficiaries choose to purchase a supplemental policy, often called “Medigap.” The project will compile premium data on existing standard Medigap premiums, formulate alternative standard benefit packages, and estimate premium costs of these alternative packages. From this analysis, the current and alternative Medigap options will be compared.

Though Medicare supplemental coverage has been available since nearly the inception of the Medicare program itself, prior to the enactment of the Social Security Disability Amendments of 1980, such insurance products were regulated only by States. Increasing concerns regarding the confusing array of different Medigap prod-
shall include an evaluation of the impact of the use of telemedicine and medical informatics on improving access of Medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries. Submission of the RTC is mandated by August 31, 2004 (6 months after the conclusion of the demonstration). The purpose of this project is to evaluate the impact of the Informatics, Telemedicine, and Education Demonstration Project and to provide input into the RTC. The Informatics, Telemedicine, and Education Demonstration project is using specially modified home computers, or home telemedicine units (HTU) linked to a Clinical Information System (CIS) maintained by Columbia Presbyterian Medical Center. The HTUs in patients' homes allow video conferencing, access to health information and access to medical data. Computerized devices read blood sugar levels, check blood pressure, take pictures of skin and feet for signs of infection, and screen for other factors that affect the management of diabetes. These data are fed electronically to the data system at Columbia. The CIS provides storage of clinical data for use in the development and application of patient care guidelines and clinical standards. Full-time nurse case-managers monitor the data and intervene if the data from a patient vary from guidelines. Patients receive feedback, including clinical data such as blood glucose levels, care reminders and suggestions on how to maintain good health. Health information specific to diabetes is to intervention group participants on a specially developed website (under development) in both low literacy and regular versions in both Spanish and English.

The demonstration project is being conducted as a randomized, controlled clinical trial. Half of the participants are receiving the intervention, consisting of an HTU and electronic services within a case-manager environment (as detailed above), and half continue to receive usual care for their diabetes. The demonstration consists of 2 components: an urban component conducted in northern Manhattan, and a rural component, conducted in upstate New York. Participants can have either Type I or Type II diabetes, and both males and females will be included. There are no racial or ethnic exclusions to participation. Demonstration participants are being recruited into the study over approximately 1 year. Once recruited and randomized, each participant will remain in the demonstration for 2 years. After completion of their time in the demonstration, participants will be phased out over approximately 1 year. Outcome data will be collected from all participants at three visits (visit 1 [baseline], visit 2 [one year follow-up], and visit 3 [two year follow-up]). The primary health outcome measures to be collected as part of the demonstration are glycosylated hemoglobin levels, blood pressure levels, and lipid levels. Other important outcomes include receipt of recommended diabetes-specific health care services (dilated eye exam, foot exams), other recommended preventive services, smoking cessation in the subset of participants who smoke, and satisfaction with care.

Impact of the telemedicine intervention on health outcomes will be evaluated by comparing mean and adjusted mean levels of glycosylated hemoglobin, blood pressure, and lipids in the intervention and the control groups. There will be two separate analyses.
Status: The final report is being prepared.

Maximizing the Effective Use of Telemedicine: A Study of the Effects, Cost Effectiveness, and Utilization Patterns of Consultation via Telemedicine

Prj #: 18-C-90617/8
Start Date: 09/01/1995
End Date: 09/28/2002
Funding: $2,198,968
Vehicle: Cooperative Agreement
PI: Jim Grigsby, Ph.D. and Robert E. Schlenker, Ph.D.
Awardee: Center for Health Policy Research, University of Colorado
PO: Joel Greer, Ph.D.

Description: This project is evaluating the medical effectiveness, patient and provider acceptance, and costs associated with telemedicine services, as well as their impact on access to care in rural areas. The demonstration involves ten rural hospitals, one rural referral hospital, and one urban hospital. Planned services for the demonstration include interactive video consults for teleradiology, telepathology, and, where available, telesonography, electrocardiography, and fetal monitoring strips. Payment for related physician services is expected to be made under a waiver of Medicare payment regulations. The goal of the project is to evaluate whether specialty telemedicine services provided by hospital networks produce change with respect to medical effectiveness, patient and provider satisfaction, cost, and access. Hypotheses include telemedicine improving differential diagnoses and treatment, patients and providers being as satisfied with telemedicine as with on-site services, telemedicine services being less costly than on-site services, and telemedicine improving access to a wider range of health care services.

Status: The evaluation design has been completed and the instrument approved by the Office of Management and Budget. Data collection has begun.

Evaluation of the Informatics, Telemedicine, and Education Demonstration

Prj #: 500-95-0055/05
Start Date: 09/30/2000
End Date: 07/29/2004
Funding: $1,419,493
Vehicle: Task Order
PI: Judith Woodridge/Stephen Zuckerman
Awardee: Urban Institute, The
PO: Carol Magee

Description: Section 4207 of the Balanced Budget Act of 1997 (BBA97) instructs the Secretary to establish a single, 4-year demonstration project using an eligible health care provider telemedicine network. The demonstration involves the application of high-capacity computing and advanced telemedicine networks to the task of improvement of primary care and prevention of health complications in Medicare beneficiaries with diabetes mellitus. These beneficiaries must reside in medically underserved rural or medically underserved inner-city areas. The statute also mandates that the Secretary submit a final Report to Congress (RTC) that: AY
our current benefit and provider-based system to a beneficiary-centered system requires several elements:

- An assessment tool that can be used and shared across provider types.
- More flexible benefit packages.
- Funding based on beneficiary health and functional needs.
- Case management that involves formal and informal caregivers in care planning and supports and encourages, where appropriate, beneficiaries to direct their own care.

Additional work that incorporates beneficiary preferences into outcome measures, as well as further attempts to differentiate outcomes by post-acute-care modality for different patient conditions, is also needed. The purpose of this project is to design several elements needed in a more integrated system—an assessment tool, potential case management models, appropriate payment systems, and outcome measures that cross settings and incorporate beneficiary preferences, with the ultimate intent of pilot testing and refining these elements in a demonstration. A second purpose of this project is to design an optional demonstration that tests the feasibility and effectiveness of creating a more integrated post-acute-care system.

Status: Work has begun on developing potential case-management models, as well as an assessment instrument.

Effects of Telemedicine on Accessibility, Quality, and Cost of Health Care

- Prj #: 18-P-90332/5
- Start Date: 07/01/1994
- End Date: 09/30/2001
- Funding: $644,086
- Vehicle: Grant
- PI: F. W. Womack
- Awardee: University of Michigan
- PO: Joel Greer, Ph.D.

Description: This project evaluated the effect of telemedicine systems on accessibility, quality, and cost of health care. A detailed methodology for evaluating telemedicine was developed by a panel of experts and implemented in existing telemedicine programs at the Medical College of Georgia (MCG) Telemedicine Center and Mountaineer Doctor Television (MDTV) at the Health Sciences Center, West Virginia University (WVU). Included in the evaluation design was a quasi-experimental survey study of clients and providers in selected experimental and control communities and a case-control study to compare the content, process, and outcomes of episodes of care with and without telemedicine. The project plan had three goals:

1. Development of a detailed methodology for a comprehensive evaluation of the effects of telemedicine on accessibility, utilization, quality, and cost of health care, using a panel of experts on quality, economics, clinical medicine, and technology. Implementation and testing of the evaluation design at the MCG Telemedicine Center. Extending the evaluation design to MDTV at WVU.
2. The general hypothesis guiding this research was that telemedicine will improve accessibility to health care, enhance the quality of care delivered, and contain costs.
a differences in differences® model that estimates differential effects over time as a function of differential degrees of impact. In this initial project, analyses will compare changes between the pre-BBA period of the 1990's and a post-BBA year, such as 1999. For the most part, the studies should focus on the interrelationships among the various post-acute care settings. However, in some cases, changes affecting a single type of post-acute care may warrant special analysis. The model needs to be applied flexibly to include a variety of beneficiary, provider, and market area analyses. In addition, analyses may involve data for individual years, as well as changes between years. Since the impacts of policy changes not yet implemented will continue to be of interest for many years, the analyses developed under this project are expected to use and refine methods that can be applied in future evaluation research. Analytically, this is a challenging project due to the numbers of provider types and policy changes involved. The staggered and overlapping temporal implementation of the changes further complicates the effort. The proposed analyses are not necessarily expected to be able to attribute causality to effects detected, nor are they expected to disentangle the effects of one policy change from the effects of another. In general, it will only be possible to determine net effects of all changes relevant to a specific analysis. However, in choosing time periods, attention will be paid to the policies that could be expected to impact behavior during the period of analysis. The project will utilize secondary data sources, primarily HCFA claims data. Claims for all relevant types of services will need to be linked with beneficiary enrollment information to create Aepisodes® of care by beneficiary. At least 2 such episode files will be required, one for a pre-BBA year such as 1995 or 1996 and another for a post-BBA year such as 1999. In addition the project will design a strategy for monitoring and evaluation of impacts across post-acute care settings. We are interested in distinguishing between the needs for regular monitoring of impacts across post-acute care settings and more detailed evaluation studies. We are especially interested in defining data requirements for monitoring sentinel events that would serve as alerts for more in-depth evaluation. The strategy will define data requirements for monitoring and evaluation activities, taking into consideration the data available for individual care modalities and the need to integrate data across modalities in as timely and efficient a manner as possible.

Status: In developmental phase.

Design of an Integrated Post-Acute Care System
Prj #: 500–96–0008/04
Start Date: 09/30/1997
End Date: 10/31/2001
Funding: $829,428
Vehicle: Task Order
PI: Robert L. Kane, M.D.
Awardee: University of Minnesota
PO: Frederick G. Thomas, III, CPA, MS, MBA
Description: HCFA intends to create an infrastructure of post-acute and long-term care delivery and payment systems that are better integrated and more flexible in meeting the needs of beneficiaries with chronic illnesses and disabilities. The transition from
Subsequent evaluation reports will focus on utilization, cost, and quality effects beyond the 120-day episode period. There will be further case-study results on agency response to the demonstration and an extension of previous work on cost impacts to include an analysis of agencies’ financial performance. Finally, supplementary analyses will consider the representativeness of the demonstration sample and the patient selection behavior of agencies.

**Medicare Post-Acute Care: Evaluation of BBA Payment Policies and Related Changes**

- **Prj #:** 500-96-0006/04
- **Start Date:** 09/21/2000
- **End Date:** 09/20/2002
- **Funding:** $636,557
- **Vehicle:** Task Order
- **PI:** Brian Burwell
- **Awardee:** MEDSTAT Group, LLC
- **PO:** Philip Cotterill

**Description:** The purpose of this project is to study the impact of BBA and other policy changes on Medicare utilization and delivery patterns of post-acute care. Post-acute care is generally defined to include the Medicare covered services provided by skilled nursing facilities (SNFs), home health agencies, rehabilitation hospitals and distinct part units, long term care hospitals, and outpatient rehabilitation providers. The changes in post-acute care payment policy enacted in the late 1990's (mostly in the 1997 Balanced Budget Act (BBA) with some subsequent modifications) were made one-by-one to most types of post-acute care. However, a beneficiary's post-acute care needs, can often be met in alternative provider settings. Hence policy changes for one post-acute care modality may have ramifications for other post-acute and acute care services. Understanding the interrelationships among post-acute care delivery systems is critical to the development of policies that encourage appropriate and cost-effective use of the entire range of care settings. The results of this work may be useful in refining policies for individual types of post-acute care, as well as in developing a more coordinated approach across all settings. Medicare utilization and expenditures for post-acute care increased dramatically in the 1990's prior to the passage of the BBA. Many of the changes enacted in the BBA were in reaction to the experience of the early 1990's and were aimed at controlling the decade's fiscally disturbing expenditure trends. Even before passage of the BBA, administrative actions (such as Operation Restore Trust (ORT)) were taken to tighten the enforcement of coverage guidelines and reduce abuses that were perceived to be significant contributory factors to the runaway growth of the early 1990s. Chief among the BBA changes was the mandate for implementation of prospective payment systems to replace retrospective cost-based payment for all the major post-acute care providers. Among the BBA policies whose impacts to be considered in this project are the following: the Interim Payment System (IPS) for home health agencies; the SNF prospective payment system; the revised inpatient hospital transfer policy for 10 DRGs; the new cost limits and rebased target amounts for rehabilitation hospitals and distinct part units; and the outpatient therapy limits. Study Overview—In general, the appropriate evaluation design is
Findings from the first 2 years of the evaluation are described in additional reports forthcoming in calendar year 2000. Findings from the interim analysis of cost impacts suggest that, on average, prospective payment reduced the cost of care during the 120-day episode period by $419 or 13 percent. The impact on cost was similar across different types of agencies, except that small agencies (less than 30,000 visits in year before the demonstration) exhibited a significantly smaller effect than large agencies. Findings from the utilization study suggest that the per-episode group of HHAs was able to reduce the number of visits provided during the 120-day episode period by 17 percent and the time from admission to discharge by 15 percent. The proportion of patients receiving care in each home health discipline changed little under episode payment. The utilization findings generally applied to agencies regardless of size, nonprofit status, affiliation status (hospital or freestanding), or use pattern (i.e., whether the agency provided more or less than the average number of visits during a base year, given its case mix).

The reduction in visits has not led to compensating utilization in other parts of the health care system. An analysis of utilization and reimbursement for Medicare-covered services other than home health found that prospective payment did not affect the use of or reimbursement for such services during the 120-day episode period. An investigation of spillover effects in settings not covered by Medicare similarly found no compensating utilization. For example, prospective payment did not affect the likelihood of receiving nonresidential services such as personal care aides and adult day care, based on results from a patient survey.

These findings suggest that a reduction in home health utilization at the level observed under the demonstration does not adversely affect care quality or shift costs to services in other settings. Other interim analyses of quality impacts found few differences in patient outcomes between treatment and control agencies, and when differences were found, they were small. Analysis of claims data indicated that PPS patients have significantly lower emergency room use. There were no significant differences due to PPS in any other outcomes studied from the claims data, including institutional admissions for a diagnosis related to the home health care and mortality. Results from the first patient survey on client satisfaction suggested that both treatment and control group clients were generally satisfied. On three specific components of satisfaction with agency staff, treatment-group clients were found to be somewhat less satisfied than control group clients, although satisfaction levels were quite high in both groups. Measures of health and functional outcomes from the survey offered equivocal evidence for small negative effects of prospective payment in a few of the functional outcomes. These results are preliminary and require further study in a planned follow-up survey. Half of the treatment agencies selected for case study early in the demonstration reported plans for specific initiatives to reduce per-episode costs spurred by their participation in the demonstration project. From the case studies, the evaluators concluded that treatment agencies were not planning to change their behavior in ways that threatened access or quality of care.
volume patients. Preliminary analyses of outcomes suggested relatively few differences in outcomes by volume. This result may mean that the additional services delivered to the high-volume group helped equalize outcomes between more severely ill and less severely ill patients. Risk-adjusted analyses planned for later in the study are necessary to further explore this possibility.

**Evaluation of Phase II of the Home Health Agency Prospective Payment Demonstration**

**Prj #:500–94–0062**  
**Start Date: 09/30/1994**  
**End Date: 09/30/2000**  
**Funding: $3,528,408**  
**Vehicle: Contract**  
**PI: Barbara Phillips, Ph.D.**  
**Awardee: Mathematica Policy Research, Inc.**  
**PO: Ann Meadow, Sc.D.**  

**Description:** This contract is evaluating Phase II of the Home Health Agency (HHA) Prospective Payment Demonstration, under which HHA's are paid on a prospective basis for an episode of care reimbursed by the Medicare program. (Phase I tested per-visit prospective payment for HHAs.) Ninety-one agencies from five states—California, Florida, Illinois, Massachusetts, and Texas—were randomly assigned to either the treatment group (prospective payment system (PPS) method, 48 agencies) or the control group (conventional cost-based reimbursement, 43 agencies). The agencies phased into the demonstration at the beginning of their 1996 fiscal year. Treatment-group agencies can reduce the cost of care they provide during a 120-day payment period by reducing visits, changing the mix of visits to make less costly visits a larger proportion of visits, reducing per-visit costs, or some combination of all three. The cost-reducing activities raise the possibility that quality of care might deteriorate under episode-based payment. Quality impacts, along with cost, utilization, and qualitative, behavioral effects, are the focus of the evaluation. 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.

**Status:** Interim findings from the evaluation, based primarily on the first 8 to 15 months of demonstration operations, are described in following documents:

- **Transition Within a Turbulent System: An Analysis of the Initial Implementation of the Per-Episode Home Health Prospective Payment Demonstration, August 6, 1997.**
- **Preliminary Report: The Impact of Prospective Payment on Medicare Home Health Quality of Care, January 30, 1998.**
- **Preliminary Report: The Impact of Prospective Payment on Medicare Home Health Use—Promising Results for a Future Program, July 22, 1998.**
- **The Impact of Prospective Payment on Medicare Service Use and Reimbursement During the First Demonstration Year, December 1998.**
- **Preliminary Report: The Impact of Prospective Payment on the Cost per Episode: Striking the Balance Between Decreasing Use and Increasing Cost, July 22, 1999.**
Vehicle: Cooperative Agreement  
PI: Peter W. Shaughnessy, Ph.D.  
Awardee: Center for Health Policy Research, University of Colorado  
PO: Ann Meadow, Sc.D.

Description: Home health care (HHC) is the most rapidly growing component of the Medicare budget in recent years. The rapid growth in home health use 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 that volume-outcome relationships are present in HHC for common patient conditions, that upper and lower volume thresholds exist that define the range of services most beneficial to patients, and that a strengthened physician role and better integration of HHC with other services during an episode of care can optimize patient outcomes while controlling costs. To test these hypotheses, a sample of 3,600 patient records is being analyzed from agencies in 20 States stratified into high, medium, and low-volume categories based on annual visits per beneficiary. Trained data collectors at each agency recorded 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 are being measured from telephone interview data at HHC admission and from 6-month follow ups. These primary data concerning patient status and outcomes will be combined with Medicare claims data over the episode of care to study the relationship between service volume in HHC and both patient outcomes and costs.

Status: Study Paper 1, Research Design Update, which summarized the research design and its evolution from the original proposal, was finalized in September 1998. Primary data collection ended in late 1998. An interim report on a subsample of 1,000 patients (February 1999) described case mix and volume relationships. Separately for the four common conditions (congestive heart failure, stroke, surgical hip procedures, and open wounds), a high- and low-volume group was selected by taking the highest and lowest 45 percent of the arrayed cases within each condition. Two-sample tests for mean differences in case mix characteristics and volume were performed to compare the two volume groups within each condition. The median volume (defined as number of visits until discharge or first inpatient admission) differed by a factor of about four to nine, depending on the condition. For home health aide services, mean volume differed by a factor of between 30 and 47. Many case mix indicators were measured at the start of care. Of these, few demographic indicators differed between the volume groups within condition. But limitations in activities of daily living (ADLs) were significantly greater for the high-volume groups, these patients had a greater prevalence of chronic conditions, and their institutional utilization within the 14 days prior to admission was less likely to be an acute-care hospital, indicating the more post-acute nature of the low-volume groups. This general case mix difference is consistent with the greater use of aide services for high-
Description: The primary focus of this study is to understand existing variation in home health resource patterns and to use this information to develop a case-mix adjustment system for a national home health prospective payment system (PPS). In this study, the Outcomes and Assessment Information Set (OASIS), which has been developed for outcome-based quality assurance and improvement for Medicare home health agencies, is being examined to see whether items included in this instrument will be useful for case-mix adjustment. Detailed information, including information on resource utilization and additional items needed for case-mix adjustment not included on OASIS, has been collected from participating agencies. (Arizona, California, Florida, Illinois, Massachusetts, Pennsylvania, Texas, Wisconsin.)

Status: Ninety agencies were recruited and trained from eight States in the spring and summer of 1997. All agencies began data collection on a 6-month cohort of new admissions to home care beginning in October 1997. Data collection ended in the spring of 1999. Analysis to date has resulted in a viable, clinically coherent system of 80 case-mix groups that explains more than 30 percent of the variation in resource use on a development sample drawn from the cohort members. Resource use is measured for 60-day periods of care, to conform to the planned unit of payment under the forthcoming national PPS. Selected OASIS assessment items, collected at the start of care, are used in the grouping system. The case-mix items fall into three major domains: clinical factors, functional-status factors, and utilization factors. Within each domain, a parsimonious set of items is summarized into a score for the patient. In two of the domains, scores are partitioned into four levels corresponding to high, moderate, low, and minimal impact, based on the relationship of the score to resource utilization. In the third domain, scores are partitioned into five impact levels. A patient's combination of levels on all three domains identifies the group into which the patient is classified for purposes of case-mix adjusting the prospective payment amount. Under this system, the patient's case mix classification is updated at the end of the payment period to reflect the actual amount of home therapy services received during the 60-day payment period. This information is necessary to arrive at a final score for the utilization domain. Results of the study to date are described in two reports:


Additional reports on model validation results refinement related analysis and OASIS case-mix data verification are expected in 2001.

Maximizing the Cost Effectiveness of Home Health Care: The Influence of Service Volume and Integration with Other Care Settings on Patient Outcomes

Prj #:17–C–90435/8
Start Date: 09/01/1994
End Date: 09/30/2000
Funding: $1,496,245
Vehicle: Simplified Acquisition  
PI: Ralph Monaco  
Awardee: InterIndustry Economic Research Fund  
PO: Edgar Peden  
Description: This project analyzes the macro-economic effects related to the introduction of a new public program, specifically an outpatient prescription drug benefit for Medicare.  
Status: In progress.

Evaluation of the Nursing Home Case-Mix and Quality Demonstration  
Prj #:500–94–0061  
Start Date: 09/30/1994  
End Date: 09/01/2000  
Funding: $2,980,219  
Vehicle: Contract  
PI: Robert J. Schmitz, Ph.D.  
PO: Edgar A. Peden  
Description: Using data from the Nursing Home Case-Mix and Quality (NHCMQ) Demonstration, HCFA is evaluating the new practice of paying skilled nursing facilities (SNF) for Medicare skilled nursing services on a prospective basis. Prior to July 1, 1996, SNFs were reimbursed on a retrospective basis for their reasonable costs. Since that date, however, following methods used in the NHCMQ demonstration, a new prospective methodology has been implemented. Under this methodology, patients are classified into resource utilization groups which are then used to calculate each facility’s case mix. HCFA then pays facilities for each covered day of care, to the case mix of patients residing there on any given day. Though some costs will continue to be  
Status: Interim analyses of admitting patterns and select outcomes have been undertaken, and visits to demonstration and non-demonstration facilities have been completed which should help in understanding provider response to the payment demonstration. Data base construction and analysis of the third phase of the demonstration, which bundled skilled therapy services into the prospectively-paid routine rate has been completed. This primary data collection activity was completed in July 1999. MDS assessments were matched to Medicare SNF and hospital claims and to HCFA Provider-of-Service records to create the analytic data base for the project. Current analytic activities center around assessing and revising the draft final report. Of special interest is the analysis of primary data regarding the provision of professional therapy services in both demonstration sites and comparison sites.

Case-Mix Adjustment for a National Home Health Prospective Payment System  
Prj #:500–96–0003/02  
Start Date: 07/26/1996  
End Date: 09/30/2000  
$\text{Funding }$3,416,984  
Vehicle: Task Order  
PI: Henry Goldberg  
Awardee: Abt Associates Inc.  
PO: Ann Meadow, Sc.D.
these limited prescription drugs exceeds spending for lens surgery, ambulance services, or oxygen. Until recently, Medicare paid for these limited prescription drugs based on reasonable charge determinations for covered prescription drug products found in the published Average Wholesale Price (AWP). Medicare paid 63 percent of the amounts billed for prescription drug products and their dispensing. A recent report from the Office of the Inspector General (OIG) concluded, however, that Medicare’s payments for 22 drugs in 1996 had an average mark-up of 41 percent over what physicians and suppliers paid for the drugs. By contrast, Medicare recognized only 49 percent of submitted charges for all other billed Part B services. The Balanced Budget Act of 1997 changed Medicare’s payment amount from 100 percent to 95 percent of the AWP. According to several OIG reports, public programs such as Medicare have been paying too much for prescription drugs relative to what pharmacies actually spend for brand name products. For example, the prevailing Medicaid discount rate has been 10 percent, whereas actual acquisition discounts average over 18 percent. For generic products, the disparity is thought to be larger. Medicaid recoups a substantial portion of prescription drug payments through rebates from manufacturers. Also, drug manufacturers frequently provide special discounted prices for drugs used by the Department of Defense, the Department of Veterans Affairs, and certain Department of Health and Human Services health care programs. In 1997, it was estimated that 68 percent of Medicare managed care plan benefit packages included broadened benefits for prescription drugs, and that some of these managed care options were offered at no additional premium to beneficiaries. Such managed care plans offering these options may receive substantial discounts and/or rebates from manufacturers either by negotiation or by use of pharmacy benefit management firms who conduct price negotiations on behalf of plans. Medicare would like to know in greater detail how its payment policy for prescription drugs compares with the policies of other payers and purchasers. But data for making such comparisons are not readily available. HCFA does obtain detailed, product specific data from state Medicaid programs that are used to calculate rebate obligations of manufacturers. Under the terms of the Medicaid rebate agreements, however, such data are held in confidence and could not be used for this study. Hence, the purposes of this study are twofold:

Data Collection (Task 1): the contractor will seek and obtain available drug payment system information from other non-Medicare organizations.

Comparative Analysis (Task 2): the contractor will compare current Medicare covered prescription drug reimbursement levels to those found in the data gathered, and prepare an analytical report.

Status: In progress.

Examine the Effects of Providing a Outpatient Prescription Drug Benefit

Prj #:HCFA-00-0046
Start Date: 01/20/2000
End Date: 02/28/2001
Funding: $15,000
place competition to establish market-based prices and to select DME suppliers. The Balanced Budget Act of 1997 (BBA) authorized competitive bidding demonstrations for Part B services (except physician services), and the current project is being conducted under that authority. The initial site of the demonstration is Polk County, Florida. Competitively bid product categories in Polk include oxygen supplies and equipment, enteral nutrition, surgical dressings, urological supplies, and hospital beds. Medicare contracts with winning suppliers commenced in October 1999. Section 4319 of the BBA specifically mandates evaluation studies addressing competitive bidding impacts on expenditures, quality, access, and diversity of product selection. This task order will study these and other outcomes of the demonstration. The evaluation will use several types of research designs, such as multiple time series analysis and pre-test/post-test comparisons. The results of the evaluation will help HCFA decide how to conduct any future competitive bidding activities.

Status: Data collection activities have begun. A pre-demonstration survey of oxygen users and users of other medical supplies was fielded in two Florida counties (Polk and Brevard) in March 1999. The results suggested beneficiaries were highly satisfied with the services and products delivered by their Medicare suppliers. A followup survey is to be conducted during CY 2000. Two site visits in 1999 were conducted as part of the evaluation's case study activities, focusing on administrative and market outcomes. Other evaluation activities now in the planning stages include claims analyses, focus groups, fee-schedule analyses, and additional surveys. The first annual evaluation report is scheduled for release in early CY 2001.

Assessment of Medicare Prescription Drugs and Coverage Policies
Prj #: 500-00-0024/01
Start Date: 09/30/2000
End Date: 02/28/2002
Funding: $202,527
Vehicle: Task Order
PI: Thomas Hoerger
Awardee: Research Triangle Institute
PO: Peri Iz

Description: The purpose of this task is to assemble and analyze recent fee-for-service and managed care plan data on Medicare spending for prescription drugs, as well as comparable data from other public and/or private payers. Using these data, the project will estimate possible financial effects of alternative Medicare payment policies for drugs currently covered by statute. This study will estimate current expenditures and possible savings from alternative reimbursement policies based on different discount rate and price schedules used by other payers, as well as examine other purchasing policies including competitive bidding and rebate mechanisms. In fiscal year 1997, Medicare's limited prescription drug benefits represented approximately 5 percent ($2.8 billion of the $56.4 billion) of the total Medicare Part B expenditures. The majority of this drug spending is provided on an inpatient basis or related to the End Stage Renal Disease program. While not the most significant source of spending under Medicare, Part B spending for
ceived a grant in the amount of $2 million in support of the evaluation of this model of care.

Status: A first-year award was made to the applicant subject to revision of the study design and work plan according to terms and conditions established by the review panel. HCFA staff met with the Principal Investigator and other members of the research team at a kick-off meeting on September 1, 1999, at which time a revised work plan and budget were submitted. As a result of changes to the study plan, the applicant requested an increase in the first-year award with a corresponding reduction in the Years 2–4 awards and no change in the total budget. This change was approved.

Study of Medicare Payments in HPSA's
Prj #: 500–95–0056/11
Start Date: 09/21/1999
End Date: 07/29/2001
Funding: $240,323
Vehicle: Task Order
PI: Donna Farley
Awardee: RAND Corporation, The
PO: William Buczko, Ph.D.

Description: Medicare includes a number of special payment provisions aimed at maintaining beneficiary access to needed services in areas where there is a scarcity of physicians and providers. These areas are designated by the Health Resources and Services Administration and are called Health Professional Shortage Areas (HPSAs). This project compiles data on trends in payment amounts, services, and recipients that have been provided by Medicare over the past decade, project future trends, and suggests and assesses alternatives to the current set of special payment provisions for HPSAs. It will review the value of all Medicare payments to HPSAs for services provided in, or to residents of, such areas. The methodology used to designate such areas is undergoing proposed changes which are expected to be finalized in the year 2000. This project will inform HCFA about the importance of several Medicare special payment policies for HPSAs and aid in the assessment of them and of alternatives.

Status: In progress.

Evaluation of Competitive Bidding Demonstration for DME and POS
Prj #: 500–95–0061/03
Start Date: 09/30/1998
End Date: 05/15/2003
Funding: $2,315,249
Vehicle: Task Order
PI: Sarita Karon
PO: Ann Meadow, Sc.D.

Description: HCFA has mounted a demonstration to test the feasibility and effectiveness of establishing Medicare fees for durable medical equipment (DME) and prosthetics, prosthetic devices, orthotics and supplies (POS) through a competitive bidding process. The fundamental objective of competitive bidding is to use market-
count the beneficiaries medical and social needs. 2. Improved beneficiaries access to treatment and prevention services, including services that may not otherwise be available through the traditional Medicare fee-for-service program (such as medications, home visits, transportation, and health education). 3. Involvement of a care Acoordinator® or Amanager® in the beneficiary medical care depending on the design of the program, this individual may exercise considerable control over the beneficiary's medical care, or may function in an adjunct role, assisting patients in making and keeping medical appointments, complying with treatment recommendations and accessing other needed resources. 4. Simplified processes for contacting providers to allow for rapid resolution of new problems that otherwise might require emergency care. 5. Increased beneficiaries (or where applicable, family members or caregivers) understanding of their medical problems, in order to improve compliance with treatment plans. 6. Improved information sharing between health care providers in order to insure that patients receive appropriate care in a timely fashion, reduce duplicative or unnecessary care; and avoid unnecessary emergency care and hospitalizations. The goal of this evaluation is to identify those characteristics of the programs of coordinated care under study that have the greatest impact on health care quality and cost, and to identify the target populations most likely to benefit from such programs. The demonstration programs to be studied as a part of this evaluation will vary widely with respect to the demographics, medical and social situations of the target population, intensity of services offered, interventions under study, type(s) of health care professionals delivering the interventions, and other factors. Furthermore, sites may be added to the demonstration as it progresses. For these reasons, the evaluator will be required to establish a basic framework for analysis that can be tailored to the requirements of each demonstration site, and will allow for between-site comparisons at the intervals and at the completion of the evaluation.

Status: In progress.

Aging in Place: A New Model for Long-Term Care
Prj #: 18-C-91036/7
Start Date: 06/18/1999
End Date: 06/17/2003
Funding: $1,169,406
Vehicle: Cooperative Agreement
PI: Karen Dorman Marek, PhD, MBA, RN
Awardee: Curators of the University of Missouri, Office of Sponsored Program Administration, University of Missouri—Columbia, Sinclair School of Nursing
PO: Barbara Silverman, MD
Description: The goal of the "Aging in Place" model of care for frail elderly is to allow elders to remain in their homes as they age, rather than requiring frequent moves to allow for more intensive care if and when it becomes necessary. The University of Missouri's Sinclair School of Nursing is in the process of implementing such a model. Although a planned element of the program is a new senior housing development, the program currently targets elderly residents of existing congregate housing. The University has re-
Evaluation of Programs of Coordinated Care and Disease Management

Prj #: 500-95-0047/09
Start Date: 09/30/2000
End Date: 09/29/2005
Funding: $3,018,839
Vehicle: Task Order
PI: Randolph Brown
Awardee: Mathematica Policy Research
PO: Barbara Silverman, MD

Description: This project will design and conduct the evaluation of a group of Congressionally mandated demonstration programs and two HCFA-initiated demonstration programs. These programs will test various methods of managing care in the fee-for-service Medicare environment. Attempts to demonstrate the effectiveness of programs of care coordination or management are complicated not only by wide variations in program staff, funding mechanisms, interventions and stated goals, but by the evaluator's definition(s) of effectiveness. Despite the widespread acceptance of the concept of care coordination, studies of the effectiveness of various approaches, including those conducted in Medicare beneficiary populations, have yielded mixed results. The results of a Medicare demonstration of case management in a fee-for-service environment carried out from October 1992 through November 1995 are demonstrative of the difficulties inherent in defining and evaluating the effectiveness of these programs. The three programs studied varied widely in their target populations and the nature of the interventions attempted; although all were associated with increased client satisfaction, none appeared to improve outcomes or reduce costs. A major defect in the three programs studied was a lack of active involvement of the primary care provider in the case management intervention. HCFA continues to investigate the potential of care coordination or case management to improve care quality and control costs in the Medicare fee-for-service program. Section 4016 of the Balanced Budget Act of 1997 (Public Law 105-33) required the Secretary to design a demonstration of approaches to coordinated care of chronic illnesses in up to nine separate sites. As required by Congress, an evaluation of best practices in coordinated care and a study of demonstration design options has been conducted. A solicitation informing interested parties of the intent to conduct this demonstration is expected in late Spring, 2000. Demonstration sites will be funded for a period of four years. A separate demonstration, the Medicare Case Management Demonstration, focuses on programs of case management specific to diabetes and congestive heart failure. This evaluation is to assess the effectiveness of various strategies for coordinating care in the fee-for-service (FFS) Medicare environment, in a total of 11 demonstration sites. The participating demonstration sites will vary considerably by a number of factors, including corporate structure, types of medical conditions addressed, scope of patient care covered, beneficiary eligibility, source of comparison data. However, the sites have in common the goal of improving quality and reducing cost of health care received by chronically ill Medicare beneficiaries through any or all of the following: 1. Individualized plans of care that take into ac-
PO: James Hawthorne
Description: This project is for the design and implementation of the Phase II evaluation of this ongoing demonstration. The Community Nursing Organization (CNO) Demonstration was mandated by the Omnibus Budget Reconciliation Act of 1987 although actual data collection for the project did not commence until 12/17/93. The demonstration was originally authorized for three years but in 1996 it received a one-year extension (from HCFA)(followed by a two-year extension authorized in the Section 10019 of the Balanced Budget Act of 1997). The demonstration was scheduled to end on 12/31/99 but (in Section 532 of the Balanced Budget Refinement Act of 1999(BBRA)) it received another two year extension from Congress and is now scheduled to run until 12/31/01. Abt Associates won a competitive contract to design and conduct an evaluation of the first phase of the demonstration. The Abt (Phase I) evaluation covers the operation of the demonstration from January, 1994 to July, 1997. In addition to extending the demonstration, Congress mandated a second evaluation of the demonstration which is this Phase II Evaluation. A final report of this evaluation is to be delivered to Congress no later than 7/1/01. This new/extended evaluation will provide for longer term follow-up of early participants and will also include assessment of the effects of the CNO intervention on later participants whose data were not available for the Abt evaluation. This second evaluation will require the use of HCC concurrent, risk adjusted estimates of Medicare expenditures for Medicare beneficiaries who participated in the demonstration as well as for a new comparison group. The calculation of the risk adjuster scores is being contracted separately and the resulting data will be made available to this Phase II Evaluation.

Study of Pharmaceutical Benefit Management
Prj #: 500–97–0399
Start Date: 09/28/2000
End Date: 07/13/2001
Funding: $299,695
Vehicle: Contract
PI: Michael Keagan
Awardee: PriceWaterhouse Coopers, LP
PO: Peri H. Iz, Ph.D.
Description: This study is an extension of an earlier HCFA ORD research (500–95–0065/02). Completed in 1996, this early study remains valuable for its description of the industry functions and the origins. However, most information contained in the early study is no longer current. This industry has undergone major stages of evolution during the past five years. While the industry size has grown impressively in size, there has been an increasing concentration of market power. The pharmacy benefit management (PBM) industry is becoming a dominant player in the administration of pharmaceutical benefits. It seems certain that the PBM sector will play a significant role in administering the Medicare program in case a drug benefit is added to Medicare. This study will systematically examine this growing PBM industry from a potential client's perspective.

Status: The project is in the start-up phase.
Act of 1987, although actual enrollment did not commence until 12/17/93. The demonstration was originally authorized for three years but in 1996 it received a one-year extension from HCFA, followed by a two-year extension through the Balanced Budget Act of 1997. The demonstration was scheduled to end on 12/31/99, but received another two year extension from Congress in the Balanced Budget Refinement Act of 1999 (BBRA). It is now scheduled to run until 12/31/01. Abt Associates was contracted to design and conduct an evaluation of the first phase of the demonstration. The Abt Phase I evaluation included beneficiaries randomized through September 1995. It addressed the experience of these beneficiaries through the beginning of 1997. The main findings were that the CNO intervention did not significantly improve care and that capitation payments to the CNO’s were significantly higher than expenditures for the same package of services provided to the control groups but paid for on a fee-for-service basis. Because of language in the BBRA, which requires that the remainder of the demonstration be budget neutral, and the findings from the Abt evaluation, HCFA notified the CNO sites that their capitation payments will be reduced. The CNO sites and Congressional staff contend that the payment reductions are such that the CNOs will be required to cease operations. As a result of requests from the CNO sites and Congressional staff, several meetings took place to discuss the future of the demonstration and the budget neutrality requirement. The CNO sites and Congressional staff question the validity of the Abt evaluation and have requested that additional analyses be conducted. The CNO sites and Congressional staff are particularly concerned about the fact that in a 1998 Interim Report by the evaluation contractor, the expenditures for the treatment and control groups were different than the expenditure amounts in the Final Evaluation Report. Several important methodological changes were made in the Final Report, including the elimination from the analysis of participants from the treatment group who enrolled after randomization stopped, the addition of 6 more months of data, and the use of an inflation adjustment that was not applied to the data in the Interim Report. The CNO sites and Congressional staff want to know the extent to which each of these methodological changes affected the expenditure amounts in the Final Report. They want to have a better understanding of the reasons behind the changes between the Interim and Final Reports. When the evaluation contractor conducted the work for the Final Report, they re-constructed the files from scratch, which means the Final Report was not simply an update of the analyses in the interim report. Therefore, to fully understand the differences between the Interim and Final Report and answer their questions and concerns, additional programming and analyses will be necessary.

**Phase II Evaluation of Community Nursing Organization (CNO) Demonstrations**

- **Prj #:** 500–95–0062/10
- **Start Date:** 09/20/2000
- **End Date:** 09/19/2002
- **Funding:** $246,367
- **Vehicle:** Task Order
- **PI:** Steve Pizer
lations, and higher mortality. Risk will be characterized in enrollment level tiers and compared and contrasted to the risk characteristics of larger health delivery organizations. Simulations and the actuarial theory of ruin will be used in this assessment. The impact of joint capitated funding streams (Medicare and Medicaid) also will be modeled. Available claims data and data sets from other studies will be analyzed under this contract.

**Community Nursing Organization Demonstration**

**Period:** September 1992—December 31, 2001

**Contractors:** See below.

**Description:** Section 4079 of Public Law 100–203 directs the Secretary of the Department of Health and Human Services to conduct demonstration projects at four or more sites to test a capitated, nurse-managed system of care. The two fundamental elements of the Community Nursing Organization (CNO) demonstration are capitated payment and nurse case management. These two elements are designed to promote timely and appropriate use of community health services and to reduce the use of costly acute care services. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. Four applicants were awarded site demonstration contracts on September 30, 1992. The selected sites represent a mix of urban and rural sites and different types of health providers, including a home health agency, a hospital-based system, and a large multi specialty clinic. All CNO sites underwent a 1-year development period and began a 3-year operational period in January 1994. The Balanced Budget Act of 1997 extended the demonstration through December 31, 1999. The Balanced Budget and Refinement Act of 1999 extended the demonstration through December 2001 and included a budget neutrality requirement for the payment rates. The Benefits Improvement and Protection Act of 2000 removes the budget neutrality requirement but will reduce projected payment rates by 15 percent for the New York site, and 10 percent for the three other sites. Actuarial adjustments will also be made for October through December 2000 and for calendar year 2001. Abt Associates Inc. was selected to evaluate the project and to provide technical assistance to the sites. Abt Associates Inc also was awarded the external quality assurance contract.

**Contractor:** Care Clinic Association, 307 East Oak, Suite 3, P.O. Box 718, Mahomet, IL 61853.

**Contractor:** Visiting Nurse Service of New York, 107 East 70th Street, New York, NY 10021–5087

**Additional Analyses of Community Nursing Organization (CNO) Demonstration Data**

**Prj #:** 500–95–0062/09

**Start Date:** 09/29/2000

**End Date:** 01/19/2001

**Funding:** $204,637

**Vehicle:** Task Order

**PI:** Steven Pizer

**Awardee:** Abt Associates, Inc.

**PO:** James Hawthorne

**Description:** The Community Nursing Organization (CNO) Demonstration was mandated by the Omnibus Budget Reconciliation
determine the formula for the minimum surplus level to assure that the probability of a site's financial ruin is less than some maximum tolerance. (2) Biased Groups—Related to the problem of small numbers, PACE organizations enroll an inherently biased group of beneficiaries. Available studies suggest that PACE enrollees are sicker, frailer, and more costly than the average Medicare beneficiary. It is not clear whether these higher costs are driven by enrollment into PACE after a precipitating event, or if these costs are ongoing as a result of enrolling patients with chronic/persistent illnesses. Either bias would likely act to increase the financial risk assumed by PACE organizations particularly in light of the assumption of a random draw in Medicare+Choice, where payment is based on the average. However, the rate setting implications are different. If PACE is enrolling beneficiaries at a high point their expenditure pattern, then remaining expenditures prior to enrollment could overstate average costs. On the other hand, paying average cost will underpay given the lingering effects of the precipitating event and higher costs in the last year of life. What is the most appropriate risk adjuster or other method of modifying capitation rates to account for these biases? (3) Medicaid Capitation—Ignoring the adequacy of the Medicaid rates, does a jointly capitated payment model reduce the financial risk to a PACE organization? This could occur if services provided by Medicare result in lower Medicaid costs. (4) Higher Mortality—PACE organizations have experienced higher mortality rates, estimated at roughly 20 percent per year. A prospective model is used in Medicare+Choice payments; however, the mortality is much lower, estimated at 3 percent. If a prospective risk adjustment model is used, payments will be adjusted in subsequent years only on living enrollees. Given the differential rates in mortality, would a prospective payment model adjusted for higher mortality result in lower financial risk to a PACE organization?

Status: Payments for medical services furnished by PACE organizations are fully capitated by Medicare and Medicaid. A variant of this capitated approach is used by Medicare to pay Medicare+Choice organizations, which generally have much larger numbers of Medicare participants than PACE organizations. Because of their unique niche, total reliance on capitated payments (Medicare and Medicaid), lower enrollee levels, and higher mortality rates, PACE organizations may have a higher level of financial risk than Medicare+Choice plans. In order to assess the potential risk elements as well as to help determine implications for policy purposes, an actuarial evaluation and assessment of payment rates for PACE will be performed under this project. Available studies suggest that PACE enrollees are sicker, frailer, and more costly than the average Medicare beneficiary. It is not clear whether these higher costs are driven by enrollment into PACE after a precipitating event, or if these costs are ongoing as a result of enrolling patients with chronic/persistent illnesses. Either bias would likely act to increase the financial risk assumed by PACE organizations particularly in light of the assumption of a random draw in Medicare+Choice, where payment is based on the average. This project will assess the financial risk that PACE organizations incur as a result of their smaller enrollment numbers, biased popu-
How does PACE affect the health status and functional status of PACE participants?

Status: All of the data collection for this project has been completed and the contractor is analyzing the impact of PACE on Medicare costs. A final report, entitled “The Impact of PACE on Participant Outcomes,” has been received. Briefly, this study found that compared to the comparison group:

- PACE enrollees had much lower rates of nursing home and inpatient hospital utilization, and higher rates of ambulatory care.
- PACE enrollees reported better health status and quality of life.
- PACE participants had lower mortality rates.

The benefits of PACE appeared to be magnified for those participants with high levels of physical impairment. Work continues on the study of the cost effectiveness of PACE.

**Actuarial Assessment of PACE Enrollment Characteristics in Developing Capitated Payments**

Prj #: 500-95-0061/09
Start Date: 09/30/2000
End Date: 
Funding: $120,460
Vehicle: Task Order
PI: James Robertson
Awardee: University of Wisconsin—Madison/Research Triangle Institute

PO: Frederick G. Thomas, III, CPA, MS, MBA

Description: The purpose of this is to investigate the impact of a number of the Program for All-Inclusive Care for the Elderly (PACE) specific issues on financial risk and payments and then to formulate alternative payment options, which would result in a reasonable approach for Medicare payments to PACE. The BBA requires the PACE program to be paid using the risk adjustment method developed for Medicare+Choice programs, but adjusted for factors specific to the PACE program. PACE is expected to differ from M+C plans in a number of attributes: enrollment size, group bias, dual Medicaid capitation, and mortality rates. An actuarial assessment is needed to explore the risk characteristics related with these factors and to formulate options that use this information in a capitated payment system. The project will explore the following issues related to PACE payments: (1) The Problem of Small Numbers—The volatility of a PACE site’s average actual Medicare service costs for a period depends upon the site’s census. Enrollment size could influence: (a) setting the minimally viable number of PACE organizations in a geographic area, (b) setting the minimum enrollment size for a viable PACE site, and (c) establishing financial reserve requirements, which may be considered by licensing agencies in assessing financial viability. Large sites should exhibit more stable per-member-per-month costs from period to period than smaller sites. So, all else being equal, smaller sites will be more likely than large sites to experience significant strains on their financial status. In the insurance industry, this exposure is managed through reinsurance agreements or minimum surplus requirements. The actuarial topic of ruin theory may be applied to
tion and evaluation. On Lok is continued to collaborative projects with other organizations in the San Francisco Bay area. A pilot agreement with the Institute on Aging (IOA) was completed and the two organizations have entered into a venture agreement in which IOA established an adult day health center, operating it under the rules of the program of All-Inclusive Care for the Elderly (PACE) protocol. The site is in the Richmond area of San Francisco. On Lok provides quality assurance oversight as well as marketing and enrollment support. IOA receives a portion of On Lok's capitation via the HCFA demonstration and a portion is retained by On Lok to cover administrative expenses. The Balanced Budget Act of 1997 authorized coverage of PACE under the Medicare program. Under the Benefits Improvement and Protection Act of 2000, this demonstration has until November 24, 2002 to transition to operational.

Status: This date can be extended one year as a State election.

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

Prj #:500–96–0003/04
Start Date: 04/23/1997
End Date: 06/30/2000
Funding: $238,917
Vehicle: Task Order
PI: David Kidder, Ph.D.
PO: Frederick G. Thomas, III, CPA, MS, MBA

Description: The Evaluation of the Program of All-inclusive Care for the Elderly (PACE) consists of both qualitative and quantitative components. The purpose of the qualitative component is to examine, in detail, the structure and process of case management as well as to gain a better understanding of the factors that drive interdisciplinary team decisionmaking in the PACE model. Since enrollment in PACE has been lower than originally expected, except for On Lok, the first part of the quantitative part of the evaluation of PACE is examining the decision to participate in PACE. This is particularly important given the anomaly of under-enrollment in virtually all long-term care alternatives, as well as the policy interest in encouraging increased use of managed care. In the evaluation, the process by which people come to participate in PACE is modeled. The "refusers," or those who apply to PACE and pass the initial screening eligibility criteria but do not actually enroll in the program, serve as the comparison group for the evaluation of the impact of PACE. The impact evaluation of PACE is addressing a broad range of questions including:

- Does the government spend less on PACE clients than it would have spent on them in the absence of PACE?
- Does the PACE program spend no more on PACE clients than the capitation amount?
- Does PACE alter the mix of services provided?
- Does the quality of life and satisfaction with services increase for participants and family members?
- Does PACE impact the presence and amount of formal in-home care, formal care outside the home, informal in-home care and informal care outside the home?
Start Date: 05/01/1997
End Date: 04/30/2002
Funding: $600,000
Vehicle: Grant
PI: Lewis A. Lipsitz, M.D.
Awardee: Hebrew Rehabilitation Center for the Aged
PO: Renee Mentnech
Description: Community care and educational protocols are used to test the hypothesis that clients can be educated and empowered to more actively participate in their own health care planning, decisionmaking, and chronic disease management. The populations studied are individuals living in the Hebrew Rehabilitation Center for the Aged and those living in subsidized housing in the Boston community. Educational protocols are used to test the hypothesis that clients can be educated and empowered to more actively participate in their own health care planning, decisionmaking, and chronic disease management.
Status: In progress.

On Lok's Risk-Based Community Care Organization for Dependent Adults: On Lok Senior Health Services
Period: November 1983-Indefinite
Funding: Waiver only
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.
Description: As mandated by sections 603(c) (1) and (2) of Public Law 98-21, the Health Care Financing Administration granted Medicare waivers to On Lok Senior Health Services and Medicaid waivers to the California Department of Health Services. Together, these waivers permitted On Lok to implement an at-risk, capitated payment demonstration in which more than 300 frail elderly persons, certified by the California Department of Health Services for institutionalization in a skilled nursing facility, are provided a comprehensive array of health and health-related services in the community. The current demonstration maintains On Lok's comprehensive community-based program but has modified its financial base and reimbursement mechanism. All services are paid for by a predetermined capitated rate from both the Medicare and Medicaid (Medi-Cal) programs. The Medicare rate is based on the average per capita cost for the San Francisco county Medicare population. The Medi-Cal rate is based on the State's computation of current costs for similar Medi-Cal recipients, using the formula for prepaid health plans. Individual participants may be required to make copayments, spenddown income, or divest assets based on their financial status and eligibility for either or both programs. On Lok has accepted total risk beyond the capitated rates of both Medicare and Medi-Cal. The demonstration provides service funding only under the waivers. Research and development activities are funded through private foundations.

Section 9220 of Public Law 99-272 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 the exception of the requirements relating to data collec-
Status: Department of Elder Affairs staff are taking the lead in coordinating planning activities and have assembled a task force comprised of consumers, providers, and representatives from the Maryland State Department of Health and Mental Hygiene to guide the planning process. They have obtained Medicare and Medicaid claims data and are linking these data in an effort to devise a rate-setting mechanism that will work for plans that enroll a disproportionate share of frail elderly.

Second Generation Social Health Maintenance Organization Demonstration: Maryland
Prj #:99-C-90868/3
Start Date: 04/30/1999
End Date: 06/30/2000
Funding: $109,211
Vehicle: Cooperative Agreement
PI: Martin Wasserman, MD
Awardee: Maryland Department of Health and Mental Hygiene
PO: James Hawthorne
Description: This Cooperative Agreement provides the Maryland State Department of Health and Mental Hygiene (DHMH) with funds to purchase technical assistance and to support planning activities for a second generation social HMO. The state has sub-contracted this work to the Center for Health Plan Development and Management (CHPD) at the University of Maryland in Baltimore County. The goal of this project is to study the feasibility of implementing a Second Generation Social HMO in Maryland and, should this prove feasible, to develop the specifications needed for the State to issue an RFP.

Status: The State has hired staff to coordinate planning activities and has assembled a task force comprised of consumers, providers, and representatives from the Department of Health and Mental Hygiene to guide the planning process. They have obtained Medicare and Medicaid claims data and are linking these data in an effort to devise a rate-setting mechanism that will work for plans that enroll a disproportionate share of frail elderly.

Evaluation of the Evercare Demonstration Program
Prj #:500–96–0008/02
Start Date: 09/26/1997
End Date: 03/25/2001
Funding: $1,544,142
Vehicle: Task Order
PI: Robert L. Kane, M.D.
Awardee: University of Minnesota
PO: Leslie M. Greenwald, Ph.D.
Description: For each EverCare site, of which there are five, two comparison groups will be selected—nonparticipating residents in EverCare site nursing homes and residents in nonparticipating nursing homes operating in EverCare demonstration cities.

Status: Site visits have been made to EverCare and non-EverCare facilities in each of the participating sites. The information gathered was developed into a paper that has been submitted to the gerontologist for review.

Age Well Option (now referred to as TLC)
Prj #:18–P–90748/1
Description: In January 1995, HCFA selected six organizations to participate in the Second Generation Social Health Maintenance Organization (S/HMO) Demonstration. The purpose of this project is to study the impact of integrating acute and long-term care services within a capitated managed care system. It was developed to refine the targeting and financing methodologies and the benefit design of the current S/HMO model, which was initiated as a demonstration in 1985. Although similar services are provided under both of these demonstrations, the Second Generation S/HMO Demonstration features a greater emphasis on geriatric care and a more inclusive case-management system. Another distinguishing characteristic of the project is its risk-adjusted payment methodology that is based on an individual's health status and functioning level. The primary focus of the project's evaluation will be to compare beneficiaries enrolled in the demonstration with beneficiaries in a section 1876 HMO program. The University of Minnesota and its subcontractor, the University of California at San Francisco, are providing technical assistance and support in the development, implementation, and operation of the Second Generation S/HMO Demonstration.

Status: The developmental phase of the Second Generation S/HMO Demonstration began in January 1995. Since that time the University of Minnesota and the University of California at San Francisco have been providing technical assistance to the organizations participating in the project. They have also developed a questionnaire that is being used to determine a beneficiary's capitated payment rate, a series of geriatric protocols is being used to help physicians identify and treat certain health conditions, and a care coordination assessment instrument is being used to assist case managers with care planning. These technical assistance contractors have made site visits during this time to review the progress of the S/HMO site. They are also assisting a contractor in preparing a S/HMO Transition Report to Congress. The Health Plan of Nevada (HPN) began enrolling beneficiaries in the demonstration in November 1996. HPN enrollment at the end of 1999 was over 35,000 members.

**Second Generation Social Health Maintenance Organization Demonstration: Florida**

Prj #:99–C–90874/4
Start Date: 05/01/1998
End Date: 06/30/2000
Funding: $150,000
Vehicle: Cooperative Agreement
PI: Charlie Liem
Awardee: Florida Department of Elder Affairs
PO: James Hawthorne

Description: This Cooperative Agreement provides the Florida State Department of Elder Affairs (DEA) with funds to purchase technical assistance and to support planning activities for a second generation social HMO. The goal of this project is to study the feasibility of implementing a Second Generation Social HMO in Florida and, should this prove feasible, to develop the specifications needed for the State to issue an RFP.
Enrollment demand.
Enrollee benefits.
Cost of the program.
Impacts on other DoD and Medicare beneficiaries.

RAND is conducting a process evaluation and a quantitative analysis for the demonstration sites and a set of control sites.

Status: The final report from the evaluation was delivered in April 1999. It is available from the National Technical Information Service (NTIS) (accession number PB 99 149056). The Interim Report conveying results of the process evaluation of the demonstration start-up period was delivered in July 1999.

Second Generation of Social Health Maintenance Organization Demonstration

Period: November 1996 Extended 30 months after the Report to Congress is submitted.
Funding: Waiver-only.
Grantees: See below.

Description: In accordance with section 2344 of Public Law 98–369, the concept of a social health maintenance organization (S/HMO) integrates health and social services under the direct financial management of the provider of services. All acute- and long-term-care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The Omnibus Budget Reconciliation Act (BBA) of 1990 authorized the expansion of the S/HMO demonstration. The purpose of this second generation S/HMO (S/HMO–II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO–II model also provided an opportunity to test more geriatrically-oriented models of care. Six organizations in the project were selected to participate. Only one plan is operational, the Health Plan of Nevada. The Balanced Budget and Refinement Act of 1999 extended the demonstration until 18 months after the submission of the SHMO transition Report to Congress. The Benefits Improvement and Protection Act of 2000 further extended the demonstration another 12 months, for a total of 30 months after the submission of the SHMO transition Report to Congress.

Grantee: Health Plan of Nevada, Inc., P.O. Box 15645, Las Vegas, NV 89114.
Period: September 1995-December 2001
Funding: $1,811,184
Contractor: Abt Associates Inc, 55 Wheeler Street, Cambridge, MA 02138
Investigator: Henry Goldberg

Site Development and Technical Assistance for the Second Generation Social Health Maintenance Organization Demonstration

Prj #:500–93–0033
Start Date: 09/27/1993
End Date: 12/30/2000
Funding: $2,251,123
Vehicle: Contract
PI: Robert L. Kane, M.D.
Awardee: University of Minnesota, School of Public Health, Institute for Health Services Research
PO: Thomas Theis
Vehicle: Delivery Order  
PI: Lyle Nelson, Ph.D.  
Awardee: Mathematica Policy Research, Inc.  
PO: Renee Mentnech  
Description: HCFA is in the process of implementing the Medicare Choices Demonstration to test the feasibility and desirability of new types of managed care plans for Medicare such as integrated delivery systems and preferred provider organizations. This evaluation project provides a detailed assessment of the overall demonstration project, which looks specifically at beneficiary experiences in the demonstration, cost and use of services within the demonstration sites, and quality of care issues. The evaluation provides some insights into whether the greater range of managed care options offered in this demonstration would be more appealing to the Medicare beneficiaries, and whether issues such as biased selection, high rates of disenrollment, and dissatisfaction exist. In addition, the evaluation project provides continuous monitoring of the demonstration sites, including a comprehensive case study of each of the managed care plans in the demonstration. This part of the evaluation activities focuses on the implementation experience and operational feasibility of the new managed care plans, as well as how plans interact with carriers and HCFA.  
Status: The contractor has completed site visits to assess the implementation difficulties the plans have encountered. The first and second interim implementation reports are available. A survey of plan enrollees and a fee-for-service comparison group has also been completed. The survey focuses on reasons for enrolling and disenrolling, enrollees' understanding of their plans, and the enrollees' perceptions of access, quality, and satisfaction. A final report is expected in the summer of 2000.

Department of Defense Subvention Demonstration Evaluation  
Prj #:500–95–0056/06  
Start Date: 09/03/1998  
End Date: 03/02/2002  
Funding: $1,411,439  
Vehicle: Task Order  
PI: Dana Goldman, Ph.D.  
Awardee: RAND Corporation, The  
PO: Leslie M. Greenwald, Ph.D.  
Description: Under the demonstration, enrollment in the Department of Defense's (DoD) Senior Prime plan is offered to military retirees over age 65 who live within 40 miles of the primary care facilities of one of the six sites, have recently used military health facility services, and are enrolled in Medicare Part B. The Senior Prime plans must meet all relevant requirements for Medicare-Choice plans. Medicare makes a capitation payment to DoD for each enrollee, and DoD must maintain a level of effort for health care services to all retirees who are also Medicare beneficiaries, whether or not they choose to enroll, that is based on fiscal year 1996 DoD experience. The evaluation seeks to answer the basic question: can DoD and Medicare implement a cost-effective alternative for delivering accessible and quality care to military-Medicare-eligible beneficiaries? The evaluation will seek the answer by examining issues in four basic areas:
Vehicle: Task Order
PI: Gregory C. Pope & Steven Garfinkel (RTI)
Awardee: Health Economics Research, Inc.
PO: Brigid Goody, Sc.D

Description: Section 4011 of the Balanced Budget Act of 1997, which establishes authority for HCFA to test competitive pricing for Medicare+Choice organizations mandates that "...the Secretary shall closely monitor and measure the impact of the project on the price and quality of, and access to, Medicare covered services, choice of health plans, changes in enrollment, and other relevant factors." The purpose of this phase of the evaluation of the Competitive Pricing Demonstration is to provide HCFA with timely feedback on the implementation and operational experience of each demonstration site. A case study methodology will be used to develop both qualitative and quantitative information required to assess the strengths and weaknesses of the demonstration. The types of questions to be answered during this phase include:

- How was the bidding process implemented?
- How did the plans react to the process?
- Can the process be improved?
- How smoothly was the demonstration implemented in each site?
- Were there operational problems for each of the stakeholders and, if so, how were they resolved?
- How effective were the Area Advisory Committees in their responsibilities to advise on implementation issues? What lessons were learned that could ease implementation in other sites or on a nationwide basis?

Status: The contractor is currently completing a case study of the advisory committee process. Since the implementation of the demonstration has been delayed until January 2002, further evaluation activities are being delayed. This delay will force a change in this contract.

Evaluation of the Medical Savings Account Demonstration
Prj #: 500–95–0057/06
Start Date: 09/28/1998
End Date: 09/27/2003
Funding: $6,546,119
Vehicle: Task Order
PI: Ken Cahill
Awardee: Barents Group, LLC/Westat
PO: Renee Mentnech

Description: This project evaluates the Medical Savings Account (MSA) Demonstration. It compares the experience of MSA enrollees with other Medicare beneficiaries. The contractor will also act as a coordinator between HCFA and the demonstration participants, including beneficiaries and health plans, in order to ensure that accurate, reliable, and complete data are collected.

Status: In progress.

Evaluation of the Medicare Choice Demonstration
Prj #: 500–92–0011/06
Start Date: 09/01/1995
End Date: 09/30/2000
Funding: $1,591,240
Description: This contract will allow HCFA to better assess and evaluate the Johns Hopkins University ACG/ADG model as an option for a potential Medicare+Choice payment system. Johns Hopkins will revise, extend and recalibrate the ADG/ACG model using recent Medicare data. They will provide HCFA with the updated software and a recalibration. Earlier work by Johns Hopkins for HCFA updated the ACG/ADG Risk Adjustment Method for application to Medicare risk contracting. In that project, Hopkins developed two diagnosis-based risk adjustor models. Work on these alternatives to the then existing demographic-only risk adjustment models was concluded in 1996. In further work entitled AApplying JHU ACG/ADG Risk Adjustment Methods to Medicare Risk Contracting, Johns Hopkins further developed their model for Medicare purposes. This concluded in early 2000.

Status: This project is getting underway.

Applying the Clinically Detailed Risk Information System for Cost (CD-RISC) to Medicare+Choice Payments

Prj #: 500-95-0056/12
Start Date: 09/29/2000
End Date: 09/12/2001
Funding: $245,934
Vehicle: Task Order
PI: Emmitt Keeler
Awardee: RAND Corporation, The
PO: John Robst

Description: This project will provide technical consulting and analytic services to assess and evaluate the Clinically Detailed Risk Information System for Cost (CD-RISC) model as an option for a potential Medicare+Choice payment system. The project will calibrate the CD-RISC model on Medicare data—which may involve the need to make adjustments to the model as it currently stands—and provide HCFA with the up to date software and calibration. During earlier work funded by HCFA CD-RISC was developed to potentially apply to capitation payments for the under-65 population. This model has not yet been calibrated or tested on Medicare beneficiaries and expenditures. In response to our mandate from the Balanced Budget Act of 1997, HCFA has implemented a risk adjustment method for Medicare+Choice payments. That method relies on inpatient data only. For a number of reasons, we believe methods that draw upon data from outpatient care delivery sites as well as inpatient sites are preferable to this model. We have announced that we plan to implement a model that draws upon diagnoses from multiple sites of care in 2004. We are now in the process of evaluating different candidates among the models that have been developed to see which ones perform the best. To make sure we have sufficient choices available, we are funding further development of contending models this one included.

Status: In progress.

Evaluation of the Competitive Pricing Demonstration—Phase I

Prj #: 500-95-0048/07
Start Date: 06/30/1999
End Date: 08/29/2001
Funding: $458,288
of the recent HMO withdrawals on the beneficiary population. There have been two efforts to assess the impact of the January 1999 withdrawals and service area reductions on beneficiaries. The first, based on survey results indicated that although most disenrollees fared relatively well after their HMO withdrew from Medicare, many experienced a reduction in supplemental benefits, an increase in premiums, and/or disruption in their care arrangements (Kaiser Family Foundation, 1999). Problems were disproportionately experienced by disabled beneficiaries, racial and ethnic minorities, the poor and near-poor, and those reporting fair or poor health. The second effort covered enrollee notification; information and assistance in exploring new insurance options; what option beneficiaries selected; changes in benefits and costs; problems encountered; and satisfaction. HCFA anticipates that additional withdrawals may occur in 2001 and subsequent years. It is desirable to know the impact on beneficiaries if a significant number of additional withdrawals occurs in 2001. In this project we will mount a survey that asks about the experience of beneficiaries whose plans withdraw from Medicare or reduce their service areas in January, 2001. A draft survey instrument has been developed. This project will: finalize the instrument; develop an OMB clearance package; identify an appropriate sample from Medicare, administrative records; administer the survey; edit and clean the data; analyze the survey responses; prepare a final report; prepare and deliver a clean data file to HCFA for use in further analyses. Beneficiaries will be asked what insurance arrangements they made after their plan withdrew from Medicare or reduced its service area; how their benefits and out of pocket costs were affected by new arrangements necessitated by their plan's withdrawal; and whether they had to change doctors. The universe from which the survey sample will be drawn is the Medicare population enrolled in managed care plans that either terminate their risk contracts or reduce their service areas in January, 2001. In the case of plans that reduce their service areas, enrollees that live in areas from which the plan withdraws will be eligible for the survey. The survey sample must be drawn from 2 strata: persons who live in geographic areas where at least one managed care plan is still available under Medicare after January, 2001; and areas where no Medicare managed care plans are available after January, 2001. Approximately 1,500 completed surveys must be produced for each stratum. The survey must be conducted by mail with telephone followup, and will consist of 20–30 questions.

Status: Research Triangle Institute is performing the work under this task order with over 90 percent of the funds assigned to their subcontract.

Updating the Johns Hopkins University ACG/ADG Risk Adjustment Methods for Medicare Contracting

Prj #: 500-00-0060
Start Date: 09/29/2000
End Date: 03/31/2001
Funding: $272,902
Vehicle: Contract
PI: Jonathan Weiner
Awardee: Johns Hopkins University, School of Public Health
timated expenditures of an individual relative to others), the risk adjustment model would simply predict expected expenditures for that individual. Then, this risk based estimated expenditure (inflated to the payment year from the model calibration year) would be multiplied by a geographic price index to adjust for local price differences. In all likelihood, these price indexes would continue to be based on prices observed in fee-for-service. It might be possible however, in the future, to estimate both the risk adjusted estimated expenditures and price indexes based on costs/prices observed in managed care (or a combination of managed care and fee-for-service). These concepts, however, are not possible to implement today, when actual costs for managed care services are all but unknown, and most national health specific price indexes are considered weak. This model presumes that the risk adjuster method would account sufficiently for practice pattern variability. In addition, this change would require agreement on the extent of parity between Medicare's expenditures for beneficiaries enrolled in fee-for-service versus managed care. This direct model could be summarized as follows: Direct payment (Individuals Risk Based Estimated Expenditures) x (Geographic Price Input). This possible future approach for Medicare may seem extreme at first glance. But because BBA had mandated that county rates by blended with a national rate, there is already a move toward national pricing. The direct model is perhaps a logical extension of this policy.

Status: In progress.

Survey of Medicare Beneficiaries Who Were Involuntarily Disenrolled from HMOs that Withdrew from Medicare or Reduced their Service Areas
Prj #: 500–95–0061/10
Start Date: 09/30/2000
End Date: 02/28/2002
Funding: $470,000
Vehicle: Task Order
PI: Bridget Booske
Awardee: University of Wisconsin—Madison/Research Triangle Institute
PO: Gerald Riley
Description: In January 1999 and January 2000 about 100 HMOs withdrew from the Medicare program or reduced their service areas. Over 300,000 Medicare beneficiaries were disenrolled involuntarily each year, and had to enroll in another HMO or go to fee-for-service (FFS). Many of these disenrollees did not have another managed care plan available to them. These beneficiaries had no choice but to go to FFS. Most HMOs that participate in Medicare offer additional benefits outside the regular Medicare benefit package. Extra benefits commonly include low copayments, prescription drugs, unlimited hospitalization, and preventive services. Many beneficiaries have come to rely on the extra benefits they receive from their HMO, particularly prescription drugs. Replacing the benefits through Medigap insurance is usually very expensive, and may be unaffordable for some. Joining another HMO or going to FFS may also force many beneficiaries to change doctors, creating dissatisfaction and disrupting existing patterns of care. There has therefore been concern among policymakers about the impact
managed care organizations, enrollment and disenrollment, and the 
variation and generosity of benefit offerings. The principal findings 
of these preliminary analyses indicate that early experience under 
vary substantially across markets, especially with respect to con-
tract nonrenewals and the availability and generosity of prescrip-
tion drug benefits. Future analyses will include additional years' 
data and expand the dimensions of performance to include access 
and quality, provider behavior, and financial viability.

Next Generation Medicare Managed Care Payment System
Prj #: 500-00-0025/01
Start Date: 09/30/2000
End Date: 04/28/2002
Funding: $635,897
Vehicle: Task Order Contract
PI: Stuart Gutterman
Awardee: Urban Institute, The
PO: Leslie M. Greenwald, Ph.D.

Description: The purpose of this project is to design a possible 
next generation payment methodology—currently called the Direct 
Model—for the Medicare+Choice program. This study will prepare 
a conceptual paper that describes and operationalizes HCFA's pro-
posed general approach. As of January 1, 2000, 10 percent of 
Medicare+Choice plans total capitated payments are based on the 
Principle In-Patient Diagnostic Cost Group (PIP–DCG) risk adjust-
ment methodology. Future years will see an increase in the propor-
tion of payments based on risk adjustment, with a comprehensive 
risk adjustment methodology due to take effect in January 2004.
The movement of the Medicare+Choice program towards increased 
emphasis on health status risk adjusted payments—though an im-
provement over current demographic adjusted payments in terms 
of potential accuracy and ability to address selection bias—still has 
a significant drawback: it is based on FFS practice patterns and 
costs. Two possible steps could be taken to separate Medicare man-
gaged care payments from their traditional fee-for-service basis. The 
first could be considered an interim approach, and would address 
the problem of basing managed care payment on FFS practice pat-
tterns. If a full encounter data model were implemented, and if a 
complete set of data were mandated (sufficient to support recalibra-
tion), risk adjuster weights could be re-estimated using managed 
care encounter data (rather than the FFS data used in the models 
development). In this way, risk score weights and resulting pre-
dicted payments would reflect actual managed care practice pat-
tterns instead of FFS practice patterns. The remaining residual of 
FFS in the approach would be FFS prices, which would be assigned 
to the managed care encounter data in the absence of reliable infor-
mation on actual managed care costs. In the longer term, HCFA 
could move to what could be called a direct payment model. Under 
this direct model, managed care payments would move away (all or 
in part) from their current county FFS basis. In this direct pay-
ment approach, risk adjustment models could be calibrated using 
either a combination of fee-for-service and managed care encounter 
data, or managed care data alone. But rather than converting en-
rollee expenditure estimates from risk adjustment methodologies to 
a risk adjustment factor (i.e. figures such as 1.05, indicating the es-

77-426 D-6
The following projects geared toward older Americans were funded by CFSAN in cooperation with FDA's Office of Regulatory Affairs:

- Development of education packets on Listeria monocytogenes for use in training health professionals working with at-risk populations in New York;
- An island-wide campaign stressing egg safety targeting at-risk populations, food service and retail workers, and health professional in Puerto Rico;
- Food safety and food allergy workshops in Pennsylvania and Delaware for hospital, nursing home, day care centers, and church food prepares;
- Development and testing of methods for improved communication of food recall and food safety messages for at-risk populations;
- Expansion of the train-the-trainer volunteer program for senior food safety education to cover the entire state of Florida; and
- Food safety workshops for food preparers in nursing homes, meals-on-wheels programs, and other elderly nutrition sites in Douglas County, Wisconsin.

HEALTH CARE FINANCING ADMINISTRATION

HCFA PROJECTS

*Evaluation System for Medicare+Choice*

Prj #: 500-95-0047/06  
Start Date: 09/16/1998  
End Date: 09/15/2001  
Funding: $746,887  
Vehicle: Task Order  
PI: Lyle Nelson, Ph.D.  
Awardee: Mathematica Policy Research, Inc.  
PO: Brigid Goody, Sc.D

Description: The Balanced Budget Act of 1997 (P.L. 105–33) makes several changes that affect the eligibility criteria for and payment to health plans contracting with HCFA to provide services to Medicare beneficiaries. The concurrent implementation of several initiatives could have unintended effects on the managed care choices available to Medicare beneficiaries, as well as on the additional benefits provided to beneficiaries and on the quality of care delivered to beneficiaries enrolled in health plans. The purpose of this task order is to design and implement a strategy for tracking and evaluating managed care performance both nationwide and within specific markets across the country during the implementation of the Medicare+Choice provisions. Dimensions of performance to be tracked include beneficiary access to managed care options, as well as the cost and quality of services delivered to beneficiaries by managed care organizations.

Status: Data preparation and analyses are ongoing. The contractor has prepared exploratory case studies of 12 markets and an interim report containing information on 69 markets representing 74 percent of Medicare managed care enrollees. Dimensions of performance included in these reports are the availability of Medicare
• PAS (New Orleans, Louisiana) staffed an exhibit at the “4th Annual Mayor’s Senior Summit.”
• PAS (New Orleans, Louisiana) participated in a “Community Resources Sharing Forum” sponsored by the New Orleans Elder Action Coalition. The purpose of the forum was to bring together key community leaders to share information, ongoing programs, concerns, and ideas. The PAS prepared FDA information packages.
• PAS (Philadelphia, Pennsylvania) gave a health fraud presentation to older Americans, older American organizations, industry, and other federal agencies.
• PAS (Denver, Colorado) gave a presentation on FDA’s role and responsibilities in drug approval to older Americans at the “Prescription for Your Future” conference.
• PAS (Indianapolis, Indiana) gave a presentation to a group of older Americans on FDA and good nutrition for the elderly.
• PAS (New Orleans, Louisiana) gave a presentation on prevention and treatments for osteoporosis and arthritis.
• PAS (San Juan, Puerto Rico) gave a presentation about the safe use of medications to a group of retired consumers.
• PAS (Parisippany, New Jersey) participated in the 7th and 8th Annual Congressional Senior Expo. Congressman Bob Franks sponsored this event in the hope of connecting senior citizens of Central New Jersey with the organizations and programs designed to serve them. PASs regularly speak with media representatives, give interviews and provide background information for newspaper, magazine, newsletters, and television and radio reporters.
• PAS (Parisippany, New Jersey) worked with the Glaucoma Foundation in developing an article on how FDA reviews drugs and medical devices.
• PAS (San Francisco, California) conducted an on-camera interview with a local NBC station on how to spot health fraud, a part of a series covering fraudulent products and the elderly.
• PAS (San Francisco, California) delivered a food safety speech on the local Cable Network that included information on microbiology, with a focus on the four messages of the “Fight BAC” program.
• PAS (New Orleans, Louisiana) taped a 30-minute interview with the WSM Radio News Director on the topics food safety for the holidays, drug approvals, and stockpiling drugs.

For the last three years, CFSAN in cooperation with FDA’s Office of Regulatory Affairs has funded grassroots food safety education projects proposed by FDA PASs emphasizing:

• The Fight BAC! Campaign materials developed by the Partnership for Food Safety Education;
• National Food Safety Education Month;
• Populations at severe risk from foodborne illness (young children, older Americans, immuno-compromised individuals);
• People of low literacy or who primarily speak languages other than English; and
• Safe handling and preparation of raw shell eggs and egg dishes.
ioral problems affecting some dogs—Clomicalm Tablets (clomipramine hydrochloride) to be used as part of a comprehensive behavioral management program for separation anxiety in dogs greater than six months of age, and Anipryl Tablets to control the clinical signs associated with canine Cognitive Dysfunction Syndrome (CDS).

Separation anxiety is a complex behavior disorder displayed when the owner or someone the dog is attached to leaves the dog. Dogs with separation anxiety may exhibit one or more of the following symptoms: barking, destructive behavior, excessive salivation, and inappropriate elimination.

Anipryl Tablets can control the clinical signs associated with CDS, an age-related deterioration typified by multiple cognitive impairments that affect the dog's ability to function normally. Behavioral changes associated with CDS include disorientation, decreased activity level, abnormal sleep wake cycles, loss of house training, decreased or altered responsiveness to family members, and decreased or altered greeting behavior.

PUBLIC AFFAIRS SPECIALISTS

Public Affairs Specialists (PASs) are located throughout the country in FDA field offices. PASs participate in diverse outreach activities to update and educate the Agency's stakeholders on a multitude of important public health issues. PASs also respond to consumer questions about the Agency, its authorities, activities, and the products it regulates. The Agency has established networks and communication channels to reach the national and local aging network with consumer-oriented information. By working with a variety of external constituencies—consumers, patients, health professionals, academia and scientific organizations, industry, women's organizations, minority groups, and the international community—FDA is able to form the collaborations and cooperative arrangements to significantly extend its outreach to older consumers.

PASs have conducted a variety of community-based programs in 1999-2000 to address the health concerns and information needs of older Americans. The Agency also exhibits at major annual meetings of national organizations, as well as at community events and local health fairs sponsored by grassroots organizations. The topics that were addressed by field programs, exhibits, training activities, and speeches were food labeling, food safety, safe use of medications, health fraud, clinical trials, dietary supplements, drug approval, food and drug interactions, and buying prescription drugs on the Internet.

- PAS (San Juan, Puerto Rico) participated in a day long health fair targeting older persons and members of the AARP.
- PAS (Houston, Texas) participated in an exhibit at the American Health Association "Living Longer-Living Well" seminar. The event was designed to guide women in taking wellness to heart by providing health information on diet, stress reduction, nutrition, and how disease affects the heart.
- PAS (San Francisco, California) worked with the local hospitals to provide workshop materials for its "Senior Medication Awareness Training Program."
11/19/99—Sun Orchard Adds an Additional Production Code to its unpasteurized Orange Juice Recalled Because of Possible Health Risk

12/23/99—Nationwide Recall of Certain Royal Baltic Brand Smoked Fish Products Due to Potential Health Risk

1/5/00—FDA Finalizes Rules for Claims on Dietary Supplements

1/10/00—Royal Baltic expands Nationwide Recall of Smoked Fish Products Due to Potential Health Risk

1/27/00—FDA Issues Nationwide Warning on Felix's, Trader Joe's, Delicioso, and the Carryout Café Brands of 5 Layer Dip because of Possible Health Risk

2/10/00—FDA Public Health Advisory: Risk of Drug Interactions with St. John's Wort and Indinavir and Other Drugs

5/26/00—FDA Advises Consumers About Fresh Produce Safety

9/5/00—FDA Authorizes New Coronary Heart Disease Health Claim for Plant Sterol and Plant Stanol Esters

9/8/00—FDA Database of Foodborne Illness Risk Factors Released

11/21/00—FDA Warns Against Consuming Dietary Supplements Containing Tiratricol

11/24/00—FDA Announces Nationwide Recall of Certain Soups Due to Potential Health Risk From Botulism

11/30/00—FDA Finalizes Safe Handling Labels and Refrigeration Requirements for Marketing Shell Eggs

WEBSITE

CFSAN's website has an informational page entitled, "Seniors and Food Safety." This page gives a broad spectrum of information about foodborne illness, food preparation and storage and additional links for seniors. Also on CFSAN's website is another informational page entitled, "Information for Women Over 65 Years Old." This site has links to information on food, nutrition, cosmetics, publications for older consumers, mammography and medications from the agency as well as links to other federal government agencies.

CENTER FOR VETERINARY MEDICINE

The FDA's Center for Veterinary Medicine (CVM) regulates the manufacture and distribution of food additives and drugs that will be given to animals. These include animals from which human foods are derived, as well as food additives and drugs for pet (or companion) animals. CVM is responsible for regulating drugs, devices, and food additives given to, or used on, over one hundred million companion animals, plus millions of poultry, cattle, swine, sheep, and minor animal species. (Minor animal species include animals other than cattle, swine, chickens, turkeys, horses, dogs, and cats.)

Pets are very important to all people including the elderly. CVM has approved drugs that may make it easier for elderly to keep their pets. CVM approved two drugs to treat two different behav-
• Bottled Water Feasibility Study—Solicited comments on the draft feasibility study in the Federal register of February 22, 2000 (65 FR 8718) and published in the Federal register of August 25, 2000 (65 FR 51833), a final report on the feasibility of appropriate methods of informing customers of the contents of bottled water, as required by the Safe Drinking Water Act Amendments.

• Advisory Committee—A standing Dietary Supplement Subcommittee was officially added to the restructured Food Advisory Committee on June 26, 2000. A request for membership nominees having the requisite scientific expertise to serve on the new subcommittee appeared in the Federal Register on July 28, 2000 (65 FR 46463).

• Biotechnology—On May 3, 2000 made a public announcement on plans to strengthen the regulatory approach for bioengineered foods. Three initiatives were announced: (1) Development of a proposed rule requiring that developers of bioengineered foods notify the agency before they market such products; (2) the addition of scientists to the Food Advisory Committee that have expertise in biotechnology; and (3) the development of labeling guidance to assist manufacturers who wish to voluntarily label their foods being made with or without the use of bioengineered ingredients.

• Food Allergens—Held meetings at 14 locations to raise consumer and industry awareness to the presence of allergens in foods and on labeling approaches to identify the presence of allergens.

• Food Safety Initiative—Completed development of the survey instrument for the Food Safety Consumer Survey Cycle IV. The survey is used to monitor the impact of food safety initiatives and to identify consumer education needs.

• Dietary Supplements—Communicated dietary supplement enforcement policies and procedures to the general public, FDA field offices, health care professionals, and industry. The Agency met with several organizations to share information concerning dietary supplement enforcement policies and procedures.

• CFSAN—FDA & HHS Press Releases, Talk Papers, Fact Sheets and Statements
  7/1/99—New Egg Safety Steps Announced, Safe Handling Labels and Refrigeration will be Required
  7/9/99—Consumers Advised of Risks Associated with Raw Sprouts
  7/10/99—FDA Issues Nationwide Health Warning about Sun Orchard Unpasteurized Orange Juice Brand products
  10/1/99—FDA Issues Nationwide Public Health Advisory about Contaminated Pet Chews
  10/20/99—FDA Approves New Health Claim for Soy Protein and Coronary Heart Disease
  10/25/99—FDA Issues Guidance to Enhance Safety of Sprouts
  11/16/99—FDA Issues Warning About Sun Orchard Fresh Squeezed Unpasteurized Orange Juice
scientific framework for assessing the safety of dietary supplements, and to apply that framework to several specific dietary supplement products.

• Ephedra—Published three Federal Register notices announcing the availability of new adverse event reports and related information on dietary supplements containing ephedrine alkaloids, and announcing withdrawal of the provisions of the ephedrine alkaloids proposed rule relating to the dietary ingredient level and duration of use limit for these products (65 FR 17474-17510; April 3, 2000). Participated in a public meeting on August 8–9, 2000 sponsored by the Public Health Service, to discuss the available information about the safety of dietary supplements containing ephedrine alkaloids.

• Health Claim Regarding Fiber and Colorectal Cancer—On October 10, 2000 issued a final determination on a second of the four Pearson claims. FDA determined that the proposed health claim about dietary fiber and reduced risk of colorectal cancer could not be authorized because the results of studies about dietary fiber consistently showed a lack of relationship between dietary fiber supplements and the risk of colorectal cancer. Neither could the claim be qualified because the suitable evidence against the claim outweighed the evidence for it.

• Health Claim Regarding Omega-3 Fatty Acids and Coronary Heart Disease—On October 31, 2000 issued a final determination on the third of four Pearson claims. FDA is using its enforcement discretion to allow a qualified claim about the use of omega-3 fatty acids in dietary supplements and the reduced risk of coronary heart disease. The qualified claim applies to daily intakes that do not exceed three grams per person per day from conventional food and dietary supplement sources.

• Claims for Mitigation of Disease—Following a public meeting on May 26, 2000 denied a petition requesting authorization of a health claim concerning the relationship between dietary supplements containing saw palmetto and benign prostatic hyperplasia (BPH). FDA’s response noted that claims about effects on existing diseases do not fall within the scope of the health claim provisions of the Act and therefore may not be the subject of an authorized health claim.

• Health Claim Petitions—CFSAN continues to meet its statutory obligations for health claims for dietary supplements. CFSAN denied, by operation of the statute (on December 1, 1999) and formally on May 26, 2000 a health claim for saw palmetto extracts and symptoms of BPH. CFSAN also denied on January 11, 2000 a petition for vitamin E and heart disease due to lack of significant scientific agreement to support the claim.

• Dietary Supplement Strategic Plan—On January 3, 2000 the Dietary Supplement Strategic Plan was distributed to stakeholders and posted on the web page. The plan establishes a clear program goal to have, by the year 2010, a science-based regulatory program that fully implements the Dietary Supplement Health and Education Act of 1994, and that provides consumers with a high level of confidence in the safety, composition, and labeling of dietary supplements products.
living in nursing homes or assisted-living facilities where all meals are provided.

A comprehensive, nationwide distribution plan is underway for the 550,000 publications and 47,000 videos produced. Health educators and program leaders at more than 10,000 senior centers; 5,000 county extension offices; 5,000 county health departments 1,000 area offices of aging; 50 state extension and health departments; as well as 50 national organizations representing seniors will be receiving the materials. FDA’s Public Affairs Specialists will be complementing this distribution with their own outreach activities. Individual consumers can receive a free copy of the publication by contacting the Consumer Information Center in Pueblo, Colorado. A small supply of publications and videos are in stock. If you would like a copy of the publication, please contact Laura Fox, FSI Education Team, at 202-260-0574; or by e-mail to Lfox@cfsan.fda.gov. The video will shortly be on the CFSAN Intranet.

PROGRAM PRIORITY ACCOMPLISHMENTS

The following is a listing of program priority accomplishments for CFSAN. Each of these accomplishments addresses an action taken by the Agency to enhance the lives of consumers while protecting the U.S. food supply and promoting public health. With an increase in the variety of foods and the number of convenience items that are currently available to consumers in the market place a number of public health concerns have evolved, especially for older Americans because of their greater susceptibility to illnesses. The accomplishments listed below will address some of those concerns.

• Nutrition, Health Claims, and Labeling—CFSAN published a final rule authorizing a health claim for soy protein and heart disease (21 CFR 101.82) on October 26, 1999. CFSAN completed the evaluation of two additional health claim petitions within statutory timeframes. One petition was for sterol esters and heart disease. The other was for stanol esters and heart disease. The agency issued an interim final rule authorizing these health claims on September 8, 2000 (65 FR 54686)(21 CFR 1010.83).

• Food Safety Report—In accordance with Senate Report 106–80, in consultation with the U.S. Department of Agriculture, prepared a report to Congress on how to educate the public about the safety of our food supply.

• Public Meeting—Held a public meeting in Chicago, Illinois on July 21, 2000 to discuss the use of term “fresh” in the labeling of foods processed with alternative non-thermal technologies. The purpose of this meeting was to solicit views on whether the use of the term “fresh” is truthful and non-misleading on foods processed with these alternative technologies and on what type of criteria FDA should use when considering the use of the term with future technologies.

• Enforcement Procedures—CFSAN established procedures to evaluate food label complaints and respond to significant or precedent setting discrepancies in food labeling.

• Safety Issues—Contracts were arranged with the National Academy of Science’s Institute of Medicine to establish a sci-
lion to $10 billion on prescriptions at retail pharmacies by substituting generic drugs for their brand-name counterparts.

**CENTER FOR FOOD SAFETY AND APPLIED NUTRITION**

While the American food supply is among the safest in the world, there are still too many Americans stricken by illness every year caused by the food they consume, and some mostly the very young, elderly, and the immune compromised die every year as a result. The FDA’s Center for Food Safety and Applied Nutrition (CFSAN) promotes and protects the public health and economic interest by striving to be a leader in food safety, protecting consumers from economic fraud, promoting sound nutrition, and encouraging innovation. The following programs and activities demonstrate the center’s commitment to provide benefits for older Americans.

**CFSAN’S OUTREACH AND INFORMATION CENTER**

CFSAN’s new Outreach and Information Center (O&IC) considerably expanded access and assistance to all consumers throughout the country, especially older consumers. Expanding coverage of the live toll-free Information Line, 1–888–SAFEFOOD (10:00–4:00) was particularly beneficial since a large proportion must rely on the telephone for information. Of the 55,000 calls received, a majority were from older persons seeking information on a variety of food and cosmetic-related issues. With more now having access to computers, we have seen a steady increase in the number of older consumers requesting food safety information through CFSAN’s electronic-mail system. However, we also responded to more than 2500 written letters, again a majority from older persons. Most notably, older consumers are the single largest group requesting FDA/CFSAN publications and other materials. The O&IC and the Consumer Education Staff have developed workshops, served as presenters, provided materials and staffed exhibits at conferences throughout the country, with a particular focus on providing information to older consumers.

**FOOD SAFETY CAMPAIGN AIMED AT SENIORS IS LAUNCHED**

“To Your Health! Food Safety for Seniors” is a new educational program developed by CFSAN’s Food Safety Initiative staff and the U.S. Department of Agriculture’s Food Safety and Inspection Service. The materials focus on seniors because they are one of the more susceptible populations for developing foodborne illness. And once they become sick, they face the risk of more serious health problems, even death.

The 14-minute video and companion publication were designed in cooperation with a variety of senior advisors including representatives from the Administration on Aging, the State Units on Aging, and the National Institutes of Health. In format and design, the materials are tailored to seniors. The publication features large type to make easy reading for older eyes. The graphics are colorful and bold. The video contains portraits of other seniors. Through them, we learn about safe food handling at home and food safety when eating out. This program is not targeted to seniors who are
about safe medical treatment among consumer groups and health professional organizations. Following the meeting, CDER produced four videotaped presentations to be used during future public meetings about safe medical treatments. In May 2000, CDER provided an exhibit at the First National Conference of the American Society of Aging and the National Council of the American Association of Retired Persons in Orlando, Florida.

Finally, CDER has prepared several brochures specifically for older Americans. Titles include: "AgePage, Medicines: Use Them Safely," "Reducing Your Risk of Heart Attack or Stroke with Aspirin Therapy: Know the Facts," and "Be an Active Member of Your Health Care Team."

POSTMARKET DRUG SURVEILLANCE AND EPIDEMIOLOGY

CDER's Office of Postmarketing Drug Risk Assessment is responsible for receiving, entering into a database, and analyzing reports sent to the Agency on adverse reactions to drugs. In 1999, there were approximately 261,000 reports entered into CDER's Adverse Event Reporting System. For 2000, the approximate number increased to 300,000. Reports representing patients aged 65 years or older numbered 54,000 (21 percent of total for 1999) and 52,000 (17 percent of total for 2000). These percentages are similar to those reported in the past.

GERIATRIC LABELING

On December 11, 1998, the Agency made public a draft publication entitled: "Guidance for Industry on the Content and Format for Geriatric Labeling." This guidance discusses the following issues related to the submission of geriatric labeling: 1) who should submit revised labeling; 2) implementation dates; 3) description of the regulation and optional standard language in proposed labeling; 4) content and format for geriatric labeling; and 5) applicability of user fees to geriatric labeling supplements. Comments submitted to the proposed rule currently are being addressed by the Agency.

GENERIC DRUGS

During 1999–2000, FDA's Office of Generic Drugs approved 699 abbreviated new drug applications. These drug products are often substantially less expensive and provide a safe and effective alternative to brand-name products. Many of these approvals represent the first time a generic drug was made available for products of special interest to older Americans such as doxazosin mesylate capsules used in the treatment of enlarged prostate and hypertension, paclitaxel injection used in the treatment of various ovarian and breast cancers, and digoxin tablets used in the treatment of heart failure. These and other recently approved generic drug products could save the American public and federal government millions of dollars. In July 1998 the Congressional Budget Office (CBO) published a report: How Increased Competition from Generic Drugs Has Affected Prices and Returns in the Pharmaceutical Industry. The CBO estimated that in 1994, purchasers saved between $8 bil-
CDER continues to maintain its long-standing tradition of involving the public in its activities. On June 28 and 29, 2000, FDA held a public meeting to get input and opinions on the type of drugs for which it would be appropriate to switch from prescription status to OTC status. Many of the drugs discussed were drugs commonly used by the aging population in America. For example, one part of the meeting focused on cholesterol-lowering drugs and whether they should be considered as candidates for OTC drug status. The meeting attracted considerable attention from consumer and patient groups, as well as industry, and was covered by C-Span.

OTC LABELING CHANGES CAMPAIGN

Many older Americans find the print on OTC labels too small to be legible. In 1997, FDA issued a proposal to establish a standardized format for the labeling of OTC drug products and provided over 7 months for interested persons to comment on the OTC labeling proposal. The Agency received more than 1,800 comments from health professionals, students, professional organizations, trade associations, manufacturers, consumers, and consumer organizations. An overwhelming majority of the comments supported the Agency's initiative to standardize the format of OTC drug product labeling and to make the labeling easier to read and understand by requiring a minimum type size, user-friendly headings, and other well-accepted visual cues. The regulations became effective on April 16, 1999. In many cases, OTC drugs with the new labeling will begin appearing on the shelves by 2002. The remainder of more than 100,000 OTC drugs will be required to adopt the new labeling within the next six years. CDER reached more than 17 million people with a print campaign and 137 million listeners with radio Public Service Announcements notifying them of the OTC labeling changes.

MATERIALS, OUTREACH, AND EXHIBITS

The FDA continually strives to establish an ongoing dialogue between the Agency and its constituents on important public health problems and issues. Of recent interest is the use of the Internet by the public to buy medical products. Many consumers, including older Americans or those who cannot leave their homes, benefit from the convenience and privacy of this new option. The safe use of the Internet by consumers is threatened, however, by fraudulent or disreputable Internet pharmacies that sell products illegally. CDER prepared a brochure, a newspaper article, and a print Public Service Announcement designed to inform the public about the potential dangers of buying medical products on the Internet, and to increase consumer awareness about the problems related to online drug purchases. This information is available on FDA's website on www.fda.gov.

In addition, the Agency actively participated in outreach activities including a two-day national workshop with the National Patient Safety Foundation to address the safe use of medical products from the consumer and patient perspectives. Held in March 2000, one of the goals of the meeting was to stimulate a national dialogue
• FDA Approves New Breast Imaging Device (T-Scan)—April 19, 1999
• Potential Cross-Contamination Linked to Hemodialysis Treatment—May 1999
• Laser Facts—June 1999
• FDA Clears Quick New Lab Test for Pneumonia Antigen—August 30, 1999
• Consumer Update on Mobile Phones—October 20, 1999
• Temporomandibular Joint Implants: A Consumer Information Update—November 1999
• First Drug Device Combined Treatment for Certain Pre-Cancerous Skin Lesions Approved—December 6, 1999
• FDA Statement about ColorMax Eyeglass Lenses—December 21, 1999
• FDA Approves First Digital Mammography System—January 31, 2000
• Risks of Burns from Eruption of Hot Water Overheated in Microwave Ovens—March 8, 2000
• Microwave Oven Radiation—March 8, 2000
• FDA Alerts Health Professionals and Consumers to a Nationwide Recall of Clinipad Antiseptic Sterile Products—March 10, 2000
• FDA Approves Treatment for Wet Macular Degeneration—April 13, 2000
• Two Firms Get FDA Approval To Continue Marketing Saline-Filled Breast Implants—May 10, 2000
• FDA Approves New Surgical Sealant For Lung Cancer—May 30, 2000
• FDA Approves New Product For Diabetic Foot Ulcers—June 20, 2000
• Risk of Electromagnetic Interference with Medical Telemetry Systems—July 10, 2000
• Serious Injuries from Microwave Thermotherapy for Benign Prostatic Hyperplasia—October 11, 2000
• FDA Approves New Implanted Hearing Device—October 23, 2000
• FDA Approves Two New Devices To Help Reduce the Risk of Repeat Coronary Stent Re-Narrowing (In-Stent Restenosis)—November 6, 2000
• FDA Approves New Device To Help Distinguish Harmless from Pre-Cancerous Growths in Colon—November 15, 2000
• Court Orders Refund to Purchasers of Gas Grill Igniters Marketed for Pain Relief—November 30, 2000

CENTER FOR DRUG EVALUATION AND RESEARCH

The mission of FDA's Center for Drug Evaluation and Research (CDER) is to promote and protect the public health by helping to ensure that safe and effective drugs are available to the American public including older Americans. FDA is continuing to make drugs safer for older Americans, who consume a large share of the nation's medications. Adults over age 65 buy 30 percent of all prescription drugs and 40 percent of all over-the-counter (OTC) drugs.
conducting studies to determine if the broad-spectrum acoustic energy that occurs when the bubbles collapse might be used to detect cavitation by “listening” with a hydrophone to the noise produced by valve closing when cavitation is present.

Electromagnetic interference with electronic implants.—CDRH scientists have conducted studies to help determine the risk of various magnetic fields to electronic implanted medical devices. Magnetic fields from various types of electrical equipment can interfere with the proper operation of implanted medical devices, such as cardiac pacemakers and defibrillators, and spinal cord stimulators. CDRH engineers have completed magnetic and electric field mapping of eight electronic article surveillance systems. A special laboratory environment was required to conduct this study. CDRH's three-dimensional electromagnetic field-strength mapping apparatus was relocated to a new laboratory and the required support structure was designed and constructed using non-magnetic components; a walk-through metal detector was obtained from the Federal Aviation Administration. The results of these tests were published in the September-October 1999 issue of Compliance Engineering.

Standards Development.—CDRH scientists have participated heavily in the development of performance standards for many types of devices of interest to older Americans. These include standards for devices to relieve the consequences of arthritis such as total orthopedic joints and mobility aids such as wheelchairs, as well as devices to assist the cardiovascular system such as pacemakers, heart valves, and cardiovascular stents. CDRH currently supports more than 500 domestic and international standards development efforts.

WEBSITE

CDRH's website provides consumer information on many topics of interest to older Americans such as mammography, newly approved medical devices, and reducing user error. There are also webpages devoted to LASIK, the popular laser surgery for improving vision, and the safety of hospital beds. CDRH's website can be found at http://www.fda.gov/cdrh/index.html.

PUBLICATIONS

• “Mammography Today: Questions and Answers for Patients on Being Informed Consumers—Better Treatments Save More Lives”
• “FDA Sets Higher Standards for Mammography”
• Mammography Matters newsletter
• “A Guide to Bed Safety; Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts”
• “Breast Implant Risks”
• “Breast Implants An Information Update—2000”

CDRH FDA & HHS PRESS RELEASES, FACT SHEETS, PUBLIC HEALTH NOTIFICATIONS AND STATEMENTS RELATED TO OLDER AMERICANS

• FDA Approves New Device To Remove Blood Clots From Coronary Arteries (Angio-jet)—March 15, 1999
Pneumonia

• A laboratory test for detecting Streptococcus pneumoniae, one of the bacteria that is a leading cause of pneumonia was approved on August 30, 1999. Pneumonia can be a life-threatening disease for the elderly.

Hearing Loss

• Vibrant Soundbridge is a surgically implanted hearing device intended to help adults with moderate to severe nerve hearing loss. Approved on August 31, 2000, this device is an alternative for people who have not been helped by hearing aids. About 20 percent of Americans—more than 56 million—experience some nerve deafness by the age of 55.

RESEARCH

Gender effects on coronary arteries and balloon angioplasty.—FDA scientists have established a large animal cardiovascular research program to develop and study models of cardiovascular disease, vascular injury, and long-term vascular implant performance. FDA scientists are using the laboratory to study effects of gender and hormonal state on the function and mechanical properties of coronary arteries and on the response of arteries to balloon injury. More than 75 subjects have been studied and the results thus far will be announced at the FDA Science Forum in February 2001. The motivation for the study is the observed greater incidence of cardiovascular death in postmenopausal women and men of all ages compared to premenopausal women.

Early detection of diabetes-related eye diseases.—One of the most threatening aspects of diabetes is the development of visual impairment due to cataract formation, diabetic retinopathy, and glaucoma. In many cases, diabetes-related ocular pathologies go undiagnosed until visual function is compromised. In order to develop techniques for early cataract detection, FDA scientists are studying the progression of diabetes in a unique animal model and monitoring the changes in the lens using a safe, nondestructive dynamic light scattering technique.

Ultrasonic measurement of bone density.—FDA has approved several ultrasound bone densitometers, which are used in the assessment of osteoporosis, and more applications for these devices are in progress. Because this is a new technology, there is little standardization between devices, and the technology is likely to continue evolving. FDA scientists are investigating the ultrasonic measurements (backscatter, attenuation, and sound speed) on 50 women ranging in age from 50–90. The objective is to investigate the diagnostic utility of the backscatter measurement for diagnosis of osteoporosis. Preliminary experiments conducted on bone samples in vitro increased understanding of how and why ultrasound bone sonometry is effective and should, therefore, lead to better review of these devices.

Acoustic detection of cavitation near heart valves.—Transient cavitation—the formation and collapse of tiny bubbles in the blood—has been observed near operating mechanical heart valves. Cavitation can damage the valve and break down the blood cells. FDA is
film. Unlike radiographic film, digital images can be electronically stored and transferred, so that a specialist at a remote location can evaluate them. The images also can be manipulated to correct for under- or over-exposure. Early diagnosis remains the best weapon against breast cancer, which annually affects 185,000 women, 46,000 of whom die of the disease. Most women who get breast cancer are over 50 years of age. The approval of digital mammography benefits older Americans because the ability to manipulate computer images means fewer call-backs for additional imaging, which can be difficult for older Americans who often depend on others for their transportation.

- FDA allowed continued marketing of two types of saline-filled breast implants that had been approved for breast reconstruction and for breast augmentation in women 18 years or older. This decision was made following the conclusion of clinical studies involving 9,000 women and the recommendations of our expert advisory committee. Many women feel that breast reconstruction is an essential part of their recovery after mastectomy because of breast cancer.
- The Optical Biopsy System is a laser system that improves a physician's ability to identify suspicious growths in the colon. It is operated through an endoscope and can be used to evaluate polyps less than 1 cm in diameter. This device was approved on November 15, 2000.
- Another device, FocalSeal-L Surgical Sealant, was approved on May 30, 2000, for sealing air leaks in lungs following the removal of cancerous tumors. FDA reviewed the sealant, which is "painted" on the lung and activated by light, on an expedited basis because of its potential importance for patients with lung cancer.
- Levulan Kerastick (aminolevulinic acid HCI) for Topical Solution, 20 percent is to be used in conjunction with photodynamic therapy for treatment of actinic keratoses (AKs) (pre-cancerous skin lesions) of the face or scalp. AKs are rough, scaly, red or brown patches that begin on the surface of the skin. They are mostly found among individuals with light complexions affecting more than 50 percent of elderly fair-skinned persons in hot, sunny climates. This product was approved on December 6, 1999.

**Diabetes**

- The Continuous Glucose Monitoring System, approved on June 16, 1999, provides physicians with continuous measures of tissue glucose levels in adults with diabetes.
- Apligraf is intended to be used on patients who have not responded well to standard methods of treating foot ulcers. Approved on June 20, 2000, Apligraf is a cellular, bi-layered skin substitute produced from bovine collagen and cells derived from human infant foreskins. Many diabetics have difficulty healing and might benefit from this product.
about bed rail use. This brochure and the work of The Hospital Bed Safety Work Group are available on the FDA web site for bed safety at: http://www.fda.gov/cdrh/beds/. Planned work includes developing clinical guidance for caregivers on appropriate bed rail use and developing a measurement tool for clinical facilities to determine if an entrapment hazard exists with their beds.

TREATMENT FOR BENIGN PROSTATIC HYPERPLASIA

On October 11, 2000, FDA sent a Public Health Notification to alert the medical community of the potential for serious injuries from microwave thermotherapy for benign prostatic hyperplasia (BPH). Although the use of microwave thermotherapy for the treatment of BPH has been demonstrated to be safe and effective, FDA is concerned about reports of unexpected procedure-related complications that have occurred since the marketing of these devices. The letter identified several factors that may have contributed to the injuries and made recommendations to avoid injury.

MEDICAL DEVICE APPROVALS

Heart and Cardiovascular System

- The AngioJet System, approved on March 15, 1999, removes blood clots from blocked heart arteries or bypass grafts prior to angioplasty. The device will provide an alternative treatment to so-called clot-busting drugs, and will be particularly useful for patients in whom these drugs cannot be used.
- On November 6, 2000, FDA approved the Cordis Checkmate™ System and the Novoste Beta-Cath™ System, both of which use catheters to deliver radiation inside a coronary stent, following the opening of a blocked artery. The radiation helps reduce the risk of new tissue growth inside the coronary stent and the resulting narrowing of the artery.
- FDA continues to review and approve for marketing improved versions of heart valves, pacemakers, implanted cardioverter defibrillators and other cardiac devices that will help many older Americans live longer, more comfortable lives.

Vision

- Verteporfin for injection (Visudyne), the first therapy to slow vision loss in people with classic “Wet Age-Related Macular Degeneration (AMD)” was approved on April 13, 2000. AMD, a retinal disease causing severe and irreversible vision loss, is a major cause of blindness in individuals older than 60 years in the Western World.

Cancer

- Approved on April 19, 1999, the T–SCAN 2000 is intended for use as a follow-up step to mammography for patients whose mammograms are ambiguous. The device has the potential to reduce the number of negative biopsies, thus saving women worry about breast lesions that turn out to be non-cancerous.
- Approved January 31, 2000, the Senographe 2000D is the first mammography system that produces digital images on a solid state receptor instead of analog images on a radiographic...
medical devices and radiation-emitting products to enhance their ability to avoid risk, achieve maximum benefit, and make informed decisions about the use of such products.

MAMMOGRAPHY

Because a woman's risk for breast cancer increases as she gets older, the need to have a regularly scheduled mammogram is critical to ensure early detection. Congress enacted the Mammography Quality Standards Act of 1992 (MQSA) to ensure that all women have access to quality mammography for the detection of breast cancer in its earliest, most treatable stages.

As of April 28, 2000, there were 9,994 MQSA-certified mammography facilities in the United States and its territories. All of these facilities are subject to clinical accreditation by outside expert bodies, and certification and inspection by FDA to ensure compliance with quality standards.

Older women are the focus of this effort:

- CDRH targets older Americans for particular outreach efforts. Groups such as AARP have been on our mailing list to receive mammography information and Mammography Matters (our newsletter) since the inception of our program.
- CDRH has collaborated extensively with FDA's Offices for Women's Health, Consumer Affairs, Public Affairs, and Special Health Issues, and they have distributed educational materials about mammography to their constituents, including newsletter editors.
- Older Americans were included in the outreach about the availability of the 1-800-4-Cancer hotline. Callers to this number can locate FDA-certified mammography facilities in their areas, get answers to questions about breast cancer, and request publications.
- Consumer representatives with ties to senior advocacy groups are members of our National Mammography Quality Assurance Advisory Committee.

HOSPITAL BED SAFETY

FDA continues its work to reduce the hazards associated with patient entrapment in hospital beds. Patient entrapment with hospital bedside rails can occur in hospitals, nursing homes and at home. The FDA continues to receive reports of death and injury when patients become entangled or trapped between the mattress and bed rail or in the bed rail openings. The patients most at risk for entrapment are frail, elderly or confused.

FDA initiated and is an active member of The Hospital Bed Safety Work Group, which most recently met in Chicago on October 24-25, 2000. The Hospital Bed Safety Work Group is made up of representatives of the federal government, national health care organizations, manufacturers of hospital beds and medical researchers. To date, the work group has primarily focused on raising awareness of the entrapment hazard and educating caregivers and family members on the problems associated with bed rail use. The work group recently issued an educational brochure, "A Guide to Bed Safety," that highlights the benefits and risks of bed rails, ways to meet a patient's need for safety, and patient or family concerns
breeder. Scientists working on the Project on Caloric Restriction have concentrated on determining the mechanisms by which caloric restriction inhibits spontaneous disease, modulates agent toxicity and affects the normal aging process. Since 1999 the only studies that have been continuing are a collaborative study with the University of Tennessee at Memphis designed to determine if the physiological, metabolic, and molecular changes that occur with caloric restriction in rodents are similar in humans, and additional rodent studies to measure how different levels of caloric restriction might influence body changes.

Although the work over the last several years has concentrated on the mechanisms of toxic interaction in the body and the role caloric restriction has on this process, studies with calorically restricted animals have repeatedly shown that caloric restriction extends the life span of animals. How this affects aging is still in question; however, the research being conducted in this area is continuing to chip away at the problem of how diet affects the aging process, and what elements or lack thereof in the human diet may help to extend human life.

MEDWATCH

MedWatch, the FDA's voluntary Medical Products Reporting and Safety Information Program, serves both healthcare professionals and the medical product-using public. MedWatch strives to educate health professionals about the critical importance of being aware of, monitoring for, and reporting adverse events and product problems to FDA and/or the manufacturer, as well as to ensure that new safety information is rapidly communicated to the medical community, thereby improving patient care. The purpose of the MedWatch program is to enhance the effectiveness of post-marketing surveillance of medical products as they are used in clinical practice and to assist in rapidly disseminating information about significant health hazards associated with these products. Health professionals, as well as consumers, are encouraged to report serious adverse reactions and product problems associated with FDA-regulated products to the Agency.

Older Americans are generally more susceptible to adverse events because of the probability they will use more medications and medical device products.

CENTER FOR DEVICES AND RADIOLOGICAL HEALTH

The FDA's Center for Devices and Radiological Health (CDRH) promotes and protects the health of the public by ensuring the safety and effectiveness of medical devices and the safety of radiological products. Medical devices include products ranging from mechanical heart valves to ophthalmic lasers to pregnancy test kits products that are intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment or prevention of disease. Radiation-emitting electronic products include such things as microwave ovens, televisions, sunlamps, medical and baggage inspection x-ray machines, and laser products such CD and DVD players, light shows and bar code scanners. CDRH provides information to consumers, including older Americans, regarding
approval. From 1983—when the Orphan Drug Act was passed—through the end of 2000, 216 products to treat small populations of patients were approved by FDA.

By the end of 2000 there were 856 designated orphan products. One hundred thirty-two of these designated orphan products (15 percent) represent therapies for diseases predominately affecting older Americans. Seventy-five are for treating rare cancers in the elderly, such as ovarian cancer, pancreatic cancer, and metastatic melanoma. Twenty-two of the orphan products designated for treating elderly populations are for rare neurological diseases, such as amyotrophic lateral sclerosis (ALS), and advanced Parkinson's disease. Twenty-nine orphan-designated therapies for elderly populations have received FDA market approval. Most noteworthy among these is Eldepryl for treatment of idiopathic Parkinson's disease, postencephalitic Parkinsonism, and symptomatic Parkinsonism; riluzole for treatment of ALS; and Novantrone for treatment of refractory prostate cancer.

FDA's orphan product grants had their beginning in 1983 as one of the incentives provided by the Orphan Drug Act. This program provides financial support for clinical studies (clinical trials) to determine the safety and efficacy of products to treat rare disorders, and to achieve marketing approval from the FDA under the Federal Food, Drug, and Cosmetic Act. Studies funded by the orphan products grant program have contributed to the marketing approval of twenty-eight products.

Because the orphan products program is issue-specific/indication-specific, it is typical for an approved product to be funded under the orphan products grant program for study in an indication unique to a distinct group of people, such as women, children, or the elderly. Under the orphan drug program, disease populations are small and in many instances the firms themselves are very small. The goal of the Orphan Drug Act is to bring to market products for rare diseases or conditions. In so doing, orphan product development promotes research and labeling of drugs for use by and for special populations. The orphan products grant program has funded more than 42 studies aimed at treatment of diseases affecting adults and older adults.

THE NATIONAL CENTER FOR TOXICOLOGICAL RESEARCH

The National Center for Toxicological Research's (NCTR) mission is to conduct peer-reviewed scientific research that supports and anticipates the FDA's current and future regulatory needs. This involves fundamental and applied research specifically designed to define biological mechanisms of action underlying the toxicity of products regulated by the FDA. This research is aimed at understanding critical biological events in the expression of toxicity and at developing methods to improve assessment of human exposure, susceptibility, and risk.

NCTR has worked with the National Institute on Aging (NIA) in the past to study the role caloric restriction plays in the aging process and what affect a reduced caloric diet has on disease etiology. The Interagency Agreement with the NIA terminated in 1999 with the animals that were raised in support of this work being transferred to Harlan Sprague Dawley, a commercial laboratory animal
153 churches participated and reached about 110,000 people with FDA materials. The Public Affairs Specialists received the American Cancer Society's "Partner of Courage Award."

- Breast Cancer Videotape—OWH developed a Breast Cancer "Early Detection Saves Lives" videotape to encourage churches to sponsor screening and educational activities. The videotape will be given to the Public Affairs Specialists, and the National Cancer Institute for distribution through their clearinghouse.

- New Publications—(1) Created a quarterly newsletter for our stakeholders focusing on FDA actions, meetings and activities of interest to women. (2) Published the first FDA history document describing the agency's role in protecting women's and the public's health over the last 100 years. The milestones presented highlight specific actions taken by the agency so that all Americans can enjoy safer, healthier lives.

- OWH Website—Redesigned the OWH website that became a recipient of the "Hot Site Award."

OTHER OUTREACH PROJECTS (FOR DELIVERY IN FY2001)

- OWH will work in partnership with the American Pharmaceutical Association Foundation and the National Wholesale Druggists' Association Healthcare Foundation to promote distribution of TTTC medicine tips in hospitals. Hospital-based pharmacies will encourage consumers to play a role in managing risks associated with medication use as in-patients and out-patients.

- In December 2000, the Emergency Nurses Association (ENA) announced to its 25,000 members its decision to adopt TTTC as a national campaign. ENA will distribute "My Medicines" brochures in emergency settings, hospital auxiliaries, civic meetings, and retirement homes.

- OWH funded a grant for the translation of materials about cervical and breast cancer screening for Asian-American Pacific-Islander communities through a website coordinated by APANet.

- OWH funded a bi-regional women's health conference in DHHS Regions II and III for health professionals and consumers to raise awareness about health disparities found in minority communities.

- OWH funded the development of a multi-media Women's Health Care Trainer's Kit and Consumer Guide to assist women in planning for screenings and preventing illnesses.

- OWH funded a "Read the Label" project that will use graphics to provide instructions for non-English readers in a variety of Asian languages. This model may then be applied to other language groups.

OFFICE OF ORPHAN PRODUCTS DEVELOPMENT

It is the intent of the Orphan Drug Act, and the Office of Orphan Products Development (OPD), to stimulate the development and approval of products to treat rare diseases. The OPD plays an active role in helping sponsors meet Agency requirements for product
OFFICE OF SPECIAL HEALTH ISSUES

The FDA's Office of Special Health Issues (OSHI) serves the public by answering their questions about the Agency's activities related to HIV/AIDS, cancer, and other diseases. OSHI works with patients and their advocates to encourage and support their active participation in the formulation of FDA regulatory policy. Additionally, OSHI (1) serves as a channel through which patient issues and viewpoints can be brought to the attention of FDA medical and regulatory staff; (2) ensures a comprehensive and timely response to individuals with questions and concerns related to life-threatening diseases and other special health issues; (3) participates in the development of national policies and practices concerning HIV/AIDS, cancer, and issues related to special populations; and (4) provides FDA representation to scientific and policy meetings related to life-threatening diseases and other special health concerns.

OFFICE OF WOMEN'S HEALTH

The FDA's Office of Women's Health (OWH) serves as a champion for women's health both within and outside the Agency. To meet its goals OWH (1) ensures that FDA's regulatory and oversight functions remain gender sensitive and responsive; (2) works to correct any identified gender disparities in drug, device, and biologics testing and regulation policy; (3) monitors the progress of priority women's health initiatives within FDA; (4) promotes an integrative and interactive approach regarding women's health issues across all the organizational components of the FDA; and (5) forms partnerships with government and non-government entities, including consumer groups, health advocates, professional organizations, and industry, to promote FDA's women's health objectives.

OWH has developed a number of initiatives to further its inclusion of older Americans in their programs such as:

• Take Time To Care (TTTC) encouraged women nationwide to educate themselves and their families about using medicines wisely. Educational grassroots programs were developed with 80 national organizations and cosponsored by the National Association of Chain Drugstores (20,000 community pharmacies). Their efforts coupled with nearly 100 media outlets brought the FDA message to 26 million readers and viewers. For these efforts, the Health Care Quality Alliance (97 health care associations) selected TTTC as a recipient of the prestigious Pin- nacle Award, which annually "recognizes pioneering contributions and exemplary leadership in medication use quality improvement."

• Breast Cancer Awareness Month—In collaboration with the Center for Devices and Radiological Health the FDA/OWH sent a letter to all 10,000 certified mammography facilities inviting them to showcase the availability of our Mammography Today brochure and distribute a one-page abbreviated version of the brochure to inform patients about their new rights.

• Pink Ribbon Sunday—OWH sponsored activities of the FDA Public Affairs Specialists in Houston, Dallas, and Atlanta to conduct “Pink Ribbon Sunday” activities that encourage “women of color” to get screened. In the city of Houston alone,
On October 26, 1999, “FDA's Consumer Roundtable” was held in Houston, Texas. This meeting provided an opportunity for consumer to engage in an open dialogue with senior Agency officials on how FDA can work with consumers and community organizations to manage and communicate the risk and benefits of drug products.

On April 27, 2000, a consumer roundtable “FDA Celebrates Alliances with Hispanic Communities: Moving Forward” was held in San Diego, California. This roundtable established interaction between the public and Agency officials on how the Agency can work with the community to manage and communicate the risks and benefits associated with drug products.

On December 13, 2000, a discussion was held in Washington, D.C. between senior FDA officials, consumer leaders, and consumers to discuss key public health and consumer protection priorities for the Agency. The purpose of this roundtable was to strengthen consumer involvement in the Agency's process for assessing how it is currently directing its consumer protection responsibilities and determining whether there is a need to redirect or shift priorities to better meet those responsibilities.

OFFICE OF PUBLIC AFFAIRS

The FDA's Office of Public Affairs (OPA) is the agency's primary point of contact for the news media. It also manages the agency's website at www.fda.gov and develops information materials on FDA-related public health and consumer protection activities. While working very closely with the different centers within the agency, OPA has published a number of FDA Consumer magazines, articles, press releases, and talk papers that focus on topics of interest and concern to older Americans.

The agency website has a page dedicated to older Americans entitled “FDA Information for Older People.” This site gives information regarding buying medicines online, seniors and food safety, and linkages to other organizations outside of FDA with information of interest to older Americans. This webpage also has numerous articles and other publications with information for older Americans on a wide range of health issues such as:

- Arthritis: Timely Treatments for an Ageless Disease
- Help Your Arthritis Treatment Work (Spanish Version)
- Preventing Colon Cancer
- FDA Sets Higher Standards for Mammography
- Lung Cancer
- Prostate Cancer: No One Answer for Testing or Treatment
- Health Claim for Foods That Could Lower Heart Disease Risk
- Keeping Cholesterol Under Control
- Taking Charge of Menopause
- Taking Time to Use Medicines Wisely
- How to Spot Health Fraud
prescription diabetic drug, glyburide. There was at least one report of an adverse reaction that required medical treatment. FDA published a brochure in cooperation with many health care organizations, designed to warn consumers about buying medical products online. FDA continues to work with the U.S. Customs Service and state law enforcement agencies to prevent the Russian product Corvalolum from entering the United States. Corvalolum contains dangerous levels of Phenobarbital.

Unapproved new drugs offered as treatments for cancer continue to be marketed illegally. FDA took action against Laetrile, a fraudulent cancer cure marketed by two firms. The Agency obtained a consent decree of permanent injunction against one firm and the second firm is under a preliminary injunction as of September 2000.

Another unapproved new drug, hydrazine sulfate, also marketed illegally as a treatment for cancer, may cause serious adverse effects. Studies have shown that hydrazine sulfate is not effective and that it may actually decrease survival time. The Agency is taking steps to stop the distribution of this product.

OFFICE OF CONSUMER AFFAIRS

The FDA's Office of Consumer Affairs (OCA) seeks consumer participation in Agency policy-making and ensures that FDA decision-makers hear consumer concerns before completing policy decisions. OCA's primary functions include encouraging public participation and consumer education and outreach. OCA routinely includes older Americans in their public participation, education, and outreach initiatives, as well as the recruitment process for consumer representatives. OCA continues to work with its Agency counterparts, as well as its constituents, to ensure consumer involvement in Agency processes.

One method the Agency uses to ensure that FDA gets consumers' points of view is by including consumer representatives on Agency advisory committees. The role of the consumer representative is to (1) represent the consumer perspective on issues and actions before the advisory committee; (2) serve as a liaison between the committee and interested consumers, associations, coalitions, and consumer organizations; and (3) facilitate dialogue with the advisory committees on scientific issues that affect consumers.

OCA co-sponsored a variety of consumer roundtables and consumer education programs that highlighted issues of importance to older Americans. For example:

• OCA in conjunction with FDA's Office of Regulatory Affairs, Pacific Region, convened three public forums. These forums entitled, "Public Input on Public Health, FDA Listens to You, A Town Hall Meeting" were held in May 1999 in Oakland, California; Los Angeles, California; and Portland, Oregon. The purpose of the forums was to provide an opportunity for FDA's primary stakeholders, U.S. consumers, to have an open dialogue with FDA's senior policy makers about their consumer protection concerns. Some of the topics addressed were safety and labeling of dietary supplements, access to clinical trials, health fraud, and food safety.
based on considerations such as the health hazard potential of the violative product, the extent of the product's distribution, the nature of any mislabeling that has occurred, and the jurisdiction of other agencies.

The FDA has developed a priority system of regulatory action based on two general categories of health fraud: direct health hazards and indirect hazards. The Agency regards a direct health hazard to be extremely serious, and it receives the Agency's highest priority. FDA takes immediate action to remove such a product from the market. When the fraud does not pose a direct health hazard, the FDA may choose from 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. The Agency also evaluates its efforts to 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. Currently, FDA is leveraging resources with the Federal Trade Commission (FTC) in an effort to target Internet health fraud. This initiative, "Operation Cure-All," is aimed at false and misleading claims, fraudulent and unproven "miracle" cures.

FDA has worked with the National Association of Attorneys General and other organizations to provide consumers with information to help avoid health fraud. Since 1986, FDA has worked with the National Association of Consumer Agency Administrators (NCAA) to establish the ongoing project called the NCAA Health Products and Promotions Information Exchange Network. Information from FDA, the Federal Trade Commission, the U.S. Postal Service, and State and local offices is provided to NCAA 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.

The Internet poses new and challenging problems to Agency efforts to prevent health fraud. Snake oil salesmen of the past have abandoned their wagons to hop on the Internet with offers of eternal youth and potions for the prevention, treatment and cure of many diseases. FDA recently seized and destroyed Chuifong Black Pills, offered as an Asian herbal treatment for the cure of arthritis. Analysis of the pills showed they contained several prescription drugs that may pose a serious health hazard, especially to consumers who were combining Chuifong with their own prescribed medications.

FDA recently worked with State of California officials to stop the distribution of an unapproved diabetic drug imported from China. This herbal product, marketed under several names, contained the
two-way communication between FDA and its constituencies. These activities included national and local consumer roundtables, meetings with organizations, stakeholder meetings, and public meetings.

PUBLIC PARTICIPATION

FDA has processes that provide access to decision-making and information programs by its stakeholders. FDA's stakeholders include industry, small business, consumers, and health professionals. Stakeholders may interact with FDA policy makers, express opinions, or ask for information to address specific concerns. FDA provides balanced opportunities for public access to the pre- and post-market regulatory processes in addition to timely education and information.

FDA convened a series of national and local roundtables and stakeholder meetings with consumers, health professional associations, and community-based organizations. These forums provide opportunities for the Agency to dialogue with diverse groups on the FDA Modernization Act and an array of regulatory and health policy issues. One of the issues addressed was risk management associated with the use of medical products, a significant matter of interest for the older American community.

ADVISORY COMMITTEE

The Agency continues its efforts to involve older Americans to serve on its advisory committees by working with aging organizations to help identify potential candidates. Advisory committees have served an important role at FDA for many decades. FDA's advisory committees help the Agency make sound decisions based on good science in its review of regulated products. Advisory committees consist of individuals who are recognized as experts in their field from many different sectors including medical professionals, scientists and researchers, industry leaders, consumer representatives, and patient representatives. While advisory committee recommendations are valuable, all final decisions related to a regulated product are made by FDA. Currently there are 32 advisory committees serving the Agency.

HEALTH FRAUD

Health fraud is the deceptive promotion and distribution of false and unproven products and therapies to diagnose, cure, mitigate, prevent, or treat disease. These fraudulent practices can be serious and often expensive problems for the elderly. 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 are often 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
and other FDA-regulated products. Further, the increasing educational needs of the elderly will require more focused educational programs, including specific dietary information and foods targeted to their nutritional requirements. The elderly population and food service workers who prepare food for the elderly also will require special education initiatives concerning proper food handling because as the population ages it becomes more susceptible to foodborne diseases. Some of the major initiatives that are underway are described below.

MISSION

The FDA is a regulatory consumer protection Agency. FDA's mission is to promote and protect the public health by providing timely clearance of safe and effective products and monitoring products for continued safety after they are in use. The Agency's primary responsibilities are to ensure that: (1) foods are safe, nutritious, wholesome, and honestly labeled; (2) cosmetics are safe and properly labeled; (3) all drug products used for preventing, diagnosing, and treating disease are safe and effective, and information on their proper use is available; (4) biological products (blood and blood products, test kits, vaccines and antigens, therapeutic agents, and other biologicals) are safe, potent, and effective for the prevention, diagnosis, and treatment of disease; (5) medical devices are safe, effective, and properly labeled, and the public is not exposed to excessive radiation from medical, industrial, and consumer products; (6) animal drugs, devices, and feeds are safe and effective; and (7) food from animals that are administered drugs are safe for human consumption.

FDA accomplishes its mission through enforcement of the Federal Food, Drug, and Cosmetic Act and subsequent regulations. FDA's current areas of emphasis are to implement the Food and Drug Administration Modernization Act of 1997, to strengthen the Agency's science-base, and to implement the Administration's initiatives on food safety and blood safety.

LEVERAGING PARTNERSHIPS

Leveraging is the creation of relationships and/or formal agreements with others outside the FDA that will ultimately enhance FDA's ability to meet its public health mission. By choosing to work with other organizations that share our public health and safety goals, FDA can significantly amplify its public health impact, leverage the intellectual capital of others, and make wise use of its resources. FDA has formed many leveraging partnerships with other government agencies, regulated industry, academia, health providers, consumers, and national and community based organizations to help the Agency meet its public health responsibilities. As part of the Agency's long-standing tradition of involving the public in its activities, FDA is forging new relationships with organizations in the aging network on national and grassroots levels. The Agency has been quite successful with its collaborations, and FDA intends to expand and build upon this foundation in developing new partnerships. During 1999 and 2000, the Agency conducted a variety of activities intended to establish and strengthen
identified by the license examiners as potential study participants. Of these, 3,238, or 60 percent, elected to participate in the study. Participant and non-participant cases were linked with the North Carolina driver history files, and initial data analyses were carried out examining the role of various cognitive and visual functional impairments in recent prior crash involvement and in current driving exposure. Follow up analyses are planned in the project’s final year to examine the usefulness of the driver functional assessments in predicting future crash involvement.

In addition to these efforts, supplemental funding was made available by NCIPC to link North Carolina driver history data to data collected by UNC's Sheps Center for Health Services Research as part of an earlier study examining changes in health status and costs associated with Medicare-reimbursed screening and health promotion services. This “add-on” effort permitted further analyses of associations between motor vehicle crashes and injuries and a broad range of health measures in a separate population of elderly NC residents.

**ELDER ABUSE**

Abuse of elderly persons is on the rise in the U.S. In 1996, the National Elder Abuse Incidence Study reported 550,000 incidents of abuse among elderly persons. There are no federal requirements for elderly protective services, nor are there regulations on training staff who provide protective services or for those investigating alleged cases of elder abuse. State protective services for the elderly vary widely; some are merged with children’s services while others are separate.

CDC’s NCIPC and Public Health Practice Program Office have awarded a grant to the University of Iowa to evaluate the implementation and impact of state adult protective service statutes and regulations on the conduct of elder abuse investigations and outcomes. This study is expected to increase CDC’s knowledge and understanding of state regulations related to elder abuse. Research findings from this study also will aid in the standardization of definitions in legislation and healthcare, and inform public health law practitioners about elder abuse reporting at the state level.

**U.S. FOOD AND DRUG ADMINISTRATION**

**INTRODUCTION**

According to the U.S. Census Bureau, America’s population aged 65 or older grew by 74 percent between 1970 and 1999, from 20 million to almost 35 million people. As the percentage of older Americans in the Nation’s population continues to increase the Food and Drug Administration (FDA) has been giving increasing attention to the elderly in the programs developed and implemented by the Agency.

Some of the challenges associated with older Americans, such as multiple drug interactions, food safety, different physiological characterizations and reactions to drug regimens, and the need for better medical device design for home self-diagnostics and therapies, will become more acute. These challenges will require greater inclusion of the elderly in clinical testing for drugs, medical devices,
NCIPC is also conducting research through peer-reviewed, investigator-initiated grants program in universities and research institutions across the country. Research grants relating to older drivers include:

Project Title: “Time Since License Renewal and Motor Vehicle Crash Risk Among Older Drivers”
Project Director: Thomas D. Koepsell, M.D, M.P.H.
Institution: University of Washington, Department of Epidemiology

States vary considerably with regard to how long a driver's license remains valid before it must be renewed. Although some states shorten the time between renewals for older drivers, most do not. The time between license renewal for older drivers is a public policy choice, balancing the risk of crashes due to drivers who have become impaired against the cost and inconvenience of more frequent renewal checks. The aim of this project is to determine the relationship between crash risk and time since last license renewal for drivers 65 years and older. Investigators hypothesize that longer time periods since last renewal will be significantly associated with a higher crash risk, compared to drivers with more recent renewals. The long term objective is to guide public policy related to license renewal for older drivers in the United States, by determining the degree to which decreasing the interval between renewals for older drivers may lessen the risk of crash.

Project Title: “Elderly Driver Referral Project”
Project Director: James McKnight, Ph.D.
Institution: National Public Services Research Institute; Landover, MD

The proposed study attempts 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 are being 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 are 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.

Project Title: “Longitudinal Study of Elderly Drivers”
Project Director/Lead Investigator: Jane Stutts, PhD;
Other Investigators: Richard Stewart, PhD; Carol Hogue, PhD.
Institution: University of North Carolina at Chapel Hill, Highway Safety Research Center

A prospective cohort study is underway to assess the impact of selected functional impairments and medical conditions on the safety of older drivers. Drivers ages 65 and above coming in to renew their licenses were asked to participate in the study which involved a series of visual and cognitive functional assessments, along with a survey to gather information on self-reported medical conditions, use of medications, and driving habits. During the 1½ year data collection period, a total of 5,438 license renewal applicants were
Considerable evidence now exists that fall severity, as defined by the configuration and velocity of the body at impact, is a stronger predictor than bone density of hip fracture risk. Data also suggest that specific protective responses exist for reducing fall severity and fracture risk, including braking the fall with the outstretched hands, and absorbing energy in the lower extremity muscles during descent. This study is designed to better define the biomechanical and neuromuscular variables that govern safe landing during a fall, and to identify the neuromuscular variables governing the efficacy of the protective responses as the basis exists for designing exercise-based interventions for reducing hip fractures in the elderly and other fall-related injuries.

Project Title: “Hip Fracture Reduction with the Penn State Safety Floor”

Project Director: Donald Streit, Ph.D.
Institution: Pennsylvania State University; Center for Locomotion Studies; Pennsylvania

This proposal builds upon previous work in which a dually stiff floor intended to reduce the incidence of hip fractures in the elderly was successfully designed and developed. The Penn State Safety Floor (PSUSF) is stiff to loads typical of everyday activities but yields when forces such as those encountered during falls occur. Laboratory testing and finite element modeling have shown the floor to be capable of reducing the impact force of a fall by 28 percent investigators are now validating these promising initial results by conducting a carefully controlled study designed to directly demonstrate that hip fractures can be reduced by the use of the floor. In addition, investigators are monitoring a double occupancy room in a local nursing home where the floor is installed to demonstrate the livability of the floor.

OLDER DRIVERS

In 1999, 7,088 people 65 years and older died in motor vehicle crashes. People 65 years and older represented 13 percent of the population in 1999 and 17 percent of motor vehicle deaths. By 2030, elderly people are expected to represent 20 percent of the population. Once they're in crashes, elderly people are more susceptible than younger people to medical complications following motor vehicle injuries. Little is known about how the physical changes that accompany the aging process and diagnosed medical conditions effect driving performance. For example, there is some evidence to suggest that Parkinson’s disease may impair driving, although the evidence is weak. More needs to be known about the connection between specific medical conditions and adverse driving outcomes.

NCIPC has analyzed fatal and nonfatal injury data to assess trends over time in motor vehicle-related deaths to older persons. The rate of both fatal and nonfatal motor vehicle-related injury increased during the study period. Rates increased as age increased, and men had rates twice as high as women. NCIPC collaborated with the University of California, San Diego to explore why older drivers stop driving. This study found that medical conditions were the most commonly given reason for stopping, and vision loss was the most common problem.
remained stable. Over 95 percent of hip fractures were caused by falls.

Previous extramural research on reduction of falls in nursing homes has shown promising results in reducing falls by as much as 19 percent. Research has also identified the following modifiable risk factors: inactivity and muscle weakness, over medication, and environmental hazards. Less well understood are other risks, e.g., impaired vision and types of footwear. To improve our knowledge in one of these areas, NCIPC is consulting with the Atlanta, GA Veteran's Administration hospital to study footwear and falls. Current extramural research grants relating to falls prevention include:

- **Project Title:** "Hip Fracture Prevention from Falls in the Elderly"
  - **Project Director:** Wilson Hayes, Ph.D.
  - **Institution:** Beth Israel Hospital; Orthopedic Biomechanics Laboratory; Boston, MA

  The goals of this project are to understand the biomechanics of hip fractures among the elderly, to resolve uncertainties regarding the relative importance of trauma severity and age-related bone loss, and to design a protective pad to be worn over the hips and test its acceptability to potential users.

- **Project Title:** "An Assessment of Fall Prevention/Safety Practices in Tennessee Nursing Homes"
  - **Project Director:** Wayne Ray, Ph.D.
  - **Institution:** Vanderbilt University School of Medicine; Nashville, Tennessee

  This study tests the hypothesis that the Tennessee Fall Prevention Program (TFPP), a reduces falls that result in serious injuries. TFPP is a statewide, safety practices training program for nursing home staff. Investigators are conducting a randomized controlled trial of an estimated 112 nursing homes with a combined population of approximately 9,000 residents. The primary analysis is assessing program effectiveness by comparing rates of falls resulting in serious injuries in intervention and control facilities. If effective, the TFPP could provide a model for feasible, cost-effective injury prevention programs in long-term care settings.

- **Project Title:** "Antidepressants and the Risk of Falls"
  - **Project Director:** Wayne Ray, Ph.D.
  - **Institution:** Vanderbilt University School of Medicine; Department of Preventive Medicine; Nashville, Tennessee

  The investigator is conducting 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 is being conducted in nursing homes because residents have the highest prevalence of depression and antidepressant use, are particularly vulnerable to tricyclic antidepressants adverse effects, and have the highest rates of falls and related injuries. Study findings are expected to further injury control by providing information clinicians need to choose pharmacotherapy that minimizes risk of falls.

- **Project Title:** "Biomechanics of Injury Prevention During Falls"
  - **Project Director:** Stephen Robinovitch, Ph.D.
  - **Institution:** Simon Fraser University; Office of Research Services; Burnaby, Brit. Col. Canada
of age or older who experience TBI, an estimated 1 in 3 men and 1 in 10 women have a fatal outcome.

Disseminating What Works

A Tool Kit to Prevent Senior Falls, developed in 1999 by NCIPC, is a comprehensive collection of health education materials and assessment tools designed to reduce falls and related injuries among older adults. In FY2000 the Tool Kit was distributed to over 14,500 organizations and agencies concerned with preventing injuries among older adults. Pfizer Pharmaceuticals is mass producing these materials for distribution to their customers.

NCIPC developed U.S. Fall Prevention Programs for Seniors: Selected Programs Using Home Assessment and Modification in November 2000. This document fully describes 18 comprehensive fall prevention programs as well as contact information for 21 additional programs. These programs are intended to be used as models by agencies or organizations that want to develop fall prevention programs for older adults.

Fall Prevention Programs

In September 2000, NCIPC funded the State of California to conduct a fall prevention demonstration program for community-dwelling older adults that includes three strategies: increased physical activity, medication review, and home assessment and safety modifications. This is the first demonstration of a combined program of several proven prevention strategies.

NCIPC funded fire/fall prevention programs in September 2000 that target older adults in North Carolina, Minnesota, Maryland, Virginia and Arizona. These programs implement a pre-developed program curricula for preventing fire and fall-related injuries among older adults utilizing home visits, group presentations, and other innovative outreach strategies.

Gathering Better Data on Falls

In order to understand more about fall risk factors and how falls occur locations, circumstances, predisposing and enabling factors, especially for sub-population groups (such as the oldest old, minorities), NCIPC is supporting the expansion of the National Electronic Injury Surveillance System of the Consumer Product Safety Commission to collect information about fall injuries from hospital emergency departments. We are also funding the 2nd Injury Control And Risk Survey, a national injury survey that will include information related to fall risk factor prevalence and fall prevention behaviors among seniors.

Research on Falls Prevention

NCIPC conducts research by NCIPC scientists, and through a peer-reviewed, investigator-initiated grants program in universities and other research institutions across the country.

In an NCIPC study using National Hospital Discharge Survey data, we analyzed hip fracture hospitalization rates occurring between 1988 and 1996, and found that hip fracture hospitalization rates for older women increased 40 percent while the rates for men
tial infection and the chronic consequences of such infections. Mi-
crobes are also suspected but not yet proven as triggers of still
other chronic conditions. CDC is developing research activities that
identify and define these relationships. The potential to use infec-
tion control in the prevention or treatment of infections that
produce chronic disease can improve the quality and length of life
for many elderly persons.

NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

CDC’s National Center for Injury Prevention (NCIPC) is involved
in a wide array of activities to promote enhanced mobility and
independent living among older Americans by preventing injuries
and injury-related disabilities. Our research and programmatic ef-
forts that target older Americans focus on falls prevention, under-
standing issues affecting older drivers, and preventing elder abuse.
We also support two organizations focusing broadly on uninten-
tional injury prevention among older Americans:

• The National Resource Center on Aging and Injury was es-
  tablished at the end of FY1999 with the San Diego State Uni-
  versity. The Resource Center applies cutting edge technology to
  collecting, organizing, evaluating, and disseminating informa-
  tion about preventing unintentional injuries among older
  adults. In FY2000 the Resource Center established a repository
  of over 1,000 resource items; developed an interactive web site
  (www.olderadultinjury.org) with a searchable data base; and
  provided information to over 636,000 people, including health
  care professionals, care givers, and other individuals concerned
  about reducing injuries among older adults.

• The Edward R. Roybal Institute for Applied Gerontology in
  Los Angeles, CA is funded to develop training materials for
  community organizations and agencies that serve Hispanic and
  other minority older adults in East Los Angeles. These mate-
  rials enable organizations to conduct outreach and educational
  programs, and to integrate unintentional injury prevention ac-
  tivities into their existing service delivery programs.

FALLS PREVENTION

National studies show that one-third of the people over 65 living
at home will fall each year, and for people over 80, this rate in-
creases to 40 percent. Falls are the second leading cause of injury
deaths among persons aged 65–84 years and the leading cause
among persons aged 85 years and older. Of all fall injuries, hip
fractures produce the greatest morbidity and mortality. Approxi-
mately 250,000 hip fractures occur each year and half of those who
sustain hip fractures never regain their former level of functioning.
Falls are the leading cause of traumatic brain injury (TBI)
among older people, accounting for more than half of TBIs among
older men and more than three-fourths among older women. TBI
is an important and under-recognized public health problem among
older people. NCIPC analyzed population-based data for 1997 from
Arkansas, Colorado, and South Carolina (NCIPC-funded states con-
ducting TBI surveillance), and found that among people 65 years
and Escherichia coli O157:H7 infections, often caused by undercooked hamburger. CDC is working with USDA and FDA to encourage use of pasteurized eggs in nursing homes and thorough cooking of hamburger meat.

Listeriosis is a severe bacterial foodborne infection that particularly affects the elderly, as well as pregnant women and immunocompromised persons. CDC is participating in the interagency federal control plan for listeriosis, that includes enhanced surveillance, investigation of sporadic cases and of outbreaks to determine the sources, so that control measures can be targeted, and increased efforts to educate persons at higher risk in prevention measures.

PREVENTING LEGIONNAIRES' DISEASE

An estimated 8,000–18,000 cases of Legionnaires’ disease occur each year in the United States. Legionnaires’ disease is a severe form of pneumonia caused by the bacterium, Legionella spp. Between 5–30 percent of persons contracting Legionnaires’ disease die depending on underlying risk factors. The elderly, particularly those with underlying chronic diseases, are at greatest risk. Although attack rates are low, legionnaires' disease can be transmitted when susceptible persons are exposed to mists that come from a water source (e.g., air conditioning cooling towers, whirlpool spas, showers) contaminated with Legionella bacteria. Novel prevention strategies are focusing on the use of new disinfectants in water systems that may have the potential for greatly reducing the occurrence of legionnaires' disease. In addition, CDC is developing improved surveillance systems to better.

GASTROINTESTINAL DISEASE

Studies using information from national data bases show that of all age groups, the elderly (≥70 years old) have the highest rates of hospitalizations and deaths associated with diarrhea in the United States. In the elderly, caliciviruses (also called Norwalk-like viruses or Small Round Structured Viruses) are likely to be the most common cause of both epidemics and sporadic hospitalizations for acute gastroenteritis and studies needed to confirm this hypothesis are now underway. These studies should lead to a better understanding of ways to prevent gastrointestinal disease in the elderly. The recent identification of rotavirus as a cause of epidemic diarrhea in the elderly suggests that one approach to control may involve use of vaccines currently used for young children. Further study is now needed to determine the importance of rotavirus to gastrointestinal disease in the elderly.

OTHER INFECTIOUS DISEASES

It is becoming increasingly evident that infections play a major role in causing or contributing to some chronic diseases. Some of these conditions result from infection acquired at a younger age (including liver cancer and cirrhosis related to chronic hepatitis B or hepatitis C, stomach and duodenal ulcers or gastric cancer from Helicobacter pylori), while others develop from exposures later in life. CDC is actively promoting and pursuing ways to prevent ini-
HEALTHCARE-ACQUIRED INFECTIONS AND ADVERSE HEALTH EVENTS

The Institute of Medicine (IOM) has reported that preventable adverse events associated with healthcare result in 98,000 deaths and $29 billion in additional healthcare costs annually. Overall, 3–4 percent of all patients suffered a healthcare related adverse event. The elderly are disproportionately affected by such adverse events.

Existing technology and knowledge can prevent many adverse events but prevention strategies have not been widely and successfully implemented. However, some successes have occurred. For example in 2000, CDC reported that bloodstream infections among patients in U.S. intensive care units, most of whom are elderly, declined by 32 percent to 43 percent during the 1990's (MMWR 2000:49;149-153). This success is due to improved efforts in infection control in U.S. hospitals, to technological advances, and to improved patient care. CDC is embarking on a 5 year plan to substantially reduce bloodstream infections in other healthcare settings such as cancer and dialysis centers, respiratory infections in long term care patients, infections following surgery, and infections due to antimicrobial resistant organisms. CDC has increased its focus on the use of new information technologies to improve efficiency, developed new collaborations with both private sector partners and public sector partners, and expanded its work in non-hospital settings (long-term care, home health care, cancer centers, dialysis centers) where a substantial portion of healthcare for the elderly is provided. Regarding antimicrobial resistance, CDC, through the Chicago Antimicrobial Resistance Project (CARP) is currently evaluating the impact of infection control strategies on the prevention of antimicrobial resistance in hospitals and long-term care facilities.

GROUP B STREPTOCOCCUS DISEASE

Group B streptococcus (GBS) is a major cause of invasive bacterial disease in elderly persons in the U.S. To document the magnitude of GBS disease in the elderly and develop preventive measures, CDC established population-based surveillance for GBS disease and case control studies to identify risk factors. An analysis of active surveillance data from 1993–1998 that was published in the New England Journal of Medicine in 2000 showed that the incidence of disease in adults ≥ 65 years old in 1998 was 20.1/100,000 population and the case fatality ratio was 15 percent compared to 8 percent in adults 15–64 years old. Consistent with findings from earlier surveillance, the incidence of disease in black adults was approximately twice that in non-black adults. These data, along with serotype data on adult invasive GBS isolates, will be utilized to develop and evaluate vaccines and to promote the prevention and treatment of GBS disease in the elderly population.

FOODBORNE DISEASE

Foodborne disease is of particular concern in the elderly, who typically can have higher illness and death rates from foodborne pathogens than younger persons. Of particular concern are Salmonella enteritidis infections, often caused by undercooked eggs,
risk factors such as lack of mobility and poor nutrition, in addition to device use.

**MONITORING INFLUENZA**

Although delivering the influenza vaccine to persons at risk is a critical step in preventing illness and death from influenza, immunization is only part of the prevention equation. Other CDC efforts to combat influenza in the elderly include: (1) improving domestic surveillance through the sentinel and state health department laboratory surveillance networks; (2) conducting studies to better define the immunological response of the elderly to influenza vaccines and to natural infection; (3) conducting immunological studies involving laboratory and clinical 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; (6) using recombinant DNA techniques to develop influenza vaccines that may protect against a wider spectrum of antigenic variants; and (7) providing laboratory training in the People's Republic of China, other Pacific Basin countries, and Latin America to develop and expand capacity for the diagnosis and detection of antigenic changes in the virus.

**PREVENTING PNEUMOCOCCAL DISEASE**

Pneumococcal pneumonia causes an estimated 7,500–12,500 deaths each year; about 60 percent of these are in persons 65 years old and older. 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. New vaccines under development, including conjugate and common protein antigen approaches, offer the potential for improved prevention of pneumococcal disease in the elderly. Improved use of current vaccine, as well as evaluation of new tools, are critical to decrease illness and death from pneumococcal infections in the elderly.

**OTHER RESPIRATORY INFECTIONS**

Recent studies have suggested that noninfluenza viruses such as respiratory syncytial virus and the parainfluenza viruses may be responsible for as much as 15 percent of serious lower respiratory tract infections in the elderly. These infections can cause outbreaks that may be controlled by infection control measures and treated with antiviral drugs. It is important to define the role of these viruses and risk factors for these infections among the elderly. CDC is working to define the disease burden associated with respiratory syncytial virus and parainfluenza virus infections in the elderly and helping to develop vaccination strategies for respiratory syncytial virus.
told federal public health officials to expect delays in flu vaccine shipments this flu season and possible shortages. This delay was due to a combination of factors including problems growing one of the virus strains used in vaccine and problems in the manufacturing process. Although all influenza vaccine is produced in the private-sector, and more than 90 percent distributed through the private-sector, CDC undertook a number of actions to minimize the adverse impact of delays. First, CDC contracted for up to 9 million doses of vaccine to be produced. This added production of additional influenza vaccine was done to make up for possible shortfalls experienced by some of the vaccine manufacturer and to help fill some gaps to vaccinate people at highest risk of complications of influenza. As a result, flu vaccine supplies were approximately what was distributed last year; however, a substantial amount of vaccine reached providers later than usual. Other actions taken to alleviate problems related to the delay in influenza vaccine availability included CDC's initiation of a media campaign to educate providers and the public regarding the recommendations for this year's influenza season, development of a web-based system to facilitate the exchange and redistribution of vaccine and ongoing communications with health care providers and partners to keep them informed of influenza vaccine availability.

**NATIONAL CENTER FOR INFECTIOUS DISEASES**

Infectious diseases remain a serious problem in the U.S. Pneumonia and influenza remain the sixth leading cause of death in the United States and septicemia has risen dramatically during the past three decades to become the 11th leading cause of death. Chronic liver disease, a substantial proportion of which is due to hepatitis C virus, is the 10th leading cause of death in the U.S. Pneumonia and septicemia are also contributing and precipitating factors in the deaths of many Americans with other illnesses, especially cardiovascular diseases, cancer, and diabetes. Infectious diseases have a disproportionate impact on older Americans, 65 years old and older. Quality of life also declines for millions of older Americans as a result of infectious illnesses. Prevention and control of infectious diseases will enhance and lengthen the lives of older Americans, make them more productive, and reduce associated medical costs.

CDC emphasizes surveillance and training to prevent and control hospital-acquired and other institutionally acquired infections in elderly patients. Additionally, CDC staff provides education regarding infection control to care providers at nursing home and patient care conferences. This education focuses on patient care treatment and procedures associated with the highest risk of infection. Through the National Nosocomial Infections Surveillance (NNIS) system, special infection risks of elderly patients have been identified. According to NNIS, over half of the hospital-acquired infections occur in elderly patients, although these patients represent about one-third of all discharges from hospitals. The use of certain devices, such as urinary catheters, central lines, and ventilators, are associated with high risk of infection in all types of patients. In elderly patients, the risk of infection is high even when a device is not used, suggesting that infection control must address other
tion activities; in CY 2000, 35 states reported having at least 0.5 FTE designated for this purpose. CDC has an annual influenza vaccine contract which many states use to purchase influenza vaccine for use by the state or local health departments. In 2000, CDC negotiated contracts for 2 million doses of influenza vaccine. Over 90 percent of local health departments deliver influenza vaccine, 85 percent deliver tetanus toxoid, 77 percent deliver hepatitis B vaccine, and 48 percent deliver pneumococcal vaccine. Since 1997, CDC has conducted the Life Preserver campaign in collaboration with state health departments, to promote influenza and pneumococcal vaccination among persons with diabetes.

UNDERSTANDING GAPS

CDC commissioned an Institutes of Medicine (IOM) Report on the financing of vaccines. Calling the Shots: Immunization Policies and Practices found that “additional funds are needed to purchase vaccines for uninsured and underserved adult populations within the states.” Work is now being done to implement and respond to the recommendations.

CDC also conducts research to better understand and improve adult vaccine delivery, including:

- Reviewing adult immunization activities in the state immunization programs, 1997–99, to determine best practices.
- Tested AFIX (Assessment, Feedback, Incentive, and eXchange) methods, very successful for childhood immunization, for physicians of Medicare beneficiaries in New Jersey.
- Surveying African American physicians to identify barriers to delivery of adult immunization, and will use the results to design and evaluate a provider-based intervention to improve vaccination services.
- Designing and evaluating a multi-component intervention in New Jersey to improve the use of influenza and pneumococcal vaccination and cancer screening (mammography and Pap testing) among African American women enrolled in Medicare.

IMPROVED MONITORING OF COVERAGE

Influenza and pneumococcal vaccination status is asked annually on the NHIS. In 1999, the BRFSS added a question on the type of place where influenza vaccination was received. Additionally, CDC has recommended standardization of pneumococcal vaccination questions in all relevant surveys (NHIS, BRFSS, HCFA’s Medicare Current Beneficiary Survey). Hepatitis B vaccination status will be included on the 2000 NHIS. CDC also worked with three HMO’s to evaluate the feasibility of including a measure of pneumococcal vaccination among persons 65 years of age and older on HEDIS. Based on the results of this work, the measure has been approved for addition to HEDIS. CDC is also developing software suitable for assessing vaccination levels in adult patient practice settings.

2000–2001 INFLUENZA SEASON

The influenza season of 2000–2001 has posed new challenges to immunization efforts. In June, influenza vaccine manufacturers
important for adults of all ages. With the senior book emphasizing the vaccines for those diseases that can cause the most serious problems, i.e., influenza, pneumococcal disease, and adult tetanus and diphtheria among the elderly.

RECOMMENDATIONS

CDC worked with the National Medical Association to develop a consensus document “Adult Immunizations: Increasing Immunization Rates among African-American Adults” published in 1999. The document clearly demonstrates the need for improving vaccination in African-American adults and offers recommendations on how to do so.

Task Force for Community Preventive Services included recommendations about successful interventions to increase coverage among adults in the published Guide to Community Preventive Services.

The National Vaccine Advisory Committee and CDC published recommendations for vaccination of adults in non-traditional sites in the March 24, 2000 MMWR.

Revision of Standards for Adult Immunization Practices, which were first developed in 1990, are under way. Revision began in 2000 and will be completed by December of 2001.

The guide, “Prevention and Control of Vaccine-Preventable Disease in Long-Term Care Facilities,” was published in the September/October 2000 issue of the Journal of the American Medical Directors Association, and widely disseminated by CDC and HCFA to state health departments and nursing home directors.

Authors from CDC published an article, “Vaccine recommendations for Patients on Chronic Dialysis,” in the March/April 2000 issue of Seminars on Dialysis.

STANDING ORDERS

Dissemination of guidelines for health care providers is another important activity. CDC, in collaboration with the Advisory Committee on Immunization Practices and the Health Care Financing Administration, has recommended a key strategy called “standing orders” to improve influenza and pneumococcal vaccination levels in nursing homes throughout the country. A standing order enables nursing homes to provide these vaccinations to nursing home residents without an individual prescription.

A project started in July of 1999 to evaluate the effectiveness of standing order programs to improve pneumococcal and influenza vaccination rates in nursing homes. It is a multi-state project (9 intervention, 5 control) to develop, implement and evaluate standing order programs and other immunization programs for influenza and pneumococcal vaccination among seniors in nursing homes funded by CDC 1 percent Evaluation funds and the National Vaccine Program Office. It is run in collaboration with HCFA and Peer Review Organization (PRO).

DELIVERING VACCINES TO ADULTS

Since 1997, CDC immunization grant guidance has instructed grantees to assign at least 0.5 FTE to coordinate adult immuniza-
sons 65 years or older. In addition, increased use of pneumococcal vaccine between 1993 and 1997 saved almost $27 million in hospital costs alone.

In spite of the progress that has been made, adult vaccines continue to be underutilized. Reasons for this include: 1) limited appreciation of the impact of adult vaccine-preventable diseases and missed opportunities to vaccinate during contacts with health-care providers; 2) failure to organize programs in medical settings that ensure adults are offered the vaccines they need; 3) doubts about the safety and efficacy of adult vaccines; 4) selective rather than universal approaches to vaccination; and 5) inadequate reimbursement for adult vaccination services.

To overcome these challenges, CDC has taken a number of steps including:

TESTING VACCINE SAFETY AND EFFECTIVENESS

CDC is actively engaged in determining vaccine effectiveness. CDC and three health plans assessed the effectiveness of influenza vaccine in patients age 65 or older in preventing hospitalizations and deaths. Results showed that vaccination prevented 18–24 percent of the hospitalizations for pneumonia and 35–61 percent of all deaths. These findings support the concept that health plans should cover influenza vaccination, as well as actively promote the vaccine each fall.


EDUCATION AND TRAINING

Enhancing education and training is a priority in adult vaccination efforts. CDC aired the first national video-conference on adult immunization technical issues in June 1998 and rebroadcast the presentation in June 1999. It was also broadcast in Spanish, with special efforts to promote it in all of the border states, Mexico, and the Caribbean.

CDC and the Association of Teachers of Preventive Medicine developed and tested the “What Works” interactive software (CD-ROM) program targeted at private primary care providers who provide health care services primarily for adults. This program focuses on strategies to increase immunization coverage levels among adults and technical issues relating to adult vaccinations.

Immunization teaching materials for physicians were developed through a collaboration with CDC, Association of Teachers of Preventive Medicine, and the Department of Family Medicine at the University of Pittsburgh. The training materials are designed to be used by medical schools for students and residents. These products were published between April 1998 and April 1999 and include a Facilitators Guide, a Small Group Booklet, and a Reference Booklet.

Two large print booklets were designed in 1999 to be distributed by health care providers to adult and senior patients. The focus of the booklets is to empower adults and seniors to take action for their own health. The vaccines presented include all immunizations
it also affects the relationship of mortality among the race groups. NCHS publications describe the extent and implications of these changes.

THE NATIONAL HEALTH CARE SURVEY

The National Health Care Survey (NHCS) is an integrated family of surveys conducted by the NCHS to provide annual national data describing the Nation's use of health care services in ambulatory, hospital and long-term care settings. Currently, the NHCS includes six national probability sample surveys and one inventory. These seven data collection activities include:

- the National Hospital Discharge Survey which examines discharges from non-Federal, short-stay and general hospitals;
- the National Survey of Ambulatory Surgery which examines visits to hospital-based and freestanding ambulatory surgery centers;
- the National Ambulatory Medical Care Survey which examines office visits to non-Federal, office-based physicians;
- the National Hospital Ambulatory Medical Care Survey which examines visits to emergency and outpatient departments of non-Federal, short-stay and general hospitals;
- the National Health Provider Inventory which is a national listing of nursing homes, hospices, home health agencies and licensed residential care facilities;
- the National Home and Hospice Care Survey; and
- the National Nursing Home Survey.

IMPROVING SELF-REPORTS OF HEALTH STATUS BY THE ELDERLY

The National Laboratory for Collaborative Research in Cognition and Survey Measurement of NCHS has conducted several cognitive research projects with elderly respondents. In 1998, Lab staff continued their investigation of recall and judgment issues that elderly respondents may have when answering questions regarding health status and quality of life. This project involved both in-house and extramural research. In-house research is conducted by recruiting subjects to the NCHS Questionnaire Design Research Laboratory. Extramural research is conducted by the University of Maryland's Survey Research Center using split-ballot field experiments.

NATIONAL IMMUNIZATION PROGRAM

CDC's National Immunization Program provides medical and epidemiologic expertise and collaborates with other CDC organizations and HHS agencies in developing strategies to enhance immunization coverage of adults, including influenza, pneumococcal, hepatitis B, measles, mumps, rubella, and varicella vaccines and combined tetanus and diphtheria toxoids. One of the greatest challenges we face is extending the success in immunization with children to the adult population.

Immunization rates for influenza and pneumococcal disease are at record highs in persons 65 years of age or older. The Healthy People 2000 Objective for influenza vaccination in this age group has been achieved. It is estimated that in 1996–1997, about 19,500 deaths were prevented by influenza vaccination in persons in per-
ANALYSIS OF NHANES III DATA

NCHS is engaged in a range of projects analyzing data from NHANES III related to aging. These projects include:

- Prevalence of Disability and Risk Factors Associated with Disability. NHANES III data will be analyzed to assess the prevalence of physical and functional limitation. It includes self-reported data obtained in the household interview and performance-based data obtained in the mobile examination center. The risk factors associated with disability will be assessed to provide a better understanding of the etiology and treatment of disability in the elderly.

- Region of Birth and Cardiovascular Risk Factors. NHANES III data will be used to assess early-life influences such as region of birth on the pattern of risk factors for cardiovascular disease in later life.

- Nutritional Intake among the Elderly. The patterns of nutrient intake among adults age 60+ in NHANES III will be analyzed.

VITAL STATISTICS ON AGING

Information on mortality from the national vital statistics system plays an important role in describing and monitoring the health of both the institutionalized and non-institutionalized elderly population. The data include measures of life expectancy, causes of death, and age-specific death rate trends. The basis of the data is information from death certificates, completed by physicians, medical examiners, coroners, and funeral directors, used in combination with population information from the U.S. Bureau of the Census.

Effective with mortality data for 1997, additional detail on the aging population was included in the official national life tables. For the first time life expectancy and other life table values for the population aged 85 to 100 years were shown in the annual life tables by incorporating information from the Medicare program on the mortality experience of the aged population with standard information from the vital statistics system.

NCHS is expanding outreach to certifying physicians on proper completion of the cause-of-death section of the death certificate by designing material appropriate for diverse settings including professional meetings and electronic death certificates.

Effective with mortality data for 1999, two important changes are being implemented for state and national mortality statistics: (1) causes of death are coded and classified by the Tenth Revision of the International Classification of Diseases (ICD–10), replacing ICD–9, which was used by the U.S. during 1979–1998; and (2) the standard population used for age-adjusting death rates is changed from 1940 to the year 2000 population. The 1940 standard has been used for about 50 years. Use of ICD–10 affects the comparability of cause-of-death trends over time; the extent of the discontinuities is measured using a Comparability Study, results of which will be available at the time the 1999 mortality data are published in early 2001. The new population standard for age-adjusting death rates affects the absolute level of death rates for many causes of death, in particular, deaths from chronic diseases;
telephone in 1986 (limited to persons age 55 and over at baseline), 1987, and 1992.

Participant tracing and data collection rates in the NHEFS have been very high. Ninety-six percent of the study population has been successfully traced at some point through the 1992 follow-up. While persons examined in NHANES I were all under age 75 at baseline, by 1992 more than 4,000 of the NHEFS subjects had reached age 75, providing a valuable group for examining the aging process. Public use data tapes are available from the National Technical Information Service for all four waves of follow-up. The 1992 NHEFS public use data is also available via the Internet. NHEFS data tapes contain information on vital and tracing status, subject and proxy interviews, health care facility stays in hospitals and nursing homes, and mortality data from death certificates. All NHEFS Public Use Data can be linked to the NHANES I Public Use Data.

NHANES IV PLANNING

The Fourth National Health and Nutrition Examination Survey began field operations in April of 1999. Although a wide range of the conditions assessed in NHANES IV are most common among the elderly, several components are particularly relevant to aging research:

• Muscle Strength, Impairment, and Disability: All persons age 50+ will have measurement of isokinetic muscle strength of knee extensors and flexors and all persons age 60+ will have an assessment of ability and time to get up from an armless chair five times and time to perform a twenty foot walk at the usual speed. Both sets of measures will provide important data on physical impairment and function in the elderly and will be correlated to other disability related self reported items and other objective measurements obtained in the survey.

• Lower Extremity Disease: For the first time, the survey includes an evaluation of lower extremity disease in persons age 40+, including Ankle-Brachial Pressure Index measurement and assessment of peripheral neuropathy. These data are especially important for assessing the complications of diabetes and the prevalence of peripheral vascular disease.

• Visual and Hearing Impairment: Vision (age 12+) and hearing (age 20+) are being assessed including assessment of visual acuity, near vision (age 50+), pure tone audiometry thresholds, and typanometry. Sensory impairment is an important component of functional impairment in the elderly.

• Bone Mineral Status: Bone mineral status is being assessed including total bone mineral content and bone mineral density by dual X-ray absorptiometry. Osteoporosis is an important risk factor for hip fractures in the elderly.

• Cognitive Function: Cognitive function is being assessed in persons age 60+ with the Digit Symbol Substitution Test.

• Balance and Vestibular Function: The standard Romberg test of postural sway is being assessed in all persons age 20+. Balance impairment is related to the incidence of many fractures caused by falling, especially hip fractures in the elderly.
All-listed procedures for hospital inpatients
Several special web-based reports based on data from DWHA have been written and will be posted to the web site and available in hard-copy formats. The topics include trends in elderly mortality, oral health of older Americans, trends in vision and hearing, and trends in nursing home use.

FEDERAL FORUM ON AGING-RELATED STATISTICS

The Forum was initially established in 1986, with the goal of bringing together Federal agencies with a common interest in database development and statistical compilation on issues in aging. The Forum has played a key role in improving aging-related data by critically evaluating existing data resources and limitations, stimulating new database development, encouraging cooperation and data sharing among Federal agencies, and preparing collaborative statistical reports.

During 1998, an organizing committee was established to coordinate the activities and goals of the Forum for 1999 and beyond. In addition to the Bureau of the Census, the National Center for Health Statistics, and the National Institute on Aging—the original core agencies—the members now include representatives from the Administration on Aging, the Bureau of Labor Statistics, the Health Care Financing Administration, the Office of Management and Budget, the Office of the Assistant Secretary for Planning and Evaluation, and the Social Security Administration.

On August 10, 2000, the Federal Interagency Forum on Aging-Related Statistics (Forum) released "Older Americans 2000: Key Indicators of Well-Being." As one of the core members of the Forum, NCHS took the lead in producing, promoting, and disseminating this well received report. The report included 31 key indicators carefully selected by the Forum to portray aspects of the lives of older Americans and their families. The report is divided into five subject areas: population, economics, health status, health risks and behaviors, and health care. The report can be accessed via the Forum's Web Site—http://www.agingstats.gov.

NHANES I EPIDEMIOLOGIC FOLLOW-UP STUDY

The first National Health and Nutrition Examination Survey (NHANES I) was conducted during the period 1971–75. The NHANES I Epidemiologic Follow-up Study (NHEFS) tracks and 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, and hospital utilization, as well as changes in risk factors, functional limitation, and institutionalization.

The NHEFS cohort includes the 14,407 persons 25–74 years of age who completed a medical examination at NHANES I. A series of four follow-up studies have been conducted to date. The first wave of data collection was conducted from 1982 through 1984 for all members of the NHEFS cohort. Interviews were conducted in person and included blood pressure and weight measurements. Continued follow-ups of the NHEFS population were conducted by
In the DWHA trend data on the elderly population in the United States is organized under six general topic areas: demography (or population composition), vital statistics, health status and well-being, risk factors and health behavior, health care utilization, and health care expenditure.

The target population is persons of 65 years of age and older, but the majority of the tables also contain data on 45–64 year olds for comparison purposes and for representation of the baby boom generation. The indicators are presented by 5- or 10-year age groups. Open-age intervals (for example, 65 and over) can be seen in a crude and age-adjusted form. Usually, for age adjustment the year 2000 standard residential population of the United States was used.

The data are aggregated in interactive tables developed using a user-friendly dissemination tool, Beyond20/20. Tables prepared in Beyond20/20 are capable of presenting the data in the form of charts and maps by the exact variables needed by the user, and the data from the table can be extracted in formats acceptable by most software packages.

Each table displays the selected measure(s) by sex, age interval, race or Hispanic origin for as many years as the data from the particular data system are available. Where possible, the tables present the information by States. Metadata accompanying each table provide important information on data sources, statistical methods used to get the information, and references to corresponding publications and supporting Internet sites.

Examples of selected tables are as follows:

**Demography (population composition)**
- Population (number and percent of people, national and state estimates)

**Vital Statistics**
- Life Expectancy
- Mortality (national and state estimates)
- Living Arrangements

**Health Status and Well-Being**
- Self-assessed health
- Functional status of older adults
- Functional limitation
- Total tooth loss
- Mental health status of nursing home residents
- Selected chronic conditions

**Risk Factors**
- Immunization
- Current cigarette smoking
- Obesity
- Exercise

**Health Care Utilization**
- Nursing home use
- Hospital discharges
tional status, health care needs, living arrangements, social support, and other important aspects of life across two cohorts with different life course perspectives. This will provide those who use the data with an opportunity to examine trends and determinants of “healthy aging.” Users of the LSOA and LSOA II data have typically consisted of researchers, both those in the Federal government and in university settings, policy planners, and agencies and organizations serving older persons.

HEALTH, UNITED STATES, 1999 HEALTH AND AGING CHARTBOOK

In October 1999, the Health, United States, 1999 Health and Aging Chartbook was published. This special study on health and aging was part of the annual report on the nation's health submitted by the Secretary of the U.S. Department of Health and Human Services to the President and Congress. In 34 figures and accompanying text, it summarizes the health of older people in the United States at the end of the twentieth century, using nationally representative health surveys and vital statistics. Measures of health status, including mortality, the prevalence of chronic conditions, disability, oral health, hearing and visual impairments are presented in the volume. In addition, health care access and utilization measures such as hospital discharge rates, use of home health care services, and health insurance coverage are included. Special attention is paid to differences in health by age, sex, and race and ethnicity. The chartbook was distributed to all members of Congress and highlighted in a Congressional briefing sponsored by Senator Mikulski and Representative Hoyer.

TRENDS IN HEALTH AND AGING

Trends in Health and Aging is a major data dissemination project funded in part by the National Institute on Aging and located within NCHS’s Office of Analysis, Epidemiology, and Health Promotion (OAEPH). Trends in Health and Aging draws upon the statistical resources of NCHS and other Federal statistical agencies to provide up-to-date information on health behaviors, health status, utilization and cost of care for the older population in the United States.

TRENDS IN HEALTH AND AGING DATA WAREHOUSE

The core of the project is the Trends in Health and Aging Data Warehouse (DWHA). DWHA is intended for use by policy and program analysts, researchers and the general public. DWHA contains information from NCHS surveys and other data systems in a format easily accessible to users. The list of topics and measures grows based on users’ suggestions and the data are updated as soon as new figures become available. The data warehouse became available to the public on the Internet in November 1999. It can be accessed at the following address: http://www.cdc.gov/nchs/agingact.htm. It serves as an important electronic resource for those seeking relevant national data on a host of issues related to future access to affordable health care and the enhancement of quality of life.
and solicits broad input from the health community in the design and development of its surveys.

A broad range of data on the aging of the population and the resulting impact on health status and the use of health care are produced from these systems. For example, NCHS data have documented the continuing rise in life expectancy and trends in mortality that are essential to making population projections. Data are collected on the extent and nature of disability and impairment, limitations on functional ability, and the use of special aids. Surveys 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.

THE SECOND LONGITUDINAL STUDY OF AGING

The Second Longitudinal Study of Aging (LSOA II) is a collaborative project of the National Center for Health Statistics and the National Institute on Aging. This prospective survey consists of a baseline interview, called the Second Supplement on Aging (SOA II), and two followup interviews fielded at two-year intervals. The SOA II interviews were conducted with a nationally representative sample of 9,447 civilian noninstitutionalized Americans 70 years of age and over. It was fielded as part of the 1994 National Health Interview Survey and interviews were collected in-person between 1994 and 1996. The two reinterviews were administered by phone with these sample persons and have now been completed, one in 1997–1998 and one in 1999–2000.

The LSOA II is designed primarily to measure changes in the health, functional status, living arrangements, and health services utilization of older Americans as they move into and through the oldest ages. Secondarily, the objective of the study is to provide a mechanism for monitoring the impact of proposed changes in Medicare and Medicaid and the accelerating shift towards managed care on the health status of the elderly and their patterns of health care consumption. Finally, the LSOA II replicates the first Longitudinal Study of Aging which was conducted ten years earlier between 1984 and 1990. To this end, questions concerning physical functioning and health status and their correlates which were part of the first LSOA are repeated in the LSOA II. These include questions on activities of daily living, instrumental activities of daily living, and work-related activities, as well as medical conditions and impairments, family structure and relationships, and social and community support. In addition to these repeated items, the LSOA II questionnaire was been expanded to include information on risk factors (including tobacco and alcohol use), additional detail on both informal and formal support services, and questions concerning the use of prescription medications.

The SOA II microdata were released to the public in 1998. The first followup is expected to be released in 2001 and the second follow up in 2003. These data, when used in conjunction with data from the LSOA, enable researchers to identify changes in func-
state health and aging agencies. The databases include literature and programmatic information about 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. 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 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 may be accessed through most library and information services. CHID may be accessed via the Internet at http://chid.nih.gov. For more information about WONDER, contact CDC WONDER Customer Support at 404-332-4569.

NATIONAL CENTER FOR ENVIRONMENTAL HEALTH

CDC's National Center for Environmental Health (NCEH) addresses the prevention of secondary conditions and promotion of health among the 54 million Americans with disabilities. The Center is analyzing NHIS and NHIS-Supplement on Aging data to identify the correlates of aging related to sensory impairments and to characterize disability in the above 55 age groups by race/ethnicity, gender, region, and activity limitation. These analyses will be included in the disability chapter of the upcoming MMWR Supplement on Aging.

The NCEH environmental health laboratory is working to improve measurement of biochemical markers of bone loss to help physicians treat people with osteoporosis. The currently accepted gold standard for measuring bone status is a bone density test. However, such tests can only be repeated every 1–2 years. The biochemical marker tests for bone loss can be performed more frequently to assess the success of treatments for osteoporosis.

The NCEH environmental health laboratory also is collaborating on the Age-Related Eye Disease Study conducted by the National Eye Institute. The laboratory is testing patients participating in the study for levels of vitamins A, C, and E, carotenoids, retinyl esters, lipids, zinc, and copper. The laboratory is also assisting with genetic testings as part of this study.

NATIONAL CENTER FOR HEALTH STATISTICS

CDC's National Center for Health Statistics (NCHS) is the Federal Government's principal health statistics agency. The NCHS data systems address the full spectrum of concerns in the health field from birth to death, including overall health status, morbidity and disability, risk factors, and health care utilization.

The Center maintains over a dozen surveys and vital statistics data files that collect health information through personal interviews, physical examination and laboratory testing, administrative records, and other means. These data systems, and the analyses that result are designed to provide information useful to a variety of policy makers and researchers. NCHS frequently responds to requests for special analyses of data that have already been collected.
Program components include weight control and nutrition, exercise and fitness, and smoking cessation, offered in the church by trained lay leaders; interwoven with the spiritual life and activities of the church, such as prayer groups, sermons, testimony, choir practice, and meals.

The St. Louis University Prevention Research Center, another NCCDPHP-supported center, has collected and analyzed determinants of physical activity among 3,000 US women aged 40 to 75 years, including 600 each from the following subgroups: African-American, Asian/Pacific Islander, American Indian/Alaska Native, Hispanic, White, and low education (high school or less).

**DISABILITY PREVENTION AND HEALTH PROMOTION**

NCCDPHP is collaborating with the AARP, the American College of Sports Medicine, the American Geriatrics Society, the National Institute on Aging, and The Robert Wood Johnson Foundation to create a "National Plan to Increase Physical Activity Among Adults Aged 50 and Older." These partners hosted the "Blueprint Conference" on physical activity promotion in Washington, DC on October 30–31, 2000.

NCCDPHP funds the Center for Health Promotion in Older Adults at the University of Washington at Seattle, School of Public Health to promote health among men and women aged 65 years or older. The Center evaluates the presence of social networks and the influence of healthy eating and physical activity on elderly residents of public housing units. The Center also focuses on reducing disability and falls in older adults through interventions to improve physical activity, nutrition, and home safety.

NCCDPHP is collaborating with the Administration on Aging (AOA) on a review of AOA's state and territorial aging agency health promotion programs.

NCCDPHP is collaborating with the Association of State and Territorial Chronic Disease Program Directors to document chronic disease prevention and control program activities within state and territorial health departments.

NCCDPHP released a monograph on quality of life and indicators of healthy days at the 15th National Conference on Chronic Disease Prevention and Control, November 29, 2000, in Washington, DC.

NCCDPHP's Office on Smoking and Health provides web-based educational materials for people who want to quit smoking and for clinicians who want to help them. For older adults, quitting smoking is one of the most important health actions they can take. Materials include:

- **You Can Quit Smoking**
- **Don't Let Another Year Go Up In Smoke: Quit Tips**
- **Treating Tobacco Use and Dependence: A Clinical Practice Guideline, Public Health Service**

NCCDPHP is studying the cost-effectiveness of different interventions designed to prevent osteoporosis in women who are perimenopausal or postmenopausal.

The Health Promotion and Education Database and Cancer Prevention and Control Database contain aging-related health information useful for health care providers and program planners in
tive and sustainable programs that will eliminate the health disparities of racial and ethnic minorities. These demonstrations require collaboration of both program and research experts for the purpose of identifying and/or developing successful community-based disease prevention and health promotion models that can be replicated for the ultimate goal of eliminating health disparities among racial and ethnic minorities. In Phase I, REACH communities are granted 12 months to develop a Community Action Plan (CAP). Phase II communities are granted four additional years of funding to implement and evaluate the CAP. Thirty-two community coalitions were funded in FY1999. The California Endowment contributed funding to support three additional organizations in the state of California identified through CDC's competitive process. In FY2000, 24 Phase II and 14 new Phase I communities were funded.

Through an inter-agency agreement, NCCDPHP provided $1 million to the Administration on Aging (AoA) to fund four demonstration projects focusing on health disparities among older racial and ethnic minority populations. In addition to the four projects funded directly by the AoA, other REACH 2010 communities include activities that impact aging populations as well. Elderly-specific projects were:

- Boston Public Health Commission was funded to address cardiovascular disease (CVD), diabetes, and immunization in elderly African American communities.
- The Latino Education Project, Inc. was funded to address CVD and late-stage diabetes among rural and urban elders of Hispanic decent.
- Special Services for Groups, Inc. was funded to lead six community coalitions to address CVH, diabetes, and immunization disparities among individuals of Southeast Asian decent.
- National Indian Council on Aging, Inc. was funded to lead a community coalition focused on Indian and Alaska native elders in nine states.

NCCDPHP funding will support Phase I of demonstration projects. These projects serve as the foundation for Phase II projects. The AoA is responsible for funding Phase II of REACH 2010 contingent upon availability of funds.

Cardiovascular disease (CVD) continues to be the leading cause of death in the United States for women. African-American women are at particular risk, with coronary heart disease (CHD) and mortality rates 35.3 percent higher and stroke rates 71.4 percent higher than for white women. Low socioeconomic status (SES) is also associated with higher CVD incidence and mortality. NCCDPHP is collaborating with the University of Alabama at Birmingham Prevention Research Center to produce the "Women’s Wellness Sourcebook Module III Heart Disease and Stroke". The Sourcebook is a culturally-appropriate training curriculum designed to promote CVD prevention among low SES minority women by teaching Community Health Advisors (CHAs) to conduct risk-reduction counseling.

The Johns Hopkins University Prevention Research Center, in partnership with the NCCDPHP, is exploring how church-based programs in Baltimore can help prevent or control chronic diseases.
In the United States, 30,000 new cases of oral and pharyngeal cancer will be diagnosed this year, and more than 8,000 people will die of these largely preventable cancers. About 1 in 3 adults has untreated tooth decay and 25 percent of adults older than 65 years have lost all of their teeth. Only about half of people with diagnosed oral or pharyngeal cancer survive more than 5 years; among African American men, only about a third survive. People who do survive are at increased risk of developing additional cancers and frequently have the physical and psychological scars of what is one of the most disfiguring of all cancers.

CDC is working with a consortium of public- and private-sector organizations to develop a national program to prevent oral and pharyngeal cancers and to promote early detection and treatment, which can improve long-term survival. With its partners, CDC is also working to promote cessation of tobacco use, which especially when combined with heavy alcohol use is the major risk factor for more than 75 percent of oral and pharyngeal cancers in the United States.

CDC is also working to
- Enhance surveillance of oral diseases using state- and community-based data
- Support water fluoridation through surveillance, training, and quality assurance
- Influence oral health policy and practice by developing and distributing guidelines based on sound science, e.g., infection control, fluoride use
- Develop a national alliance of partners to prevent and control oral cancer
- Train dental and public health professionals through residency and fellowship programs

ELIMINATION OF HEALTH DISPARITIES

Chronic diseases disproportionately affect racial and ethnic minority populations in the U.S. The leading causes of death and disability (such as cardiovascular disease) are dramatically higher among these populations. Rates of death from stroke are 60 percent higher among African Americans than among whites. The prevalence in diabetes is higher among every racial and ethnic minority compared to whites of similar age. Among persons 65 years of age or older with one or more physician visits in the past year, influenza and pneumococcal vaccination levels among African Americans and Hispanics are substantially lower than those of whites. Death rates due to cancers, such as prostate and breast, are often higher among minorities as well.

NCCDPHP administers the Racial and Ethnic Approaches to Community Health Program (REACH 2010), a major part of the President's Initiative on Race. The goal of this program is to eliminate disparities in health status experienced by racial minority and ethnic populations in key health areas (including cardiovascular disease, diabetes, and immunizations) by the year 2010. REACH demonstration projects are two-phase projects through which communities mobilize and organize their resources in support of effec-
• Funding 5–6 additional states to implement CVD prevention and control programs with environmental interventions and policy strategies.
• Assisting states to better measure the burden of CVD, monitor progress in reducing risk behaviors, and determine the economic cost of the disease.
• Funding state programs and research that address racial and ethnic disparities in CVD.
• Enhancing CDC's National Standards Laboratory to improve state laboratory capacity and tailor screening procedures for youth, elderly and minority populations.

While strategies for preventing CVD (lipid management, hypertension control, diabetes awareness, smoking cessation, dietary modification, and physical activity behavior) exist, more efficient and practical methods for reaching low-income women and making prevention services available to them are needed. The NCCDPHP is collaborating with the University of North Carolina Prevention Center to produce a monograph that describes appropriate research and programmatic methods and protocols for integrating cardiovascular disease screening, intervention, and evaluation programs aimed at financially disadvantaged women. This monograph will include recommendations for laboratory tests, clinical measurements, interviews and surveys, field procedures, program tracking systems, and analytic plans. It will include practical examples of how to integrate CVD screening and intervention into existing health service programs that come from the experience of the WISEWOMAN (Well Integrated Screening and Evaluation for Women) projects in North Carolina, Massachusetts, and Arizona. This monograph will be written as a practical guide for state and local health departments for use in designing and adapting their own integrated prevention programs.

DIABETES

The burden of diabetes is heavier among elderly Americans. More than 18 percent of adults over age 65 have diabetes. NCCDPHP funds diabetes control programs (DCP) in all 50 states, the District of Columbia, and eight U.S. affiliated island jurisdictions to effect changes and improvements in systems that care for and support people with diabetes. The primary goal of the DCPs is to improve access to affordable, high-quality diabetes care and services. Priority is on reaching high-risk and disproportionately burdened populations which include the aged. NCCDPHP provides resources and technical assistance to state-based diabetes control programs to:
• determine the size and nature of diabetes-related problems and why they exist,
• develop and evaluate new strategies for diabetes prevention,
• establish partnerships to prevent diabetes problems,
• increase awareness of diabetes prevention and control opportunities among the public, the health care and business communities, and people with diabetes, and
• improve access to quality diabetes care to prevent, detect, and treat diabetes complications.
HEALTH STATUS SURVEILLANCE

NCCDPHP conducts surveillance of the health status of the elderly. Projects include:
- the publication of "Surveillance for Selected Public Health Indicators Affecting Older Adults United States," Morbidity and Mortality Weekly Report, December 17, 1999;
- the assessment of the prevalence of electroconvulsive therapy on older adults by age, gender, and ethnicity;
- the assurance of complete, timely, and accurate cancer surveillance data at the state, regional, and national levels;
- the generation of national and state estimates of the prevalence and incidence of diabetes, the processes and outcomes of care, and the costs of care in the Medicare population;
- the use of several health-related quality-of-life measures in the state-based Behavioral Risk Factor Surveillance System (BRFSS) to track quality of life in the States; and
- determination of the feasibility of a Medicare claims-based surveillance system for possible adverse effects of folic acid food fortification among persons with vitamin B12 deficiency.

CANCER

More than 30 percent of deaths from breast cancer in women over age 50 are preventable through widespread use of mammography screening for early detection. The National Breast and Cervical Cancer Early Detection Program targets underserved women, including older women with low income, and women of racial and ethnic minority groups. NCCDPHP currently funds the 50 states, 4 U.S. territories, the District of Columbia, and 15 American Indian/Alaska Native organizations through this program.

NCCDPHP supports a project to generate information about attitudes towards prostate cancer screening and treatment. The project investigates (1) how quality of life is related to early detection and treatment; (2) whether screening for prostate cancer actually reduces mortality; and (3) the development of appropriate health messages for men and their families about prostate cancer screening and early detection.

NCCDPHP sponsors a program promoting the early detection of colorectal cancer. The objectives of the project are (1) to promote awareness and use of colorectal cancer screening among health care providers and the public, especially the older population; (2) to support research that promotes the inclusion of colorectal cancer screening in quality measures applied to managed care organizations; and (3) to support the development of standards for screening sigmoidoscopy.

CARDIOVASCULAR HEALTH

Recognizing the immense burden of CVD, in FY1998, Congress made available funding to initiate a national, state-based CVD prevention program, starting with eight states, and in FY1999 to expanded to eleven states. In FY2000, CDC will spend more than $25 million for the prevention and control of CVD and its disabling conditions. These activities include:
• widely disseminated the National Arthritis Action Plan—
A Public Health Strategy. This plan was released in November of 1998 and was developed under the leadership of CDC, the
Arthritis Foundation, and the Association of State and Territorial Health Officials. The plan proposes action in three major
areas: surveillance, epidemiology, and prevention research;
communication and education; and programs, policies, and sys-
tems. It is designed to encourage public health organizations,
arthritis organizations, and other interested organizations to
work together at the national, state, and local levels.
• analyzed the Arthritis Self-Help Course. This analysis
showed the course to be a cost-saving intervention from both
the societal and health care system perspectives.
• determined the prevalence of hip and knee osteoarthritis
among whites and blacks in Johnston County, NC, a rural,
southern county. The Johnston County Osteoarthritis Project is
beginning follow-up of 3200 Caucasian and African-American
residents of a rural North Carolina county to determine factors
associated with the development and progression of hip and
knee osteoarthritis—the leading causes of arthritis disability.

ALZHEIMER'S DISEASE

Chronic neurological diseases, conditions common among elderly,
causes high levels of morbidity, disability, family stress, and eco-
nomic burden. For example, the costs due to dementias were esti-
mated at $24–$48 billion in 1985, and will increase as the popu-
lation ages. However, the epidemiology of these conditions is poorly
understood. NCCDPHP is studying the epidemiology of Alzheimer’s
Disease to determine disease rates, risk factors, and prevention fac-
tors.

HEALTH CARE AND LONG-TERM CARE NEEDS

The WISEWOMAN (Well-Integrated Screening and Evaluation
for Women in Massachusetts, Arizona, and North Carolina) pro-
gram is funded by NCCDPHP to determine whether adding other
preventive services such as cardiovascular disease risk factor
screening and intervention to the National Breast and Cervical
Cancer Early Detection Program is effective in improving the
health status of uninsured women age 50 and older.

NCCDPHP conducted an assessment of long-term care needs
among older adults in the Indian Health Service Santa Fe Service
Unit, New Mexico. The objectives of the project were (1) to provide
estimates of the population of functionally dependent adults age 55
and over within the Santa Fe Service Unit (SFSU) and distinguish
clinically relevant subgroups; (2) to document the extent of inform-
al care provided by family members to elders with chronic care
needs; (3) to analyze the strengths and weaknesses of the current
formal long-term care service system within the SFSU to accommo-
date the needs of the target population.

NCCDPHP has initiated the EnPOWER project to improve pre-
vention services in older women in HMO's. The project aims to en-
hance and promote preventive health services for older women in
a managed care setting.
The Contribution of Changes in Medication Use to Improvements in Functioning among Older Adults

Philadelphia Geriatric Center

A possible explanation for the recently observed decline in the prevalence of disability in the U.S. elderly population is that better treatment of chronic diseases through medical procedures and pharmaceuticals has led to an improvement in functioning in the elderly population. Lending some credence to this hypothesis is research by Freedman and Martin (forthcoming in the American Journal of Public Health) that documents an increase in the prevalence of chronic health conditions such as arthritis, diabetes, stroke and heart disease during the same period that disability has fallen. They hypothesize that changes in the management of chronic disease—and changes in medication use in particular—have caused chronic health conditions to become less debilitating as their prevalence has increased.

This project supplements an existing National Institute on Aging. Under that grant, the role of changes in the use of medications in explaining aggregate changes in functioning in the U.S. population aged 51-61 will be examined. The data sets for the analyses are the first (1992) and fourth (1998) waves of the Health and Retirement Survey (HRS), which provide nationally representative cross-sections of the noninstitutionalized population in this age range.

Funding: Total Award $125,000 (FY00 $125,000)
End Date: September 30, 2001

CENTERS FOR DISEASE CONTROL AND PREVENTION

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) is involved in a wide array of chronic disease prevention and control activities on behalf of older Americans. NCCDPHP programs include musculoskeletal diseases (osteoarthritis, osteoporosis), cardiovascular health, Alzheimer's disease, urinary incontinence, the health care and long-term care needs of women and minorities, health status surveillance, physical activity promotion, disability prevention, diabetes management, cancer prevention and control, oral health, and the elimination of health disparities. Each is reviewed briefly below.

ARTHRITIS

Arthritis and other 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. To address the burden of arthritis, NCCDPHP:
the effects of the demonstration according to the varying characteristics of the consumers including age, disability, gender, family support, and other factors.

Funding: Total Award $1,902,794 (FY97 $350,000; FY98 $111,389; FY99 $250,000; FY00 $191,405)
End Date: September 30, 2004

Synthesis and Analysis of Medicare Hospice Benefits

Urban Institute

The rapid rise in Medicare hospice expenditures, particularly on behalf of nursing home residents, has drawn the attention of a wide variety of health policy makers and the Office of the Inspector General (OIG). In a recent study, the OIG recommended ways to modify how Medicare and Medicaid pays for hospice services. Most experts agree that, however, that a larger study is needed to examine key hospice trends nationally and in selected States. This current study will collect additional information on the Medicare hospice benefit, including trends in utilization and expenditures, who is covered, and in which care settings. This information will help inform health policy makers as they consider alternative hospice benefit and payment designs.

End Date: April 1, 2000
Funding: Total Award $234,970.04 (FY97 $174,980.60; FY98 $59,989.44)

Synthesis and Analysis of Medicare Post-Acute Care Benefits and Alternatives

Urban Institute

This two-part project synthesized what was known about: (a) coverage and payment policies for post-acute care (PAC); (b) predictors of PAC use and nonuse and of the type, amount, and duration of PAC use; (c) PAC utilization including characteristics of PAC patients, patterns of PAC utilization, and geographic distribution of providers; (d) Medicare expenditures during the course of PAC episodes; (e) outcomes of patients in and across PAC settings; and (f) State policies designed to maximize Medicare PAC coverage.

The first report, “Medicare's Post-Acute Care Benefits: Background, Trends, and Issues to be Faced”, provides background on post-acute care expenditures and utilization, and Medicare policy changes that have contributed to these trends; the supply and changes in distribution of post-acute care providers; beneficiary, provider, and market characteristics associated with differential post-acute care provider use; and issues that need to be addressed regarding Medicare post-acute care services.

The second report, “Interviews with Provider and Consumer Groups, and Researchers and Policy Analysts”, summarizes discussions with key stakeholders regarding issues with Medicare's skilled nursing facility, home health, rehabilitation and long-term care hospital benefits. Many comments were raised regarding the impact of the changes enacted in the Balanced Budget Act on these benefits.

Funding: Total Award $227,675.88 (FY97 $162,731; FY99 $64,944.88)
End Date: May 2000
and delivery systems that integrate primary, acute and long term care services under combined Medicare and Medicaid capitation payments based on functional status. The CCNs will enroll, over a five-year period, at least 10,000 Medicare-only and dually eligible beneficiaries who are 65 or older in Monroe County, New York. This population will include those residing in nursing facilities, the nursing home certifiable living in the community, and the unimpaired. This is a voluntary program for both Medicare and dually eligible beneficiaries. The approval is the first to combine the authority under Section 402 of the Social Security Amendments with the authority of Sections 1915(a) and 1915(c). The State will amend the (Medicaid) State Plan to include a new class of managed care organizations that will allow them to capitate Medicaid service costs with home and community-based services and to pay the CCNs one capitated payment for each Medicaid enrollee. The State will also apply a parallel 1915(c) waiver to support case management and invoke spousal impoverishment protection for nursing home certifiable enrollees living in the community. A limited chronic care benefit of up to $2,600 per year (and not to exceed a $6,000 lifetime maximum) will be available to all that join the CCNs as community-based unimpaired participants on enrollment. The DMS–1 assessment instrument, which is normally employed to assess nursing home certifiability in New York State, will be used to place enrollees who are nursing home certifiable in the community into one of the three rate cells based on level of impairment. An independent third party assessor will conduct initial and subsequent DMS–1 assessments, since the result of this assessment will be used for both care planning and rate cell determination.

Status: In progress.

Demonstration Project for Institutionalized Dually Eligible Persons

Prj #:99–C–90869/3
Start Date: 04/30/1999
End Date: 06/30/2000
Funding: $59,538
Vehicle: Cooperative Agreement
PI: Martin Wasserman, MD
Awardee: Maryland Department of Health and Mental Hygiene
PO: James Hawthorne

Description: This Cooperative Agreement provides the Maryland State Department of Health and Mental Hygiene (DHMH) with funds to purchase technical assistance and to support planning activities to develop two demonstration projects to assist persons with physical disabilities who are under age 65 to move from nursing facilities to community-based settings. The demonstrations would provide care coordination on a capitated basis and would emphasize consumer choice and direction. The demonstrations would depend on existing Medicare Managed Care Organizations (MCOs) to enroll eligible beneficiaries and to provide their medical care. The MCO’s would sub-contract with community based organizations, such as Centers for Independent Living, to assist participants in obtaining appropriate support services in the community and to facilitate coordination of these services and the beneficiaries medical care. DHMH has sub-contracted the developmental work for this
demonstration to the Center for Health Plan Development and Management (CHPDM) at the University of Maryland in Baltimore County.

Status: DHMH has subcontracted the developmental work for this demonstration to the Center for Health Plan Development and Management at the University of Maryland in Baltimore County. The project has hired staff to coordinate planning activities and has assembled a task force comprised of consumers, providers, and representatives from DHMH to guide the planning process. The project is on schedule for the projected completion date of June 30, 2000.

**Multi-state Dual Eligible Data Base and Analysis Development**

Prj #:500–95–0047/03  
Start Date: 09/30/1997  
End Date: 09/30/2001  
Funding: $2,135,418  
Vehicle: Task Order  
PI: Don Lara  
Awardee: Mathematica Policy Research, Inc.  
PO: William D. Clark  
Description: This project will use available Medicare/Medicaid-linked statewide data in 10–12 States to develop a uniform database that can be used by States and the Federal Government to improve the efficiency and effectiveness of the acute- and long-term-care services to persons eligible for both Medicare and Medicaid (dual eligible). It will also conduct analyses derived from these data to strengthen the ability to develop risk-adjusted payment methods and deepen the understanding of Medicare-Medicaid program interactions as they relate to access, costs and quality of service. Finally, it will recommend longer-range options that will improve the usefulness of the database for operational and policy purposes.

Status: The project is constructing a multistate dual eligible database and using these data for analyses.

**Case Studies of Managed Care Arrangements for Dual Eligible Beneficiaries**

Prj #:500–95–0048/08  
Start Date: 08/26/1999  
End Date: 02/25/2001  
Funding: $367,135  
Vehicle: Task Order  
PI: Edith Walsh  
Awardee: Health Economics Research, Inc.  
PO: William D. Clark  
Description: The purpose of this project is to obtain greater knowledge of the dynamics of Medicare and Medicaid coordination of eligibility, benefits, and services at the health plan level. It will provide preliminary identification of issues that the Health Care Financing Administration, States, health plan contractors and beneficiaries should prioritize and address. It will identify exemplary and routine approaches implemented by health plans for further consideration and potential adoption by others. This project examines health plans including their provider networks, care management activities and beneficiary experiences. It will identify exemplary and routine approaches implemented by health plans for
further consideration and potential adoption by others. In 1997, an estimated 6.7 million Medicare beneficiaries received some level of additional benefits through Medicaid buy-in at some point during the year. These dual eligible beneficiaries are estimated to represent 17 percent of all Medicare beneficiaries in 1997, and are estimated to account for at least 28 percent of total Medicare expenditures. For Medicaid, enrollment and expenditure experience is strikingly similar. Dual eligible beneficiaries are estimated to represent 19 percent of total enrollment and 35 percent of Medicaid expenditures, of which 57 percent is Federal match to States. The growing importance of the dually eligible population is magnified by the fact that the population of Americans over 80+, those most likely to become dually eligible due to frailty and impairment, is expected to grow by 100 percent for men and 50 percent for women by the year 2025. Beneficiaries dually entitled for Medicare and Medicaid obtain health insurance coverage from these programs in many combinations. They may be entirely in traditional fee-for-service, Medicare+Choice risk contract plans with Medicaid benefits in fee-for-service, Medicaid managed care arrangements of varying definitions with Medicare fee-for-service, or in combinations of Medicare and Medicaid contractual arrangements within the same health plan organization. Some Federal demonstration health plans more consciously attempt to integrate Medicare and Medicaid financing at the plan level. It is believed that, through improved contractual arrangements, additional efficiencies in the organization and delivery of services may lead to improved health plan performance. The combined financing is intended to facilitate the integration of medical care, hospitalization, and post-acute services with community and/or residential supportive services and other benefits, including prescription drugs. The availability of this array of options varies considerably in health plans across the United States. Even though total enrollment and costs for services used by dual eligible beneficiaries in Medicare and Medicaid represents a substantial figure, the bifurcation of responsibility for this population results in a consideration of dual eligibility as a subset of each program subject to the statutory requirements of each. Rarely has a lens been applied to program changes mandated in either program that considers the impact of changes in one program and resulting consequences on the other. The Balanced Budget Act changes in Medicare home health payment and consequences for State Medicaid illustrates this point. Similarly, research that illuminates dual eligible issues often is focused on either Medicare or Medicaid, but rarely both. There are many reasons for this including data incompatibility, source of funding, and primary purpose of the research. This task order is one of a number of efforts intended to apply a lens to dual eligible issues as the central point of focus. In this study the dynamics of Medicare and Medicaid interactions at the health plan level are to be investigated. Given the difficulty in seeking to change both Medicare and Medicaid programs by Statute or through demonstration and program waivers in order to improve service delivery systems for dual eligible beneficiaries, it is essential to develop a more complete understanding of the way these programs interact at the provider and beneficiary level. While it is important to determine ex-
emplary solutions to common problems that may have potential for replication by others, it is equally important to obtain a realistic portrait of the abilities and limitations of health plans in working with the Medicare and Medicaid programs to accomplish the facilitation, coordination, and integration of health and supportive services for dual eligible beneficiaries.

Status: The project is in the start-up phase.

Factors Associated with Low Mammography Rates among Elderly Blacks
Prj #: 20-P-90895/4
Start Date: 09/27/1998
End Date: 09/26/2000
Funding: $240,035
Vehicle: Grant
PI: Alma R. Jones
Awardee: Morehouse School of Medicine
PO: Richard Bragg

Description: The overall objective for the research is to provide information that will ultimately lead to reductions in breast cancer mortality among African American Medicare beneficiaries, 65 years old and older in Fulton County and DeKalb County, Georgia, by increasing the percentage of this population that is screened for breast cancer annually. The project will address the low mammography screening rates for African American, nonhealth-maintenance-organization Medicare beneficiaries in Fulton and DeKalb counties. The study will develop, field test, evaluate, and disseminate a model for identifying barriers to test breast cancer screening among various populations. The proposed study will build upon research previously performed by the breast cancer prevention research group at Morehouse. In this instance, a trial to increase the rate at which inner-city African American women of various ages obtain breast and cervical cancer screening was designed. Hence, the Principal Investigator wants to: Increase the knowledge of breast cancer and improve the attitude toward breast cancer screening. Increase the rate at which annual screening mammograms are secured in the study population.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

Health Promotion in the African American Community: A Computer-Based Nutrition Program
Prj #: 20-P-91120/6
Start Date: 09/25/2000
End Date: 09/24/2001
Funding: $120,754
Vehicle: Grant
PI: JoAnn Blake
Awardee: Prairie View A&M University
PO: Richard Bragg

Description: The purpose of the study is to investigate the effectiveness of a computer-based nutrition education program on the use of health promotion behaviors by African American adults in community settings as compared to traditional methods of instruction. An interactive multimedia computer program will be used to
teach nutrition to African American adults. A research team of faculty and nursing students will implement project activities. The investigators plan to validate the feasibility of computer based intervention strategies and materials that are designed to teach African American adults about nutrition in a community setting when compared to traditional methods of instruction. The project goals are: (1) to form collaborative partnerships within minority communities in need of health promotion focusing on nutrition, (2) to examine the difference in outcomes of health education using a computer based delivery method when compared to traditional methods, and (3) to determine the feasibility of using a computer-based education program to teach health promotion to African American adults in urban community settings. A study population of 200 individuals will be recruited from the community. A two group pretest (Nutrition Survey and Health Promotions Lifestyle Program (HPLP) behavior rating scale)—posttest design will be used. The software program will present information in a cultural relevant way that may be individualized to the subject. A panel of experts will review the program.

The experimental group will complete the pretest that consists of a questionnaire on nutrition and the Health Promotion Lifestyle Profile. The pretest instruments are designed to determine baseline knowledge and use of health promotion behaviors. After the baseline data is collected, the experimental group will complete a multi-media interactive computerized nutrition program developed by the investigators. Instruction on nutrition in the areas of need identified by the computer program will be provided. The control group will complete the baseline data collection process, receive printed information in the form of pamphlets and will be provided with group instruction on nutrition. The researchers will be available to assist with use of the computers and completion of the data collection instruments. A body mass index will be calculated for all participants and the posttest will be administered 3 months and 6 months after the start of the project. The applicant will develop and test the computer program before using it with the experimental group.

Status: Study is in development phase.

Increasing Breast Cancer Screening in African American Women: A Community Pilot Project

Prj #: 20–P–91123/4
Start Date: 09/25/2000
End Date: 09/24/2001
Funding: $124,990
Vehicle: Grant
PI: Margaret Hargreaves
Awardee: Meharry Medical College
PO: Richard Bragg

Description: The study seeks to determine the extent to which breast cancer screening can be increased among low income and elderly African-American women living in the Nashville area (more specifically, around the East Nashville Family Health Care Group Practice -ENC), using a combination of culturally appropriate strategic approaches that are implemented through a coordinated community effort. The main goal is to develop, implement, and evalu-
ate a culturally-sensitive multi-faceted pilot program that seeks to improve breast cancer screening knowledge (K), attitudes (A), and practices (P) in a high risk population of poor and elderly African American women. The specific objectives are: (1) to increase breast cancer knowledge (K) in the targeted risk groups by 20 percent above baseline; (2) to improve attitudes toward cancer screening (A) by at least 1 standard deviation above baseline values; (3) to increase the number of mammograms completed (P) among the targets risk groups by 20 percent above baseline rates; and (4) to improve the rate of early detection in the targeted risk groups by 20 percent above baseline levels. This 2 year project will involve a collaborative venture between Meharry's Cancer Control Research Unit, the East Nashville Family Health Care Group, the Community Coalition for Minority Health, the Middle Tennessee Breast and Cervical Cancer Screening Coalition, and other selected organizations and individuals in the East Nashville Community who have an interest in breast cancer prevention and control. The study has three phases: Phase 1: Planning, 1–6 months; Phase 2: Implementation, 7–22 months; and Phase 3: Evaluation, 9–24 months. Under Phase I four main activities are proposed to be conducted: These activities are: (1) Working with community organizations (becoming knowledgeable with how the East Nashville community is organized). (2) The development of an intervention program: (a) cluster profiling methodology, (b) social marketing methodology, and (c) stages of change methodology. (3) Training health educators for the project. (4) Baseline data collection KAP and barriers questionnaires administered. Random sample of at least 100 women selected from cluster profiles around the target area. Questionnaires will be administered by telephone.

Status: Project is underway.

Efficacy of a Culturally Sensitive Health Promotion Program To Improve Exercise and Dietary Behaviors in African American Elders with Hypertension

Prj #: 20–P–91130/7
Start Date: 09/25/2000
End Date: 09/24/2001
Funding: $98,838
Vehicle: Grant
PI: Lucille Davis
Awardee: Southern University and A&M College, School of Nursing
PO: Richard Bragg

Description: The project is to test the efficacy of a culturally sensitive health promotion program that seeks to improve exercise and diet, two behaviors important in controlling hypertension in African American elders with hypertension. The project will compare the impact of outcomes of: (1) knowledge, (2) efficacy expectations and outcomes (beliefs about performing exercise and dietary behaviors), and (3) stages of change on exercise and dietary behaviors of elders who participate in one of two versions of a health promotion program. One version would use a culturally sensitive health promotion videotape (HPV) and the other, a culturally sensitive health promotion self-care manual (HPM). These tools have already been developed under a previously funded project. The project will have
a quasi-experimental design to test the efficacy of using culturally sensitive videotapes and self care manuals as part of a health education program to improve hypertension knowledge, efficacy, stages of change, and exercise behaviors in African American elders with hypertension. The first year will be conducted in Baton Rouge, LA and the second year in Jackson, MS, under the coordination of the two participating universities. The intervention will be conducted at public housing complexes and involve resident coordinators who would serve as liaison between participants and researchers. In Louisiana, the study population will be drawn from 6 housing complexes involving approximately 700 units with a large proportion of older African Americans. In Mississippi, 498 units including 152 units exclusively for the elderly, and 346 units for multigenerational families will comprise the target population. The sample size will consist of 150 African Americans, 50 individuals in each of the 3 groups. Buildings will be randomized to one of the three groups. Recruitment will involve meeting with staff and residents in the designated buildings. Strategies to prevent attrition will include weekly classes. Group one will use the videotape as part of a lecture-discussion and skill building class. Elders will also be given a copy of the videotape and instructions on its use between classes. The control group will not receive the intervention.

Provisions and incentives are incorporated into the design to assure retention of subjects and to control for potential intervention variability across sites. For example, a small stipend will be paid for each interview. Inclusion criteria for participating in the study are explicit and appropriate to the goals and objectives of the study. Data will be collected at baseline and remeasured at 3 and 6 months on 9 variables.

Status: Project is in development

**A Population-Based Case Control Study of Ethnic Differences in the Utilization of Elective Hip or Knee Replacement Surgery for Arthritis**

Prj #: 25-P-90948/6
Start Date: 09/30/1998
End Date: 09/29/2000
Funding: $250,000
Vehicle: Grant
PI: Agustin Escalante
Awardee: University of Texas Health Science Center at San Antonio
PO: Richard Bragg

Description: This project examines the utilization of elective hip or knee replacements for arthritis among Hispanics and non-Hispanics in Bexar County, Texas. It directly assesses persons hospitalized for these procedures between February 1999 and January 2000. The objectives of the project are to: Compare ethnic background between persons hospitalized for elective arthritis-related hip/knee replacement surgery and persons hospitalized for other reasons. Examine the association between socioeconomic status and acculturation and the likelihood of recipients of hip/knee replacements being Hispanics compared to others. Measure age-adjusted
rates of elective replacement surgery. Investigate to what extent Bexar County residents who are Medicare and Medicaid beneficiaries undergo these elective procedures outside the county. First, a case-control study will be conducted comparing the ethnic background of recipients of an elective arthritis-related hip or knee replacement surgery against the ethnic background of age- and gender-matched controls hospitalized for other reasons. Second, population-based utilization rates will be developed for these elective procedures using census-derived demographic information as the denominator population. Finally, the completeness of these estimates will be assessed using Medicare and Medicaid claims data to measure the extent to which Bexar County residents selected these elective procedures in hospitals outside their county of residence.

Status: This project, which was awarded under the Hispanic Health Services Research Grant Program, is in progress.

Cervical and Breast Cancer Screening for Post-Reproductive Age Hispanic Women Residing Near the U.S.-Mexico Border
Prj #: 25-P-91062/9
Start Date: 09/20/1999
End Date: 09/19/2001
Funding: $263,281
Vehicle: Grant
PI: Francisco A.R. Garcia, MD, MPH
Awardee: University of Arizona, Arizona Board of Regents
PO: Richard Bragg

Description: The U.S.-Mexico border area in general and the Arizona (U.S.)-Sonora (Mexico) border area in particular has had a history of economic ties and the sharing of physical, economic ties, cultural, and health characteristics. The proposed study, which focuses on the border community of Douglass/Sulphur Springs Valley in Arizona, highlights the immense and unique health problems that plague the U.S.-Mexico border region. Some of the main contributing factors associated with the myriad of health problems in the region include: poverty, unavailability, and accessibility of preventive health and treatment services. Because there is a sparsity of research in the area that addresses the health of the population, as well as the dynamics associated with the etiology of prevalent diseases, there may very well be an underestimation of the incidence and prevalence of various diseases that seemingly disproportionately afflict the population. Of particular interest to the researchers is the preventive value of screening for cervical and breast cancers associated with Hispanic women who live in a border community (Douglass) on the U.S.-Mexico border. Reports suggest that breast and cervical cancers may be two to three times higher for Mexican Americans than for non-Hispanic whites.

The study proposes to address these problems by providing information on: (1) the prevalence of breast and cervical cancers, (b) barriers that affect access to and utilization of health care, including screening services; and (c) successful intervention strategies (involving health workers or promotoras) that increase participation in and sustained involvement with breast and cervical cancer screening services. To achieve this, the researchers propose to develop culturally competent health promotion activities that
will: (a) increase rates of routine breast and cervical disease screening, (b) promote disease prevention strategies, and (c) address the significant cultural and structural barriers faced by these women. This study will allow the researcher to address these problems by using a 2-year community-based cohort intervention study. Using data collected from a population-based cross-sectional survey involving 600 women who will be interviewed, the study seeks to gather information relating to utilization and barriers to utilization of breast and cervical cancer screening services. Following the completion of the interview, the interviewer will assist the participant in scheduling a clinic visit to have a variety of screening tests (e.g., pelvic examination, including a pap smear; telecolposcopy; sampling for HPV infection; and breast examination. Instruments or questionnaires to be used in the study will be built from previous or existing questionnaires associated with earlier and ongoing projects that the PI and his research team are associated with.

Status: In progress.

Understanding the Role of Culture in the Access and Utilization of Telemedicine Health Services Among Hispanic, Native Americans and White Non Hispanic Populations

Prj #: 25–P–91143/9
Start Date: 09/25/2000
End Date: 09/24/2001
Funding: $124,594
Vehicle: Grant
PI: Ana Maria Lopez
Awardee: University of Arizona Cancer Center
PO: Richard Bragg

Description: This project will provide a profile of telemedicine service utilization by Mexican American, Navajo and Non Hispanic white patients. The study focuses on the health needs of rural Arizona residents, including some who live near the U.S. border. These residents face geographic barriers (distance) and supply barriers (lack of specialty care) to access to care. These problems are compounded by environmental hazard along the U.S. border and the lack of economic opportunity in rural areas in Arizona. The applicant provided a clear and compelling Description: of these problems through the use of statistics and multiple academic citations on health care in Arizona. The objectives of the study are to: (1) identify if telemedicine increases or decreases the number of clinic encounters between patient and clinician at the same rate for Mexican American, Navajo, and non-Hispanic White populations, (2) examine if telemedicine alters the type or complexity of the clinical encounter at the same level for these populations, (3) assess if telemedicine affects the cost of providing clinical services for the management of chronic and/or rehabilitative conditions at the same amount for these populations, (4) examine if telemedicine affects patient compliance (e.g., taking medications as prescribed, doing exercise as instructed, etc) at the same level for these populations, (5) assess if minority patients perceive that cultural competency is an important factor in the delivery of telemedicine services such that it may impact utilization of these services, and (6) examine how telemedicine impacts the quality of life for these populations.
There are two goals that are offered for this study: (1) To provide a profile of telemedicine service utilization, and (2) to deepen and broaden the understanding of the role of culture in access and utilization of telemedicine health services. These goals will be achieved via the development and implementation of a patient satisfaction survey, a provider survey, and chart review. The project has access to a cohort of 200 patients stratified by location. This research is tracking individuals within an existing service project. The enrollment is constrained by the scope of current services. It is estimated that 50 participants will be studied at each of the four sites for a total of 200 individuals. The ethnic distributions are assumed to be as follows: the population of Springerville is 100 percent non Hispanic white, the population of Ganado is essentially 100 percent Navajo, and the populations of Douglass and Nogales are approximately 80 percent Mexican-American and 20 percent non Hispanic white. These population distributions result in an expectation for enrollment Mexican-Americans, 70 non Hispanic whites, and 50 Navajo. The first three objectives will be evaluated from direct patient chart review and assessment of the discharge and billing code data. The compliance objective will be assessed using a simple survey technique. The final two objectives will be assessed via patient surveys. These surveys are based on an existing self-administered questionnaire that serves to measure patient satisfaction with telemedicine services in terms of quality of care.

Status: Project is in development phase.

A Systematic Approach to Improving Pap Smear Screening Rates Among Hispanics/Latinas

Prj #: 25–P–91150/9
Start Date: 09/25/2000
End Date: 09/24/2001
Funding: $124,450
Vehicle: Grant
PI: Helda L. Pinzon-Perez/Vera Kennedy
Awardee: California State University, Fresno Foundation, College of Health and Human Services, Grants and Research
PO: Richard Bragg

Description: This project will identify barriers to Pap smear screening facing Hispanic/Latina women within a Medicaid managed care system. The American Cancer Society (ACS) criteria for Pap smear screening will be used: testing with the onset of sexual activity and repeat pap smears every 1–3 years at the physician’s discretion. Hispanic/Latina populations are the ethnic groups with the highest incidence of cervical cancer, and it is increasing. Cervical cancer rates in the San Joaquin Valley are 10.6 new cases and 3.3 deaths per 100,000 women, i.e., 10 percent and 50 percent higher, respectively, than the state as a whole. A major reason for these high rates is under-utilization of Pap smear screening. The goals of this project are: to identify the alterable barriers to Pap smear screening facing Hispanic/Latina women within a Medicaid managed care system; to measure the proportion of Latina women within a Medicaid managed care system who are screened for cervical cancer; and to design a comprehensive community-based outreach and health education intervention strategy to improve the cervical cancer screening rates among the Hispanic/Latina popu-
lation. The results from this study will be used in the training of medical residents at the University of California San Francisco in Fresno and it will be shared and disseminated to other health care providers, which will enhance the ability of service providers to provide culturally competent training and services as well. The study will focus on the major aspects of care affecting Pap smear screening. The participants will be recruited from 4 large community health centers (urban vs. rural) that serve predominately Hispanics in the Central Valley and the Blue Cross Managed MediC-aid system. The study design involves structured interviews (covering the above aspects of care) with a random sample of 300 with 100 from each of three groups of women: (1) seen by a physician + Pap smear within 3 years, (2) seen by a physician + No Pap smear within 3 years, and (3) Not seen by a physician + No Pap smear within 3 years. A pilot study will be done with 30 women. A comprehensive community-based outreach and health education intervention strategy and prevention program will be compared (involving strategies such as call and recall system with incentives, “Consejeras” community health workers, mailed reminders, discussion groups in native language, use of female providers and interpreters, provision of transportation, etc.) to improve pap screening rates among the target group of Hispanic women.

Status: Project is in development phase.

**MassHealth: Senior Care Options Medicare Enrollment Broker**

Prj #: 500-00-0038
Start Date: 09/28/2000
End Date: 09/28/2001
Funding: $170,289
Vehicle: Contract
PI: Marion E. Reitz
Awardee: Maximus, Inc.
PO: William D. Clark

Description: This project involves demonstration-specific design development in Phase I. If awarded Phase II, the project will provide operational support for features being implemented in the MassHealth: Senior Care Options research/demonstration initiative sponsored by the Health Care Financing Administration (HCFA) and the Massachusetts Division of Medical Assistance (DMA). The Phase I consists of a developmental design phase culminating in the preparation of an Enrollment Broker Operations Protocol and the performance of operational system pilot tests. Phase II will implement the operational support activities. A decision to award Phase II is to be based on the feasibility of the proposed enrollment broker operational activities as described in the Enrollment Broker Protocol and the readiness of the contractor to perform such activities. Award of Phase II also is to be determined by the separate approval by HCFA and DMA of MassHealth: Senior Care.

Status: Project is in development phase.

**Readmission and Access**

Prj #: 30-P-91022/7
Start Date: 01/10/1999
End Date: 01/09/2000
Funding: $21,600
Vehicle: Grant  
PI: Cindy Hornberger  
Awardee: University of Kansas Medical Center  
PO: Carl Hackerman  

Description: The primary aim of this study is to determine the relationship between access to health services and heart failure outcomes among Kansans aged 65 years and older who were discharged with DRG 127 during 1995. Heart failure is the only major cardiovascular disorder that is increasing in incidence and prevalence as the population ages. Heart failure is the most common diagnosis related grouping billed to Medicare. A significant portion of these costs are due to repeated readmissions. Readmission rates for heart failure within the first 14 days to 1-year range from 12.5 to 47.5 percent. Readmission frequency and mortality are related to access, which includes (a) availability of services, such as distance to health care services, (b) individual and community social determinants of well being, such as income and educational levels, and (c) actual utilization of health services. The project will use Individual-level and ecological-level analyses to examine the relationships between the dependent variables of readmission rate and mortality, and the independent access variables using merged data sets. The access variables will include the availability of emergency and/or community hospitals, emergency transportation, specialty and/or primary care providers; the number of home health care visits; and county-level social determinants. The Medicare data come from the Kansas and Missouri peer review organizations. Other data sources include the Area Resource File; Kansas Kids Coalition, Inc.; the Kansas Hospital Association; and the Kansas Health Institute. Validity concerns regarding readmission rates, as an unbiased indicator of disease severity will be addressed. Statistical methods will include descriptive statistics, correlational studies, analyses of variance, and linear regression techniques.  

Status: In progress.  

Home Care Services: The Effect of Unmet Need on Health Care Utilization  
Prj #: 30-P-91010/9  
Start Date: 01/10/1999  
End Date: 01/09/2000  
Funding: $21,600  
Vehicle: Grant  
PI: Lisa G. Matras-Schmidt  
Awardee: University of California, Department of Health Services  
PO: Carl Hackerman  

Description: The main objective of this study is to examine how the need for home care services and the service delivery mechanism itself affect the use of health care services among a population of Medicare-eligible elderly and disabled persons receiving home care. Home care is one of the fastest growing components of personal health expenditures. However, among persons receiving home care, there is still a considerable amount of unmet need—either a lack of, or insufficient help with, activities of daily living and instrumental activities of daily living. Moreover, different models of service delivery have been developed to provide home care. Both of
these factors, unmet need and service delivery mechanism, can have significant impacts on costs of home care, as well as quality of life for home care recipients. However, the effect of these factors on the utilization of health services has not been included in past studies of home care programs. This research addresses the following: (1) Do persons with more unmet home care personal assistance needs utilize more health services than those with fewer unmet personal assistance needs and (2) Does the service delivery method of home care (client self-directed versus home care agency model) affect health care utilization? Data come from two sources which will be linked together, (1) a survey of individuals receiving home care services through the California In-Home Supportive Services program and (2) Medicare claims data. Multiple regression analysis will be utilized to examine the effects of service delivery mechanism and unmet personal assistance needs on use of health services. In addition, a stratified analysis based on level of disability will be done in order to determine if the effects vary by degree of disability.

Status: In progress.

Customer Utilization of Prescription Drugs

Prj #: 30-P-91007/5
Start Date: 01/10/1999
End Date: 01/09/2000
Funding: $19,171
Vehicle: Grant
PI: Julie M. Ganther
Awardee: University of Wisconsin—Madison, School of Pharmacy
PO: Carl Hackerman

Description: The main objectives of this study are to: (1) examine the effect of insurance on prescription drug utilization, (2) examine the effect of medical care preferences on prescription drug utilization, and (3) explore the interaction between medical care preferences and insurance coverage. The expansion of insurance coverage for prescription drugs may be one factor in the large growth in prescription drug expenditures over the past two decades. However, consumer preferences for treating health problems also may affect prescription drug utilization. Some consumers prefer to see a doctor and/or take a prescription drug almost any time they have a health problem while other consumers prefer to self-treat most health problems. In addition to directly affecting prescription drug utilization, these preferences may influence the effect of insurance coverage on prescription drug utilization. For example, it is unlikely that consumers who prefer to avoid using prescription drugs would increase their utilization dramatically just because they had insurance coverage. Data will be collected via mail survey from a random sample of Wisconsin consumers age 50 and over. A two-part econometric model will be used to examine whether health insurance coverage and medical care preferences effect the number of prescriptions and the cost of prescriptions used in a 30 day reference period. Medical care preferences will be measured using a 10-item scale. In order to account for possible selection bias in insurance choice, consumers will be asked to report the source of their prescription drug insurance. The analysis will be done separately for the respondents who received their insurance
from a large employer. These insurance coefficients will be compared to the insurance coefficients for the entire sample to determine the magnitude of the selection bias.

Status: In progress.

*Factors of and Variations in Hospitalization Rates among Elderly Nursing Home Residents: Searching for Indicators of Appropriate Levels of Acute Care*

Prj #: 30–P–91009/1  
Start Date: 01/10/1999  
End Date: 01/09/2000  
Funding: $21,561  
Vehicle: Grant  
PI: Mary Ellen Whelan  
Awardee: University of Massachusetts-Boston  
PO: Carl Hackerman  

Description: This project aims to further the understanding of the interface between nursing homes and hospitals. It will closely examine one aspect of this care continuum, hospitalization among nursing home residents. The project involves an empirical investigation of the relative explanatory contribution of individual patient risk factors, facility-level structural factors and area market health delivery factors in explaining variations in hospital utilization rates among dually-eligible, nursing home residents in the state of Massachusetts. Using longitudinal data, all hospitalizations will be analyzed via multivariate regression techniques to help disentangle the influence of practice style differences from medical needs among nursing homes and to determine whether variations in transfer rates are associated with high (low) discretionary and/or certain ambulatory care sensitive conditions. In an attempt to curb burgeoning Medicaid expenditures associated with nursing home care, various state Medicaid cost containment strategies for nursing homes have been implemented. By and large, the payment policies enacted reflect prospective rate setting methodologies, meaning that Medicaid reimbursement to nursing homes is based on a capitated system, often with case-mix adjustment allowances, rather than an individual based or flat-rate cost strategy. Although research suggests that these changes in Medicaid reimbursement polices succeeded in improving access to nursing homes for certain heavy-care residents, policy concerns remain regarding the overall effects of these payment systems on health care accessibility.

Status: In progress.

*Effect of Competition on Quality of Medicare*

Prj #: 30–P–91016/5  
Start Date: 01/10/1999  
End Date: 01/09/2000  
Funding: $21,596  
Vehicle: Grant  
PI: Tiffany Radcliff  
Awardee: University of Minnesota  
PO: Carl Hackerman  

Description: This research examines the relationship between market structure and quality of care using data that defines quality with conformity to accepted clinical practice guidelines. This
project explores the role of competition in the provision of appropriate care once patients are admitted to hospitals with acute myocardial infarction.

Price regulation within the U.S. health system is increasing. For example, during the 1980s the Health Care Financing Administration implemented the Prospective Payment System with predetermined and fixed hospital payment rates based on diagnosis codes. Movement from cost-based payment to external price regulation for health services has consequences. What happens to quality of care across different types of competitive environments when the price of health services is fixed by external regulation? Descriptive statistics and multivariate regression are used to test the following research hypotheses: 1. Under price regulation, quality of care will increase with the level of market competition. 2. Other factors, including whether the market is rural, will affect quality of care. Quality of care for urban residents will be higher than for rural residents. In this work the sample includes the majority of Medicare patients hospitalized with acute myocardial infarction during 1994–95. The quality indicators were abstracted from inpatient medical charts by Peer Review Organizations as part of the Health Care Financing Administration's Cooperative Cardiovascular Project. Competition will be measured using various definitions of market areas and measures of market competition.

Status: In progress.

Post Acute Care Use and Early Hospital Readmission of Hospitalized Elderly Medicare Patients

Prj #: 30–P–91018/5
Start Date: 01/10/1999
End Date: 01/09/2000
Funding: $21,596
Vehicle: Grant
PI: Wen-Chieh Lin
Awardee: University of Minnesota
PO: Carl Hackerman

Description: The objective of this project is to investigate the variation in hospital discharge location and subsequent early hospital readmission attributable to patient, hospital, and market area characteristics for elderly Medicare patients. The Balanced Budget Act of 1997 (BBA) expanded the prospective payment system to post-acute care. The BBA also expanded the definition of transfer cases by treating discharge to post-acute care as hospital transfers (for selected Diagnostic Reimbursement Groups.) These expansions are likely to result in new patterns of post-acute care choice and utilization. Understanding the attributable variations of will provide information for reforming post-acute care services and policy options for bundling post-acute care payments in the future. The specific aims for this study are: (1) investigate patient, hospital, and market factors affecting hospital discharge location (a two-level [patient and hospital] hierarchical model will be established to investigate the variation in the probability of receiving a specific type of post-acute care for patients (a) within hospital-market and then (b) across hospital-market. The hospital and market area [county] characteristics are attached to the hospital.) (2) To investigate quality of care using early hospital readmission as the indicator
(the similar structure of the two-level hierarchical model will be used to investigate this issue by including the post-acute care choice in the model.)

Status: In progress.

*Improving Health Outcomes Using New Psychosocial Screens*

Prj #: 30–P–91025/2
Start Date: 01/10/1999
End Date: 01/09/2000
Funding: $21,595
Vehicle: Grant
PI: Deborah N. Peikes
Awardee: Princeton University
PO: Carl Hackerman

Description: This study addresses a central challenge faced by the Medicare program, to control costs by reducing the demand for health services. This study characterizes critical sociodemographic, psychological, and social factors, which place people at risk for later illness so that appropriate interventions can be made to reduce those risks. It will identify key protective factors that contribute to the maintenance of long term health information critical to increasing the number of disability-free years enjoyed by the population. The project uses the Wisconsin Longitudinal Survey (WLS), an extensive set of longitudinal data collected on roughly 10,000 Wisconsin high school graduates born in 1939. This cohort precedes the bulk of the baby boom generation by about a decade. The "boomers" are expected to tax the Medicare system in the coming years.

Hence lessons gained from this sample can be used to target preventive efforts to reduce the amount of ill health faced by the younger baby boomers, and, in the process, lower Medicare expenditures. The project will isolate constellations of factors in the Wisconsin respondents' life histories, which predict health outcomes in later life. To do so, it will construct life histories which incorporate extensive survey information about adversity and advantage across multiple domains, occurring throughout life (e.g., early background and starting resources, educational and occupational attainment, job conditions, marriage and parenting, social support and participation in voluntary organizations). The integration of these multiple domains, organized around the person as the unit of analysis, constitutes a novel approach to explicating later life health status. It will then apply Boolean-logic analytic methodology to isolate key factors affecting health outcomes and utilization patterns.

Status: In progress.

*Economic Impact of Outpatient Prescription Drug coverage on Total and Specific Health Expenditures and Service Use of Medicare Beneficiaries*

Prj #: 30–P–91017/5
Start Date: 01/10/1999
End Date: 01/09/2000
Funding: $21,579
Vehicle: Grant
PI: Margaret Artz
Awardee: University of Minnesota
PO: Carl Hackerman
Description: This research investigates the economic impact of outpatient prescription drug coverage for Medicare beneficiaries in terms of health care expenditure and service use. Prescription medications play a significant role in the health care regimens of the elderly and represent a significant portion of their out-of-pocket health care expenses. Medicare does not cover outpatient prescription drugs, yet little more than half of Medicare beneficiaries who purchase a supplemental insurance policy choose one with a prescription drug benefit. Specifically, this research will determine if those elderly possessing Medicare supplemental insurance with prescription coverage have lower total and specific health care expenditures and/or specific health care use compared to elderly possessing either Medicare supplemental insurance without prescription coverage or Medicare alone. Estimation of per capita differences in annual expenditures and service use will also be calculated. Generosity of the outpatient prescription drug coverage in terms of cost sharing is figured to play an important role in the expenditures spent and/or service used by the elderly.

Status: In progress.

*Nursing Home Quality of Care: Time, Competition and Demand*
Prj #: 30-P–30238/4
Start Date: 01/03/2000
End Date: 01/02/2001
Funding: $30,669
Vehicle: Grant
PI: Virender Kumar
Awardee: University of North Carolina at Chapel Hill, Office of Research Services, for Department of Health Policy and Administration
PO: Carl Hackerman

Description: The project assesses how competition and its influence on the chronic health care market, and the OBRA 87 regulations affect the quality of nursing home care. Variation in competition over a twelve year time period and variation across the country will be used to identify how competition affects quality. Measures of quality will be health outcomes of individuals assessed through claims data. Three waves of the National Long-Term Care Survey will be used as a basis to identify individuals admitted to a nursing home for the study sample. The analysis will use simultaneous equation methods to derive consistent estimates of the Medicaid reimbursement rate, competition, and OBRA 87 effects on quality and accessibility of nursing home care. In this time of concerns about limited funds and the quality of nursing home care and accessibility to care for Medicaid beneficiaries, the topic is of great interest.

Status: In progress.

*Access to Medicare Home Health Care in the Wake of the Balanced Budget Act*
Prj #: 30-P–30245/3
Start Date: 01/03/2000
End Date: 01/02/2001
Funding: $32,390
Vehicle: Grant
PI: Joan F Davitt
Awardee: Bryn Mawr College, Graduate School of Social Work and Social Research

PO: Carl Hackerman

Description: Recent changes to the Medicare home health benefit have altered the way that home health care agencies will be reimbursed. It has been estimated that the new reimbursement system, referred to as the Interim Payment System, will reduce agency revenues by 15–22 percent. Such reductions may encourage agencies to alter the amount, duration or type of benefits provided to certain types of home health care patients. This study will investigate whether certain types of patients are experiencing reductions in access to care or in service receipt including: (1) not being admitted to home health services; (2) being discharged early; (3) receiving less services; or (4) receiving less expensive services. This study consists of a secondary analysis of data from the Medicare Current Beneficiary Survey (MCBS) Access to Care, Public Use File and HCFA claims files for the years 1996 and 1998. These will comprise the primary data sources for this study. The researcher will also obtain the Provider of Services Extract File from the OSCAR data base. The researcher will also conduct qualitative interviews with home health agency staff in an attempt to enhance the depth of understanding of these issues.

Statistical analyses will allow the researcher to: determine whether this particular policy change is affecting access to care; to test hypotheses regarding utilization patterns; to understand which factors (such as patient characteristics, agency characteristics, and supply-side factors) are more predictive of specific utilization patterns; and to understand the explanatory power of sets of independent variables. Qualitative interview data will allow the researcher to understand agency practices post-IPS, providing greater sensitivity to contextual elements and provider perspectives. These interviews will also be used to check for validity in the interpretation of quantitative data and to identify provider practices that may not be reflected in the claims files. Information from this study will be shared with policy makers and home health agency providers and may be utilized to improve the design of the prospective payment system or to design necessary clinical criteria for reimbursement limit exemptions in home health care.

Status: In progress.

Outcomes and Reimbursement of Stroke and Hip Fracture Rehabilitation

Prj #: 30-P-30247/2
Start Date: 01/03/2000
End Date: 01/02/2001
Funding: $32,400
Vehicle: Grant
PI: Anne Deutsch

Awardee: State University of New York at Buffalo, Sponsored Programs Administration, for School of Nursing

PO: Carl Hackerman

Description: Inpatient rehabilitation services for Medicare beneficiaries may be delivered in either rehabilitation hospitals/units or in skilled nursing facilities (SNF) and the distinctions between services provided in these 2 settings has narrowed in recent years.
Given the differences in costs, it is of interest to compare functional outcomes of beneficiaries who have received rehabilitation services in comprehensive versus SNF-based settings after experiencing a hip fracture or stroke. The study sample will include Medicare beneficiaries who recently experienced a hip fracture or a stroke and were discharged from either a rehabilitation hospital/unit or a SNF that subscribed to the Uniform Data System for Medical Rehabilitation. This data system includes both admission and discharge measurements of functional status. The study will compare ability to perform motor functions, Medicare reimbursement data, rehabilitation length of stay; and total length of stay between beneficiaries in the 2 settings while adjusting for admission functional ability, age, co-morbid conditions, and a number of other demographic, diagnosis-related, and health system related variables.

Status: In progress.
Healthy Aging Project
Prj #: 500-98-0281
Period: 10/30/1998–9/29/03
Funding: $3.7 million
Award: Cost reimbursement contract
PI: Larry Rubenstein, M.D.
Awardee: RAND, 1700 Main Street, Santa Monica, CA 90401
PO: Pauline Lapin, Office of Clinical Standards and Quality
Description: A key challenge to the health care system will be to determine how to prevent or slow the progression of disability in the senior population. There will be a total of 76 million seniors living in the United States in 2030—a dramatic increase from the 35 million today. This population surge will substantially increase the demand for health care by older people, who experience much higher rates of morbidity and mortality than younger people. The Health Care Financing Administration (HCFA) developed the Healthy Aging Project to identify, test and disseminate evidence-based approaches to promote health and prevent functional decline in older adults. HCFA awarded RAND a five-year contract to produce reports synthesizing the evidence on how to improve the delivery of Medicare clinical preventive and screening benefits. RAND is also exploring how behavioral risk factor reduction interventions, such as smoking cessation, might be incorporated into Medicare.

The first evidence report, Interventions that Increase the Utilization of Medicare-funded Preventive Services for Persons Aged 65 and Older, is an important guide for providers and health care systems seeking to improve the use of influenza immunizations, pneumococcal vaccinations, mammography, Pap tests and colon cancer screening. A key finding from this report is that organizational changes are effective in improving the delivery of preventive services. Standing orders are a type of organizational change that allow appropriate non-physician staff to offer services, usually vaccinations, without an individual physician prescription. HCFA and the Centers for Disease Control and Prevention (CDC) are collaborating on a demonstration project to implement standing orders to increase influenza immunization rates in all of the nursing homes located in nine states. Medicare's quality improvement contractors,
the peer review organizations or PROs, are working on this initiative.

Another demonstration being conducted under the Healthy Aging Project tests the feasibility of implementing a smoking cessation benefit in Medicare. Three benefit options, including telephone counseling, are being compared to assess their effectiveness in promoting smoking cessation. HCFA commissioned an evidence report on smoking cessation, and this demonstration is based on that report and the U.S. Public Health Service clinical practice guideline on smoking cessation.

HCFA is interested in comprehensive and systematic approaches to health promotion, which address both clinical prevention and behavioral risk factor reduction. Health risk appraisals with tailored feedback and follow-up are a promising tool for doing just that. HCFA has commissioned an evidence report on health risk appraisals, as well as chronic disease self-management, physical activity and falls prevention. RAND is synthesizing the evidence on these strategies and addressing the Medicare program and policy implications involved in testing them in Medicare demonstrations in its reports.

HCFA coordinated the development of the Healthy Aging Project with the Agency for Healthcare Research and Quality (AHRQ). This project was designed to complement other Departmental initiatives, such as Healthy People 2010, and the U.S. Preventive Services Task Force. HCFA is conducting the Healthy Aging Project in collaboration with the AHRQ, the CDC, the Administration on Aging, and the National Institutes of Health.

Status: Two evidence reports are currently available—Interventions that Increase the Utilization of Medicare-funded Preventive Services for Persons Aged 65 and Older and Interventions to Promote Smoking Cessation in the Medicare Population. A pilot project testing the implementation of standing order interventions in nursing homes is being conducted in nine states. A demonstration to test the feasibility of implementing a Medicare benefit for smoking cessation will be conducted in seven states. Final revisions are being made to the evidence report on health risk appraisals and targeted interventions; this report should be available in the next few months. Reports on chronic disease self-management, physical activity and falls prevention are currently in various stages of the evidence review process.

NATIONAL INSTITUTES OF HEALTH

Older Americans are generally better off healthier and wealthier than ever before. A combination of factors, including the translation of critical research advances into prevention and treatment strategies and the advent of health and social welfare programs, have dramatically improved the quality of life for older people. Average life expectancy in the United States has at least doubled over the past century, from an average of 49 years in 1900 to age 76 at the turn of the century. The rate of disability among people age 85 and older substantially declined from the 1980s through the

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mid-1990s, and currently a majority of people age 65 and older rate their health as good or excellent. Programs such as Social Security and Medicare have improved the fiscal well-being of older people in the United States, enabling many individuals to enjoy a healthy and active retirement.

Although the news is promising, good health is far from a universal reality for older Americans. The latest national surveys indicate that about one-fifth of people age 65 and older, more than 7 million people, report some disability. Chronic disease, memory impairment, and depressive symptoms affect large numbers of older people and the risk of such problems significantly rises with age. Nearly half of those age 85 and older suffer from Alzheimer's disease.2 These millions of less fortunate older people struggle with daily activities as simple as bathing and dressing, with families and friends taking on the difficult and often costly role of caregiver. The outlook for aging minority groups is particularly troublesome given the obvious health disparities that research has shown exists between older white Americans and their minority counterparts.

An increasing interest in aging research is driven in part by a projected dramatic increase in the older population. According to the United States Census Bureau, by 2030 the population of people 65 years and older will double. The over-85 group, often referred to as the "oldest old," is the fastest growing segment of the older population and is projected to comprise 20 million people by the middle of this century. The implications of this dramatic increase in the aging population are numerous and research has an important role to play in providing solutions to the challenging issues posed by an aging society.

Understanding the difference between advanced years that are active and independent and those that are characterized by frailty and dependence is at the heart of research supported by the National Institute on Aging (NIA), a component of the National Institutes of Health (NIH). The NIH is the principal biomedical research arm of the Federal government. The NIA, which was established by Congress in 1974, sponsors biomedical and behavioral research on the aging process and diseases and conditions affecting the elderly. NIA also leads the Federal research effort on Alzheimer's disease. Through independent, as well as collaborative, research efforts, the NIA and the other Institutes and Centers that comprise the NIH are working to reduce disability and disease and promote healthy lifestyles for older people.

This report highlights a number of significant aging-related research advances and activities supported or conducted by the NIH in 1999 and 2000. Section I of this report outlines key advances reported by the NIA for 1999 and 2000 in four major areas of research. Section II provides selected findings from some of the other NIH institutes involved in aging research. They are: National Institute on Mental Health (NIMH); National Eye Institute (NEI); Office of Research on Women's Health (ORWH); National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK); National Institute of Arthritis and Musculoskeletal and Skin Diseases

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For 25 years, the NIA has led a national scientific effort to understand the mechanisms of aging and to extend healthy, active years of life for all Americans. This enterprise has rapidly expanded knowledge about the biological, behavioral, and social changes that occur with advancing age. Many of these advances have saved lives and prevented disability by contributing to improvements in public health and health care and enhancing physical and cognitive abilities in old age. Other discoveries have provided exciting insights into the secrets of aging and longevity. Through its support of training programs and research infrastructure, the NIA has provided critical tools to the next generation of investigators entering the field of aging research. Also, the NIA has maintained a variety of programs, including the Alzheimer’s Disease Education and Referral Center and the NIA Information Clearinghouse, to communicate the results of aging research and related health information to the research community, health care providers, patients, and the general public, providing guidance on health care, health promotion and disease prevention for older people.

Recent significant advances reported by the NIA can be categorized under four major headings: 1) Alzheimer’s Disease and the Neuroscience of Aging; 2) Biology of Aging; 3) Reducing Disease and Disability and 4) Behavioral and Social Research.

ALZHEIMER’S DISEASE AND THE NEUROSCIENCE OF AGING

Alzheimer’s disease (AD), the most common cause of dementia among older persons, is the result of abnormal changes in the brain that lead to a devastating decline in intellectual abilities and changes in behavior and personality. Tragically, as many as four million Americans now suffer from AD, and that number is expected to increase significantly as the baby boom generation reaches the age of greatest risk. Scientists do not yet fully understand what causes AD, but it is clear that the disease develops as a result of a complex cascade of events, influenced by genetic and non-genetic factors, taking place over time inside the brain with age being the most prominent risk factor. These events cause the brain to develop beta amyloid plaques and neurofibrillary tangles and lose nerve cells and the connections between them in a process that eventually interferes with normal brain function.

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In the last decade, researchers have made tremendous strides toward solving the mystery of AD, improving understanding of its underlying molecular processes, developing innovative diagnostic tools, devising effective treatments, and testing prevention strategies. For example, the convergence of evidence from basic laboratory science and epidemiology studies has led to the identification of candidate interventions, such as vitamin E, estrogen, and anti-inflammatory agents, that may treat or prevent AD. In addition, advances in basic research have uncovered enzymes called secretases that are involved in the clipping of a normal cell surface protein to produce the amyloid peptide that forms the senile plaques found in the brains of AD patients. Identifying and understanding how these enzymes work will accelerate the development of interventions to specifically block their action and stop the development of AD plaques.

As a result of these and other scientific discoveries, in 1999, the NIA kicked off the NIH Alzheimer’s Disease Prevention Initiative. The goals of this Initiative are to: invigorate discovery of new treatments, identify risk and preventative factors, enhance methods of early detection and diagnosis, advance basic science to understand AD, improve patient care strategies, and alleviate caregiver burdens. In 1999, the NIA launched the first large-scale AD prevention clinical trial supported by the NIH, the Memory Impairment Study (MIS). This study is evaluating vitamin E and donepezil (Aricept) over a three-year period for their effectiveness in slowing or stopping the conversion from mild cognitive impairment (MCI), a condition characterized by a memory deficit without dementia, to AD. It will be taking place at more than 70 sites in the U.S. Other ongoing or upcoming AD prevention trials will examine whether treatment with a variety of agents, such as anti-inflammatory drugs, estrogen, aspirin, vitamin E, antioxidants, or combined folate/B6/B12 supplementation can prevent development of AD. The effects of each of these agents on normal age-related decline will also be evaluated. Information about ongoing AD clinical trials supported by the NIA is now available on the Alzheimer’s Disease Education and Referral Center home page, a service of the NIA, at: http://www.alzheimers.org/

Advances in the field of AD research also have implications for other neurodegenerative disorders, such as Parkinson’s disease. For example, advances in imaging techniques may one day enhance the ability of practitioners to detect early changes in the brain and intervene before symptoms of diseases progress. Building on the progress of NIA-supported research in the area of Alzheimer’s disease and the neuroscience of aging, efforts will continue to identify critical diagnostic, treatment and prevention strategies for AD as well as other neurodegenerative diseases.

1999 SELECTED SCIENTIFIC ADVANCES

Alzheimer’s Disease and the Neuroscience of Aging

Age-associated memory loss might be reversible.—Researchers have identified a process by which the normal primate brain degenerates with aging, and were able to show that this degeneration can be reversed by gene therapy. They found that cholinergic neu-
rons in a specific area of the brain are most dramatically affected by aging. An actual count of brain cells in rhesus monkeys showed that very few cells are actually lost in the cerebral cortex with advancing age. In contrast, cholinergic neurons in another part of the brain (the basal forebrain) were found to shrink in size and to stop making regulatory chemicals, a change that seriously affects the ability to reason and store memories. Using skin cells from each individual monkey, researchers inserted a gene that makes human nerve growth factor (NGF) and then injected the modified cells into the brains of these monkeys. After three months, the cholinergic neurons of the monkeys with the NGF injections had an almost youthful appearance. The number of cells detected was restored to about 92 percent of normal for a young monkey, and the size of the cells was restored to within 3 percent of normal young values. Such gene transfer approaches restoring cellular function have important implications for the treatment of chronic age-related neurodegenerative disorders, such as AD.

Brain atrophy measured by imaging techniques predicts progression from MCI to AD.—Mild cognitive impairment (MCI) is characterized by a memory deficit, but not dementia. Compared to normal memory changes associated with aging, memory loss associated with MCI is more persistent and troublesome. Each year, 12–20 percent of people over age 65 with MCI develop AD, compared with 1–2 percent of people in this same age group without MCI. A study found that MCI can reliably be clinically defined and diagnosed. The ability to differentiate patients with MCI from healthy control subjects and persons with very mild AD hopefully will lead to useful, practical, and cost-effective means to test drug interventions for AD. To help make these distinctions, researchers recently used magnetic resonance imaging (MRI) to determine volume measurements of the hippocampus, a region of the brain important for learning and memory, in patients with a clinical diagnosis of MCI. The hippocampus was selected for imaging because this brain structure plays a central role in memory function. Patients were assessed annually for approximately three years using both clinical and cognitive assessments. In older individuals with MCI, the smaller the hippocampus at the beginning of the study, the greater the risk of developing AD later. Imaging studies such as these can actually identify deviations from normal cerebral function or normal anatomy before a clinical diagnosis can be made. The ability to detect early disease will enable researchers to test the effectiveness of treatments or interventions designed to stop brain changes before clinical deterioration sets in.

Normal cellular enzyme becomes a marker for AD.—Researchers examining the brains of people who had died from AD found abnormally large amounts of a normal enzyme called casein kinase-1 (CK-1) in nerve cells inside cellular sacs (vacuoles) called granulovacuolar degeneration (GVD) bodies. Previous research had shown that these vacuoles tended to accumulate in the hippocampus. Looking for an enzyme that adds phosphate to tau molecule, a key protein in the development of dementia, the investigator found a 30-fold increase in one form of CK-1 inside GVD bodies in the hippocampus. This finding enables researchers to use CK-1 as a molecular label for studying the vacuoles and forges a link
between them and the plaques and tangles commonly studied in AD brains. Analysis of GVD bodies could provide valuable clues useful both for the diagnosis of AD and for gaining a better understanding of the disease.

Study results show promise for developing treatment of early-onset AD.—Most early-onset AD is the result of mutations in one of two human presenilin genes, PS-1 and PS-2. Mutations in PS-1 are found in about 40 percent of people with familial (early onset) AD. Every known presenilin mutation affects the processing of amyloid precursor protein (APP) into smaller fragments, such as beta-amyloid peptide, the primary constituent of the distinctive plaques that accumulate in the brains of Alzheimer’s patients. When scientists altered the amino acid sequence of the presenilin protein from its normal sequence in two critical locations, amyloid formation was reduced. Evidence indicates that mutated PS-1 protein may be able to clip the beta-amyloid fragment from APP. If true, the identification of the long-sought enzyme involved in producing neuritic plaques associated with AD should hasten development of drugs that inhibit the enzyme, blocking production of amyloid-beta in much the way cholesterol-lowering drugs work. These studies have implications for the treatment of AD and related disorders of amyloid accumulation. The challenge will be to develop drugs that reduce or alter the activity of presenilin, but do not completely eliminate it, since complete elimination of presenilin is lethal in mice, and presenilin is likely to have a similar essential function in humans.

Gene causing a form of familial dementia may yield clues to AD.—A form of dementia that spans seven generations of members of the same family in England has been linked to a newly discovered, dominant gene, BRI, on chromosome 13. Familial British dementia (FBD), which has an onset at approximately age 50, is characterized by progressive dementia, muscle spasticity, and loss of muscle tone due to disease of the cerebellum. The predominant pathological lesions are abnormal protein deposits in the brain, plaques in the vicinity of blood vessels, and neurofibrillary tangles. FBD is similar to AD because in both disorders the production of a small insoluble protein is a key feature. Further, the neurofibrillary pathology observed in both FBD and AD is identical. While much remains unknown about the BRI gene and the function of the protein that it produces, understanding how the gene defect causes the disease will lead to insights into the pathogenesis of other neurodegenerative diseases characterized by amyloid “deposition.” Understanding how the genetically distinct disorder FBD develops will contribute to efforts to understand the development and progression of the more prevalent AD. Further, insights gained in FBD may aid the design and development of treatments intended to disrupt peptide aggregation and prevent the ensuing neurodegeneration not only in FBD and AD but also in other diseases such as those caused by infectious particles called prions.

One form of the ApoE gene protects brain cells from injury.—The protein apolipoprotein E (ApoE) participates in the transport of serum lipids (fats) and the redistribution of lipids among cells. Although the mechanism through which it works is unknown, the
only accepted risk factor for sporadic late-onset AD is the ApoE4 structural variant of the ApoE gene. To test the hypothesis that ApoE3, but not ApoE4, protects against age-related neurodegeneration, researchers analyzed mice expressing similar levels of human ApoE3 or ApoE4 in the brain. It was determined that ApoE3 protected the brain against excitotoxic injury but that ApoE4 did not. ApoE3, but not ApoE4, also protected against age-dependent neurodegeneration. This study presents compelling evidence to suggest that the presence or absence of a particular ApoE structural variant or isoform affects the way neurons respond to injury. These differences in the effects of ApoE isoforms on neuronal integrity may relate to the increased risk of AD and to the poor outcome after head trauma and stroke in humans. The significance of this finding is that it may help to explain how ApoE4 functions as a risk factor for the development of AD, and, if confirmed, might suggest useful therapeutic strategies that could be started in advance of any cognitive impairment in at-risk individuals.

New mouse model produces tangles similar to those in AD.—Developing mouse models with features of human AD is vital in helping researchers gain insights into the etiologies, mechanisms, and progression of AD. Mice implanted with human genes for beta-amyloid, the precursor to neuritic plaques, were developed in 1997. Now, for the first time, researchers have developed a transgenic mouse strain that expresses human tau genes and develops AD-like tau tangles. Unlike their litter-mates that lack the tau gene, these genetically altered mice developed masses of abnormal tau filaments in nerve cells within the spinal cord, cerebral cortex, and brainstem, and in three other critical regions of the central nervous system, as well as undergoing nerve cell degeneration as they aged. While this new strain of transgenic mice does not completely model AD, they closely resemble human diseases that accumulate AD-like tau deposits in the brain. The development of this mouse model will help researchers understand how tau produces disease in the brain, and together with other partial models of AD will move closer to developing effective preventive or treatment interventions against AD.

Study finds that the hormone melatonin does not decrease with age.—Melatonin, a natural sleep inducer, is secreted by the pineal gland located deep within the brain. The hormone is produced at high levels during a person’s normal sleeping hours and is lowest during the day. A number of factors, including light and many common medications, such as aspirin, ibuprofen, and beta-blockers, can affect melatonin secretion. In the past two decades, more than 30 reports have suggested that the level of night-time melatonin peak declines progressively with age. These reports have led to a proliferation of over-the-counter supplements aimed at augmenting melatonin levels in the elderly. A five-year study was recently completed that measured serum melatonin levels in 120 healthy men and 24 women aged 18–81. The analysis found no statistically significant difference in night-time melatonin concentrations between the younger and older study participants. This outcome means that in most healthy people, concentration of melatonin probably does not decline with age, and aging probably does not affect the regulation of melatonin secretion.
Alzheimer's Disease and the Neuroscience of Aging

Use of Positron Emission Tomography (PET) Imaging to Identify Pre-symptomatic Decline in Brain Function.—The gene APOE-ε has been associated with increased risk of AD. Scientists have been increasingly interested in whether the brain and brain function of people who carry one or more copies of APOE-ε 4 are different from those of individuals who do not carry the gene to ultimately see whether AD-like symptoms can be identified before the disease is diagnosed clinically. PET imaging can provide information on metabolic function of specific brain regions. Recent studies using PET show that, despite similarities in age, gender, education, family history of dementia, and baseline performance on memory and other cognitive tasks, individuals with the APOE-ε 4 gene(s) have reduced cerebral glucose metabolism in several areas of the brain compared to people who have none. The differences in metabolism were even greater two years after initial evaluation. Lower baseline metabolism at the start of the study predicted a greater cognitive decline in subjects at genetic risk for AD. Though longer follow-up studies are needed to determine how many of the APOE-ε 4 carriers actually develop AD, these findings suggest that a combination of cerebral metabolic rate and genetic risk factors may be one way to help detect AD pre-clinically.

In Vivo Detection of Amyloid Plaques.—Scientists have been searching for a marker to be used in living patients (in vivo) to identify amyloid plaques that may be present in brain long before clinical diagnosis of the disease. A new molecular probe has recently been developed that sensitively labels plaques in post mortem AD brain sections. This probe now has been shown as well to label plaques throughout the brain after intracerebral injection in living transgenic mice. This probe is a prototype for molecules that could be used for radiological imaging of plaques in the brains of living people, permitting monitoring of the development and progression of AD as well as the clearance of plaques in response to anti-amyloid therapies.

Standardized Clinical Information Can Predict Conversion to AD.—Researchers have identified components of a standardized clinical assessment instrument that also appear to predict which individuals with very mild impairment (symptoms) or "questionable" AD have a high likelihood of converting to AD over time. The assessment instrument was the Clinical Dementia Rating (CDR), a clinical interview which stages AD from normal to severe based on six functional categories. After receiving a CDR rating of normal or questionable, participants were followed for three years to determine who converted to probable AD. Likelihood of progression to AD during follow-up was related to the sum of the scores in the six CDR categories. This score, combined with selected clinical interview questions, identified 89 percent of those questionable individuals who converted to AD in the study. These findings provide guidelines for using a clinical assessment to identify patients most likely to convert from questionable AD to AD, improving the possibility of earlier diagnosis and earlier implementation of available interventions.
Identification of the Amyloid Forming Enzymes Offers New Targets for Drug Development.—Amyloid is a small peptide fragment produced as a result of snipping (cleavage) of the much larger amyloid precursor protein (APP) by two enzymes known as beta (β) and gamma (γ) secretases. For years, scientists knew that something was snipping the APP into fragments and they even went so far as to name the suspect secretases. But no one had been able to physically and precisely identify the enzymes that did the actual clipping of APP until the past year, when the identities of the β and γ secretases at last were revealed.

The identity of secretase was discovered simultaneously by several drug companies. However, γ secretase has proven more elusive. Its activity was known to be affected by mutations in one of the genes (presenilin 1 or PS1) that cause AD in early onset families. PS1 was identified several years ago and structural evidence suggested it might actually be the γ secretase. To test this possibility, scientists identified a radioactive molecule that binds tightly to the active site of the enzyme, thus labeling the enzyme molecules. They found that PS1 was the labeled protein, strongly suggesting that it itself is the γ secretase. It is believed this line of research could lead to the discovery of drugs that inhibit the production of amyloid without inhibiting other essential functions these secretase enzymes might have. Ultimately, clinical trials on such secretase-inhibiting drugs will show whether this approach will work.

Immunization Against Amyloid-β Can Reduce Brain Amyloid-β Deposition.—Recent studies in animal models have been important in understanding the etiology of AD and in testing potential new therapies. In transgenic mouse models showing extensive plaque formation with advancing age, researchers are now evaluating plaque-reducing drugs. The results of this research have been promising. In one breakthrough, pharmaceutical company scientists showed that repeated long-term injections of an amyloid vaccine can cause an immune response in test mice, nearly eliminating amyloid plaques and associated neuropathology, with no obvious toxicity. A number of NIH-funded scientists have confirmed and extended these observations. In a novel approach, one group administered the vaccine to mice nasally, and also induced an immune response. In that study, when young transgenic mice were repeatedly given the human amyloid-β via the nasal route, the mice had a much lower amyloid burden at middle age than animals not receiving the vaccine. Interest in the vaccine approach heightened upon recent preliminary reports that amyloid vaccination prevents cognitive decline in another transgenic mouse model of AD, suggesting that a vaccine might indeed make a difference in the clinical symptoms of AD. Human trials are only now beginning to test both the safety and the efficacy of these vaccines as a possible therapy for people with AD.

A New Model of Parkinson's Disease (PD).—There are many similarities among neurodegenerative diseases such as AD, PD, and other dementias, and research on one can provide valuable clues about the others. PD is a common age-related and progressive neurodegenerative disorder characterized by death of neurons that make the neurotransmitter dopamine. Loss of these neurons results in rigidity, tremor, slowed movement, and impaired gait. An-
other hallmark of PD is the formation of fibrous protein deposits, called Lewy bodies, in neurons. Mutations in the \( \alpha \)-synuclein gene have been linked to some forms of inherited PD and insoluble \( \alpha \)-synuclein accumulates in Lewy bodies, as well as in plaques in AD. A new \( \alpha \)-synuclein transgenic model has been developed, using the fruit fly Drosophila, that exhibits many essential features of human PD including age-dependent onset, progressive loss of dopamine neurons and motor function, and development of Lewy body-like pathology. This model will be useful in identifying underlying mechanisms mediating \( \alpha \)-synuclein toxicity and in identifying genes that modify the \( \alpha \)-synuclein mediated neurodegeneration, and which may play a role in the pathogenesis of PD. These transgenic flies may also be valuable in screening potential drugs affecting the onset and progression of PD.

**Ongoing Research Highlights Importance of Testing Interventions.**—REACH (Resources for Enhancing Alzheimer's Caregiver Health) is a multi-site intervention trial, at six sites and a coordinating center, to conduct social and behavioral research on interventions designed to help caregivers of patients with AD and related disorders. REACH projects are testing such interventions as educational support groups, behavioral skills training programs, family-based interventions, environmental modifications, and computer-based information and communication services. Some 1,222 caregivers and care recipients have participated in the study, which includes large numbers of African Americans, Cuban Americans, and Mexican Americans. Data from the REACH study are just being analyzed.

**Biology of Aging**

Research on the biology of aging has led to a revolution in aging research. This new gerontology investigates the progressive, non-pathological biological and physiological changes that occur with advancing age and the abnormal changes that are risk factors for or accompany age-related disease states. Progress is being made in understanding the gradual changes in structure and function that occur in the brain and nerves, bone and muscle, heart and blood vessels, hormones, nutritional processes, immune responses, and other aspects of the body. Research has begun to reveal the biologic factors associated with extended longevity in humans and animal models, such as fruit flies, roundworms and rodents. The ultimate goal of this effort is to develop interventions to reduce or delay age-related degenerative processes in humans. Areas of research include the effects of calorie restriction on various organisms, the identification of genes and genetic mutations that may be related to longevity, and the study of cellular function in human and animal models.

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**Biology of Aging**

*Mitochondrial DNA mutations increase with aging.*—One hypothesis of the cause of aging is the accumulation of mutations in mitochondrial DNA (mtDNA). Although earlier research has shown
that a particular deletion mutation of mitochondrial DNA increases with age, it appeared that this mutation only occurred in less than 4 percent of mtDNA molecules. However the methods used to quantitate the level of this mutation would not have detected other deletions, so it was argued by some that the common deletion mutation represented the “tip of the iceberg” of mitochondrial mutations. Skeptics responded that this unproven hypothesis represented wishful thinking. By use of a sensitive method to look at point mutations in mitochondrial DNA, researchers found hard evidence that mtDNA point mutations increase with aging and mitochondria deteriorate as people age. These scientists show that one particular point mutation in the control region of the mtDNA occurs in a high proportion of the mtDNA molecules of more than 50 percent of people over the age of 65, but is absent in younger individuals. Because the mitochondria are the cellular sites for energy metabolism, deterioration of mitochondria could deprive cells of the energy they need to function and ultimately could lead to premature cell death.

*Caloric restriction prevents age-associated changes in gene expression.*—Most multicellular organisms exhibit a progressive and irreversible physiologic decline during the aging process. The only intervention known to slow the intrinsic rate of aging in mammals is caloric restriction. Given 30 to 40 percent fewer calories than in usual feeding schedules, but fed all the necessary nutrients, rodents and other non-primate laboratory animals studied not only have lived far beyond their normal life spans but have reduced rates of several diseases, especially cancers. In a new study, the gene expression profile of the aging process was analyzed in skeletal muscle of mice. Of the 6347 genes surveyed by new micro-array techniques, only 58 (0.9%) displayed a greater than twofold decrease in expression. Thus, the aging process is unlikely to be due to large, widespread alterations in gene expression. The major effect of caloric restriction seems to be to heighten animals’ stress response in response to damage to proteins and other large molecules. Caloric restriction also completely or partially suppressed age-associated alterations in expression of a large proportion of genes. This is the first global assessment of the aging process in mammals at the molecular level. Potentially, gene expression profiles can be used to assess the biological age of mammalian tissues, providing a tool to evaluate experimental interventions.

*Link established between telomeres and mammalian aging.*—Telomeres are highly repetitive DNA sequences located at the end of chromosomes. They are essential for the stability of chromosomes and cell survival in a wide variety of organisms. In human cells grown in culture, telomere length shortens with each cell division and the progressive telomere shortening ultimately limits the ability of cells to divide. To test the possibility of a link between telomere shortening and aging of an organism, investigators have created genetically altered mice lacking telomerase, an enzyme that adds new telomeric DNA sequences to existing telomeres. In this transgenic model, telomeres progressively shortened throughout the lifespan, providing a unique opportunity to understand the cellular consequences and aging significance of telomere shortening in the living animal. Although loss of
telomeres did not elicit a full spectrum of the classical symptoms of aging, age-dependent telomere shortening was associated with a shortened life span, reduced capacity to respond to physiological stress, slow wound healing, and an increased incidence of spontaneous cancers. As individuals age, older organs show a markedly diminished capacity to cope with acute and chronic stress. The telomerase-deficient mouse provides a valuable model to study the role of telomere maintenance in cellular stress responses in the aging organism.

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Biology of Aging

Extension of Average Life Span of Nematodes by Pharmacological Intervention.—It is widely accepted that oxidative stress is a factor in aging. To date, however, it has not been demonstrated convincingly that natural anti-oxidants such as vitamins C and E or b-carotene extend life span in model experiments with mice, fruit flies, or nematodes (a kind of worm). Varied results have been obtained in genetically altered fruit flies over-expressing either superoxide dismutase (SOD) or SOD and catalase, enzymes that reduce oxidative damage. Now, an artificial compound, EUK–134, which mimics both SOD and catalase activity, has been shown to increase the average life span of nematodes by about 50 percent. EUK–134 also reversed premature aging in a nematode strain subject to elevated oxidative damage. These results strongly suggest that oxidative stress is a major factor in rate of aging in the nematode, and that this rate can be slowed by pharmacological intervention. It may be that similar compounds could lessen oxidative stress in humans and delay or reduce age-related pathology.

Cell Transplantation and Aging.—An alternative to tissue or organ transplantation that appears to have great potential is formation of functional tissue from cell transplants. Recent research has shown that isolated cow or human adrenal gland cells inserted into immunodeficient mice formed functional adrenal tissue that resembles normal adrenal gland. This approach may potentially be used for any organ, either to study its functional regeneration in a living organism with age or to therapeutically regenerate lost function as in a case, for example, when defective genes might be replaced in cells isolated from a patient and then placed back into the same patient for tissue regeneration. This technique can also reduce the need for immunosuppressive therapies and offers an alternative to stem cell therapies.

Genetically Mimicking Caloric Restriction (CR) Significantly Extends Yeast Life Span.—CR has been shown to significantly extend life span in a variety of organisms. In organisms studied to date (yeast, nematodes, fruit flies, mice and rats), CR increased both mean and maximum life span, as well as significantly reducing signs of disease. In all species examined, the extended longevity and health of the animals was accompanied by changes in the regulation of energy metabolism. Recent research has determined that genetic manipulation of glucose availability, metabolism, and signaling pathways can mimic the longevity-extending effects of CR in the yeast model. This discovery makes the yeast model of aging
and longevity a powerful tool for uncovering the underlying cellular and molecular mechanisms responsible for increased longevity and health span, with a view to developing effective interventions.

**CR Increases Neurotrophic Factor Production in the Brain and Protects Neurons.**—Beyond extending life span, CR also reduces development of age-related cancers, immune and neuroendocrine alterations, and motor dysfunction in rodents. Recent animal model studies of neurodegenerative disorders provide the first evidence that CR can also increase resistance of neurons to age-related and disease-specific stresses. One possible mechanism is that the mild metabolic stress associated with CR induces cells to produce proteins that increase cellular resistance to disease processes. Indeed, CR increases production of one such protein, a neuronal survival factor, BDNF. BDNF signaling in turn plays a central role in the neuroprotective effect of CR. This work suggests that CR may be an effective approach for reducing neuronal damage and neurodegenerative disorders in aging, providing insight into the design of approaches that might mimic CR's beneficial consequences.

**Use of Gene Expression Microarrays in Aging Research.**—Aging is normally accompanied by changes in expression, or activity, of a large number of genes, but it is not clear which of these changes are critical in the aging process. Gene expression microarrays, which allow profiling the activity of many thousands of genes at once, provide an opportunity to obtain a more complete picture of what these changes are, and to design tests of whether these changes are causally associated with aging. In three recent studies, investigators looked at differences in gene expression patterns in young and old mouse skeletal muscle, liver, and brain tissue and also made several observations on changes brought about by caloric restriction. Though the data analyses are complex, some initial observations are: 1) aging results in lower levels of activity of metabolic and biosynthetic genes; 2) aging is accompanied by patterns of gene expression that are indicative of stress responses, including inflammatory and oxidative stress; 3) many, but not all, age-related changes in gene expression in mouse liver and skeletal muscle are slowed by caloric restriction; and 4) caloric restriction appears to increase expression of genes for repairing and/or preventing damage to cellular macromolecules. Microarray technology is proving to be an efficient approach to answering long-standing important questions about molecular mechanisms of aging and how these may be manipulated, for example, by calorie restriction. Profiling changes in gene activity may eventually provide useful biomarkers of the aging process itself, markers that might be important in assessing the effectiveness of strategies to retard aging-related processes.

**Reducing Disease and Disability**

As life expectancy increases, there is an ever greater need to keep these additional years disease and disability-free. Research has shown that life-style and other environmental influences can profoundly impact outcomes of aging, and that remaining healthy and emotionally vital until advanced age is a realistic expectation. NIA-supported investigators at institutions across the nation, including those that are the recipients of Claude Pepper Older Amer-
icans Independence Centers awards, are helping to define optimal needs regarding diet, diet supplements, exercise, safety, and other factors. The goals are to ensure that endurance, strength, and balance are kept at the highest possible level and that the risks of disease, such as osteoporosis, cancer, and cardiovascular disease, and disability are kept to a minimum. In addition to its support of biomedical and behavioral research, the NIA is committed to helping reduce disease and disability by translating research findings into effective interventions, such as exercise, for the public. Toward this end, in 1999, the NIA published a free manual, Exercise: A Guide from the National Institute on Aging, the cornerstone of the Institute’s ongoing campaign to encourage older people to exercise. The Guide is based on scientific evidence and is intended to help people design their own exercise program. Information about the Guide, and other NIA publications, is available on the NIA home page at: http://www.nih.gov/nia/health/.

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Reducing Disease and Disability

Delirium can be prevented in hospitalized older patients.—Delirium, an acute-confusional state, in older hospitalized older patients is associated with poor outcomes, and is a common, serious, and potentially preventable source of both prolonged illness and early death. Between 20–30 percent of all hospitalized elderly patients have episodes of delirium, resulting in treatment costs exceeding $4 billion per year in the U.S. Previous studies of delirium focused on the treatment of delirium rather than on primary prevention. A recent study done by researchers evaluated the effectiveness of a multi-component strategy for the prevention of delirium. Study participants received either usual, standard hospital care or care under a multidisciplinary team of specialists that included staff nurses, recreational therapists, physical therapists, geriatricians, and trained volunteers. Patients in this study had one or more of six risk factors for delirium, including cognitive impairment, sleep deprivation, immobility, dehydration, or impaired vision or hearing. To address these risk factors, team members were trained to recognize and counteract the danger signs before confusion, agitation, and hallucinations set in. Interventions include making sure patients got enough fluids, taking them for walks, and providing warm drinks at bedtime to promote sleep. While 15 percent of patients receiving standard hospital services experienced at least one episode of delirium, only 9.9 percent of those receiving the team approach experienced an episode. Once an initial episode of delirium had occurred, however, the intervention had no significant effect on the severity of delirium or the likelihood of recurrence. This study holds substantial promise for the prevention of delirium in hospitalized older patients. Further evaluation is needed to determine the cost effectiveness of intervention to prevent delirium and its effects on related outcomes, such as mortality, re-hospitalization, institutionalization, use of home health care, and long-term cognitive functioning.

Predictors of healthy aging can be identified and interventions can reduce risk of disability.—There is a need to understand
whether there are modifiable risk factors that can decrease the risk of disability and death with aging. A long-term study with Japanese-American men in Hawaii has shown that these men have one of the highest life expectancies of all Americans. Because a number of baseline measurements were taken of these men in midlife, from 45 to 68, it was possible to explore predictors of long life expectancy and prevention of physical disability. Among over 6500 healthy men at baseline, about 60 percent remained free of major illness and were not physically or cognitively impaired over the next 25 years. Data from mid-life that proved to be predictive of healthy aging included optimal blood pressure, low blood sugar and cholesterol levels, lack of obesity, lack of smoking, and strong hand grip. At an older age the men were examined to determine the presence of functional limitation and disability. Of various factors considered, mid-life hand grip strength was associated with less physical disability and faster walking speed. In a clinical trial, participants were randomized into intervention and control groups. At the end of one year after a regimen of increased physical activity and chronic-illness self-management, the intervention group experienced fewer hospitalizations and fewer total hospital days. Factors leading to a long and active life are of prime importance as the population ages worldwide. This study suggests that preventive and/or therapeutic interventions are most effective when initiated at younger ages, although the clinical trial results suggest that successful intervention can occur at older ages. Researchers will need to work with clinicians to develop strategies to address modifiable risk factors in order to promote healthy aging.

Testosterone replacement men may have protective effects against age-related diseases.—Many older men have blood levels of testosterone well below the normal range for younger men. Earlier studies have shown that low testosterone levels may increase risk factors for disease and disability, including loss of bone (leading to osteoporosis and fractures), loss of muscle (causing decreased strength), and increases in body fat (increasing risks for diabetes and heart disease). In a recently completed clinical trial of men over 65 years old with low serum testosterone, study participants were given a testosterone or placebo skin patch for three years. Levels of testosterone in the treatment group rose to those generally found in younger men. Men with the lowest endogenous serum testosterone (3 micrograms per liter or less) prior to beginning the trial had significant increases in bone density in response to testosterone replacement. The testosterone treatment also increased lean body tissue and significantly decreased body fat. Study participants were monitored for possible adverse treatment effects, particularly on the prostate. Testosterone treatment did not increase symptoms of an enlarged prostate, such as impaired urinary function, nor was there statistically significant evidence that the administered testosterone increased the incidence of prostate cancer. The results of this study suggest that testosterone replacement could help protect many older men with low testosterone levels against common diseases of aging such as diabetes, heart disease, and osteoporosis. However the possibility that testosterone replacement could increase adverse events such as prostate diseases, though not observed in this small study, reinforces the need for
well-designed larger studies as well as the development of strategies to minimize risks of testosterone therapy while still providing benefits.

Postmenopausal estrogen use is associated with decreased arterial stiffness.—Arterial stiffness has been identified as a potential risk factor for cardiovascular disease. Earlier research has shown that estrogen may improve blood vessel pliability by altering the structure and function of vascular tissue, including smooth muscle cells. This study, conducted at examined the influence of age and current estrogen replacement therapy (ERT) on stiffness in the common carotid arteries (the main arteries that pass up the neck and supply blood to the head). The common carotid arteries of 172 women, 37 of whom were current users of ERT, were examined by ultrasound, and the degree of arterial stiffness was measured. Arterial stiffness was found to increase linearly with age, and was modestly related to other cardiac risk factors. The degree of stiffness was lower in women using ERT than in postmenopausal nonusers. Furthermore, the effects of age and ERT on the stiffness persisted after adjustments for other cardiovascular risk factors. Carotid stiffness was similar in ERT users, whether or not they also took progesterone. This study suggests that the cardiovascular protection seen in women using ERT may involve overall reduction of age-associated arterial stiffening.

Chronic inflammation in the elderly predicts disability and early death.—Inflammation is a normal biologic response of the immune system to a number of different stimuli, including infections, allergens, and physical trauma. However, inflammation can become chronic and increase the onset and severity of a number of age-related disabilities and diseases. An indicator of this process is the elevation of a pro-inflammatory protein, interleukin-6 (IL-6), which plays a central role in inflammation and increases with age. High circulating levels of IL-6 are associated with such diverse conditions as depression, heart failure, and arthritis. One study of nearly 1,700 men and women, ages 70 or greater living in North Carolina, measured IL-6 levels against a standardized test for depression. After controlling for age, race, and gender, IL-6 levels remained the only biologic variable significantly associated with depression. In another study in men and women 71 years or older, participants with the highest levels of interleukin-6 were almost twice as likely to develop mobility-disability and were about twice as likely to die within 5 years of the beginning of the study. It is known that IL-6 stimulates the synthesis of C-reactive protein, an indicator of systemic inflammation. When levels of both IL-6 and C-reactive protein were elevated simultaneously, there was a 3-fold increased risk of mortality. Further studies are needed to improve our understanding of the complicated system of stimulus and response with regard to inflammation. These findings may broaden our understanding of the health correlates and consequences of chronic inflammation, as well as provide a new way to identify high-risk individuals to determine whether they would benefit from anti-inflammatory intervention.

Behavioral training is more effective than drug therapy for urge urinary incontinence.—Approximately 15 million Americans adults have urinary incontinence (UI) with associated health costs esti-
mated in a range of $16-$26 billion dollars annually. Urinary incontinence is especially a problem for women. Nearly 40 percent of community dwelling women age 60 years and older suffer from some form of UI. While behavioral training and drug therapy have both been previously demonstrated to be effective treatments for urge urinary incontinence in older adults, drug therapy is commonly used as the first course of treatment. A recent clinical trial directly compared behavioral training (instrument-assisted pelvic muscle exercises to improve bladder control) to drug treatment for urge UI in older women and demonstrated that behavioral training was significantly more effective than drug therapy in reducing the episodes of accidental urine loss. Thus, behavioral training should be considered the first treatment option given the potential side effects of drug therapy, and to avoid further problems with drug interactions among older persons taking multiple medications.

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Reducing Disease and Disability

Fitness Affects Mortality Risk—Regardless of Body Fat.—Both obesity and being unfit increase risk for chronic disease and death. However, the interrelationship between fitness, body fat, and mortality has not been clear. Recent research suggests that it is fitness, not fat, that may count most. In one study, investigators followed men 30–83 years of age for an average of eight years, classifying participants according to body fat as well as relative fitness based on exercise testing. Not surprisingly, the study showed that the higher the level of fat, the lower the level of fitness. But what intrigued researchers most were data showing that, within each category of body fat, “fit” men were at lower risk of death. Most strikingly, among those more fit, obesity was not significantly related to risk of death. In another study, low fitness increased mortality risk in men approximately fivefold for cardiovascular disease, and threefold for all-cause mortality. These findings suggest that, beyond interventions focusing on weight-loss to prevent and treat obesity-associated conditions, there may also be important benefits for the obese from improved fitness.

Stress Testing May Not Be Needed for Starting an Exercise Program.—The role of exercise stress testing and safety monitoring for older people who want to start an exercise program is unclear. Current guidelines for routine exercise stress testing may deter older people from beginning an exercise program, either because of the cost of testing or because it may lead people to believe that exercise poses higher risks than it actually does. The latest research suggests that, in the absence of cardiovascular contraindications, the benefits of exercise for the elderly, balanced against a somewhat minor increase in risk, may be sufficient for starting an exercise program without prior exercise stress testing.

Commonly Prescribed Diuretic Protects Against Osteoporosis.—The lifetime risk of osteoporotic fracture in the U.S. is 40 percent in women and 13 percent in men. Because age-related bone loss increases susceptibility to fracture, strategies aimed at preserving bone mass are important. Large observational studies have consistently shown that the use of thiazide diuretics, usually prescribed
to treat high blood pressure, is associated with higher bone density and about a 30 percent lower risk of hip fracture. Investigators recently completed a clinical trial to directly test the effect of taking thiazides on bone density in older men and women with normal blood pressure. Among healthy older adults, low-dose hydrochlorothiazide did preserve bone density at the hip and spine. The modest effects observed over three years, if accumulated over 10–20 years, may explain the 30 percent reduction in hip fracture risk associated with thiazides in the earlier observational studies. The results of this trial suggest that low-dose thiazide therapy may have a role in strategies to prevent osteoporosis.

Regulation of TGF-β Type II Receptor and Atherosclerosis.—Atherosclerosis or narrowing of the arteries is the major risk factor for both heart disease and stroke and is a major complication after arteries have been surgically enlarged by balloon angioplasty. Throughout life, artery wall cells successfully repair injuries related to smoking, high blood pressure or cholesterol, making new cells to replace damaged ones. But constant exposure to such stresses eventually causes the artery wall cells to lose control of their replication. The growing mass of cells forms plaque, which eventually clogs the vessels and causes reduced blood flow. New research is helping to identify the complex series of cellular events causing cells to lose control of their division. In normal circumstances, a protein called TGF-β prevents excessive cell division. It acts on the cells through binding to a protein receptor on the cell surface, the TGF-β receptor, causing intracellular changes that stop cells dividing. In atherosclerotic lesions, it has been shown, unrestricted growth in some cells is caused by mutations in this receptor, inactivating it. Another way of preventing normal receptor function is to make too little TGF-β receptor to be effective. One protein that inhibits the production of TGF-β receptor is called Egr-1. This protein is found at very high levels in plaques, perhaps being induced by artery injury. Finding drugs to repress the activity of Egr-1 may be one way of keeping the key TGF-β receptor functioning effectively to stop excessive cell division and prevent atherosclerosis.

Exendin-4 as a Treatment for Type 2 Diabetes.—Type 2 diabetes mellitus (DM) is caused by an inability of the beta cells of the pancreas to compensate for increasing insulin demands; consequently, blood glucose levels rise. Scientists are searching for compounds that act on the pancreatic beta cells to prevent this progressive rise in blood glucose. GLP-1, a gut peptide, can stimulate beta cells to produce more insulin even in type 2 DM; however, its biologic half-life is short and its effects quickly wear off. Exendin-4, a newly studied peptide analog of GLP-1, is long-lived and more potent than GLP-1, and has been shown to reduce blood glucose levels in rodents. A recent study conducted by researchers in the NIA intramural research program with small numbers of diabetic and non-diabetic humans demonstrated Exendin-4’s efficacy in inducing insulin and normalizing blood sugar, even in diabetics. In the near future, an exendin-like drug possibly may become an effective treatment for type 2 DM.
A goal of NIA behavioral and social research is to maintain or enhance the health and well-being, including physical and cognitive function, of older individuals throughout the life span. For example, new interventions are being developed to encourage long-term changes in health behaviors that will lead to a reduced risk of disease and disability. Cognitive interventions are being tested to maintain cognitive function and retain independence. Components of the physical environment are being redesigned to match the skills and abilities of older persons, thus helping to prevent injuries and to improve performance of daily activities. Such human factors research has produced new and improved medical devices and treatment regimens, instructional designs, and product labeling. As the number of older people who are able and willing to work well into late adulthood increases, researchers are studying the physical and social barriers to their sustained participation in the workforce and the factors needed to enhance their skills and productivity. A related body of demographic research documents trends in health, disability, retirement, long-term care, and the economic aspects of aging, and uncovers their causes and inter-relationships.

A major focus of ongoing research supported by the NIA Behavioral and Social Research (BSR) program involves tracking the declining chronic disability rate in the elderly U.S. population. First reported in 1997, researchers at Duke University found that between 1982 and 1994, the prevalence rates for chronic disability in the U.S. elderly population, age 65 and older, declined 3.6 percentage points, based upon data from the 1982, 1989, and 1994 National Long Term Care Surveys. The decline is highly significant statistically and occurred at nearly all levels of disability. In absolute terms, the differences in prevalence suggest that there were approximately 1.2 million fewer disabled people in 1994 than would have been predicted if the 1982 rates had remained the same; that is, 7.1 instead of 8.3 million people. Subsequent waves of the survey revealed that disability rates for older people have continued this downward movement. The NIA BSR program is supporting research to understand the dynamics of this trend with the goal of accelerating it in future years.

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Behavioral and Social Research

Social and productive activities confer survival advantages to the elderly.—When previous studies found that older people who remained active lived longer, scientists assumed that the survival advantage resulted from improved cardiopulmonary fitness attributable to physical activity. A new study from a research team suggests that social activities (church attendance, travel, etc.) and productive activities (gardening, community work, etc.) involving little or no enhancement of fitness lowered the risk of all-cause mortality over a 13-year period to a degree similar to that achieved by fitness activities (e.g., swimming, and walking). This study suggests that a wider range of mechanisms, both psychological and psychosocial, may be involved in the association between activity and mortality.
than had been previously thought. The finding has important implications for public policy and clinical practice. If confirmed, it suggests that clinicians might consider recommending a broader range of activity options for older patients.

Centenarians live most of their lives in good health.—Scientists have found preliminary evidence that many centenarians remain functionally independent for the vast majority of their lives and then experience a relative rapid decline near the end of their lives. Relative to others in the older population, they also appear to either experience a marked delay in the onset or, in some cases, escape diseases such as cancer and Alzheimer’s disease. Scientists also find a strong familial component to extreme longevity. Siblings of centenarians tend to live longer compared to siblings of individuals who died in their mid-70’s. This may be due in part to shared genetic traits among family members. Understanding the genetic and environmental factors responsible for centenarians’ prolonged good health could provide insights for improving the health of all older people. Further work is needed to elucidate the genetic and environmental factors that contribute to centenarians’ extreme longevity.

Socioeconomic status and health disparities are strongly related over the life course.—There is a striking and well-documented relationship between socioeconomic status, health, and longevity. People with higher incomes and more wealth tend to be healthier and to live longer. The causes of this relationship are largely unknown, but may be related to health behaviors and access to care. In a recent study done by researchers, African-American men were found to have lower life expectancy in disparate income groups than did white men in the same income groups for the years 1979 to 1989. African-American men with family incomes below $10,000 averaged 7.4 fewer years of life than black men in families with more than $25,000; among white men, the differential between the two income groups was 6.6 years. Less work has been focused on the effect of health events on subsequent income and wealth. The strong interrelationship between health and wealth at older ages may be due, in large part, to the adverse economic impact of major health events. One major reduction in wealth appears to be reduced earnings that stem from taking early retirement or otherwise decreasing work. People who have heart attacks, strokes, or other acute health events are especially likely to reduce their work levels. There are equally large reductions in wealth among those with and without health insurance (although those with health insurance have lower out-of-pocket medical expenses), suggesting that health insurance does not fully protect people from the economic costs of major illnesses. This finding demonstrates how differences in health status can cause differences in economic circumstances. These results also suggest some direction for policy. They show, for example, that health insurance deals with only a small part of the economic cost of declining health. The much larger economic costs of decreased work and lost earnings might be more effectively addressed in other ways. To aid in understanding this causal relation between health and wealth, future clinical trials could include more economic content so that the impacts of health on economic status can be measured.
Neighborhood and socioeconomic characteristics hamper progress in fitness.—Physical inactivity is a leading cause of both death and disability among older adults. Recent analyses from the Alameda County Study, which was conducted by investigators, show that socioeconomic variables such as neighborhood characteristics affect physical activity levels and thus may contribute to health disparities. Living in a poor neighborhood is associated with a decline in physical activity, even adjusting for age, individual income, education, smoking status, body mass index, and alcohol consumption. Other survey analyses reveal that poor weather and fear of crime were major barriers to exercise among low-income urban older adults, as was the lack of information from physicians and family/friends regarding the safety and benefits of exercise. These studies demonstrate the importance of designing physical activity/exercise programs that can counter the negative effects of disadvantaged social conditions.

2000 SELECTED SCIENCE ADVANCES

Behavioral and Social Research

Mortality Continues to Decline in Industrialized Countries.—During the twentieth century, mortality rates have shown steady and significant declines in the G7 countries of Canada, France, Italy, Germany, Japan, the United Kingdom, and the U.S. Mortality decline has occurred most significantly in older populations due to decreases in deaths from heart attack, stroke, and cancer. Examining mortality data of the G7 industrialized countries over the last five decades, researchers found that long-term patterns in mortality rates have continued to decline exponentially at a remarkably constant rate, without evidence of slowing. Therefore, official estimates of longevity in the G7 countries underestimate life expectancy and also underestimate the ratio of people 65 and older to working age people (20–64 year olds). By the year 2050, these ratios may be between 6 percent (UK) and 40 percent (Japan) higher than official projections. These findings have significant implications for public policy regarding future demands on health care, long-term care, retirement support, and other services.

Emotional Vitality is associated with lower Mortality and Progression of Disability in Disabled Older Women.—Using data from the Women's Health and Aging Study, a longitudinal study of community-dwelling disabled women aged 65 years and older, researchers examined whether emotional vitality protects against progression of disability and mortality. At the start of this study, a substantial proportion of even the most disabled older women were identified as emotionally vital. Three years later, results showed that these upbeat, positive women did better than women who were not emotionally vital in maintaining physical function over time. These results suggest that helping older people maintain a high level of emotional vitality might play an important role in slowing or preventing a downward spiral in health status. Further study may be warranted of why and when positive emotions protect against health decline in older people.

The Influence of Stereotypes on Cardiovascular Health and Cognitive Function.—Recent research indicates that exposure to nega-
tive beliefs about aging can contribute to adverse health outcomes, even when an individual is not consciously aware of such exposure. In this study, exposure to negative stereotypes elicited heightened cardiovascular stress (increased blood pressure and heart rate in older adults) in response to mathematical and verbal challenges designed to elicit a stress response. Positive messages about aging protected participants from a stress response. The older adults exposed to positive stereotypes also exhibited more confidence in their ability to perform computations than those exposed to negative stereotypes, and then outperformed them as well. These preliminary findings suggest that further research is need to examine the potentially powerful influence of stereotypes not only on the physical well being of older adults but also on their performance in tasks known to become progressively more difficult with age. Perhaps positive age-related stereotypes could be used to reduce cardiovascular responses to stress and to improve cognitive performance and daily function.

SECTION II.—RESEARCH SPONSORED BY OTHER NIH INSTITUTES

NATIONAL INSTITUTE OF MENTAL HEALTH

The National Institute of Mental Health (NIMH) program of research on aging includes studies in the basic sciences as well as research in neurobiology and brain imaging, clinical neuroscience, treatment assessment, psychosocial and family studies, and service systems research. Studies involve mental disorders with initial occurrence in late life as well as illnesses that begin in early adulthood but continue throughout the life course. Major areas of research focus are the psychiatric aspects of Alzheimer's disease and related dementias, depressive disorders, schizophrenia, anxiety disorders, and sleep disorders.

Alzheimer's Disease

An estimated 4 million Americans age 65 and older suffer from Alzheimer's disease or other forms of dementia. An important area of NIMH research on Alzheimer's disease focuses on genetic factors. NIMH-supported researchers recently identified a new gene mutation strongly associated with the risk of developing late-onset Alzheimer's disease, the most common form of the brain disorder. Using the NIMH Genetics Initiative Alzheimer's disease sample (a collection of DNA samples and clinical information from hundreds of families in which more than one individual has Alzheimer's), and new methodology, the researchers found that a particular gene mutation, alpha-2 macroglobulin-2 (A2M-2), was significantly associated with Alzheimer's. Different teams of investigators are continuing to analyze the NIMH Genetics Initiative sample, and recent evidence has been found by three different groups to support linkage between genetic markers on chromosome 10 and Alzheimer's disease. Researchers are actively working to find the specific gene involved. These findings, if replicated, will offer important clues into the disease process and will help discern the role of additional genetic and environmental factors involved in creating vulnerability to the disease.
Depression

Nearly 5 million of the 32 million Americans age 65 and older suffer from depression. Significantly, many late-life depressions are amenable to treatment. Recent NIMH-supported studies provide important information relevant to depression treatment in the elderly. One study compared treatment response among elderly depressed patients who had their first depressive episode early in life and those whose first episode occurred at age 60 or older. Although age at onset did not affect overall efficacy of treatment, patients who had experienced their first depressive episode early in life took 5–6 weeks longer to reach remission. This slower treatment response, combined with the increasing rates of suicide among the elderly, particularly among males, indicates that elderly depressed patients with early-onset illness need particularly careful management.

Another study found that a combination of pharmacotherapy and psychotherapy is extremely effective in preventing recurrence of depression among the elderly. Older adults who received interpersonal therapy and an antidepressant medication during a three-year period were much less likely to experience recurrence than those who received medication only or therapy only. Positive long-term outcome, however, was less durable in individuals above age 70 than in those below this age.

NIMH-supported research has suggested that, among depressed older adults, slower and less complete response to antidepressant treatment tends to be associated with cerebrovascular pathology, ventricular enlargement, and impairment of frontostriatal brain pathways. Patients with such brain pathology often also show particular clinical features, including psychomotor retardation, lack of insight, and impairment of higher-order executive functions. One recent study extended this picture by examining the prognostic value of executive dysfunction in older adults after their depressive symptoms had remitted with treatment. The presence of abnormalities of initiating behaviors and perseverating, but not memory impairment or other clinical features, predicted fluctuations in residual depressive symptoms and greater relapse and recurrence of depressive disorder. These clinical features thus can help identify patients who need particularly vigilant monitoring and follow-up. This body of research is leading to further studies on the role of specific prefrontal brain pathways in predisposing toward or perpetuating depressive symptoms and syndromes in elderly patients.

Suicide

Older Americans are disproportionately likely to commit suicide. Comprising 13 percent of the population, they account for nearly 20 percent of all suicide deaths. The rate of suicide is particularly striking among white males aged 85 and older: in 1997, the most recent year for which statistics are available, the rate in this group was 65 per 100,000 - about six times the national U.S. rate of 10.6 per 100,000. Researchers interviewed families and associates of elderly individuals who committed suicide to determine the state of mind of such individuals just prior to their suicide. The investigators concluded that major depression was the most common predictor of suicide in this study population. At least 70 percent of those
who committed suicide had visited primary care providers within a month of the suicide. The findings point to the urgency of enhancing both the detection and adequate treatment of depression in primary care settings as a means of reducing the risk of suicide among the elderly. NIMH is currently funding a multi-site study in the elderly to test the effectiveness of an intervention aimed at improving the recognition of suicidal ideation and depression by primary care providers.

Sleep Disorders

Insomnia and other sleep difficulties tend to be highly prevalent, chronic ailments among older adults that are most commonly managed clinically by prescribing hypnotic medications. However, long-term use of such medications can often complicate the sleep difficulties. NIMH-supported research has demonstrated that psychotherapy can also be used successfully to treat chronic primary insomnia in middle-aged to elderly individuals. Cognitive-behavioral therapy focused on sleep issues proved equal to the sleep medication temazepam in alleviating insomnia in older adults, and led to more enduring improvements in sleep at 12- and 24-month follow-ups. Combining the psychotherapy with medications did not yield advantages over the outcomes achieved with either treatment individually. Such results indicate that psychological interventions are useful techniques in treating sleep problems in late life and that, as in other disorders, older patients with chronic insomnia respond to psychotherapy comparably to younger adults.

NATIONAL EYE INSTITUTE

Age-Related Macular Degeneration

Age-related macular degeneration is the leading cause of blindness in patients over the age of 65. As the population in this country ages, this disease will have an even greater impact. The condition affects the retina and leads to varying degrees of vision loss depending on the form and severity of the disease. In initial phases, the disease causes reductions in the ability to read fine print and see in dim light. In the later stages of the disease, abnormal blood vessel growth takes place under the retina and causes severe vision loss resulting in an inability to drive, read, recognize faces, and perform other visual tasks of day to day living. While the disease has been recognized for many years, our understanding of the causes and reasons for progression of this disease are still limited. Work in humans with this conditions has indicated that certain proteins involved in growth of blood vessels are elevated in these patients and that one growth factor, vascular endothelial growth factor (VEGF), is consistently elevated in patients with abnormal blood vessels associated with age-related macular degeneration. For the first time, scientists at the National Eye Institute (NEI), using a system to manipulate the expression of VEGF have been able to cause development of abnormal blood vessels in rodent eyes that are identical in location and appearance to those seen in humans afflicted with the disease. This finding is important, because, to date, no animal model has been developed that mimics the disease in humans. Modeling this condition in animals will pro-
vide an invaluable research tool to study the causes and to test treatments for this condition. Because the model takes advantage of a stimulus known to occur in the human condition, a more precise understanding of the trigger factors for the growth of the blood vessels will be gained. Subsequently, these trigger factors can then be manipulated through various therapeutic mechanisms that should be directly applicable to patient care. By understanding and using this new model, scientists hope to develop better tools to treat patients with age-related macular degeneration.

**Age-Related Cataract**

Visual impairment and blindness from cataract is an important public health problem throughout the world. Age-related cataract accounts for about 16 million cases of blindness worldwide, about half of all cases of blindness. Most people with severe impairment from cataract are in the developing countries of Asia and Africa where barriers to cataract surgery are greatest. In the population-based Baltimore Eye Study and the Salisbury Eye Evaluation Project, cataracts were the leading cause of visual impairment (best corrected visual acuity in the better eye of worse than 20/40 but better than 20/200) among older adults. In both studies, rates of blindness and visual impairment from cataract were higher in blacks than in whites. While surgical treatment for cataract is effective, the cost of the large number of procedures done each year is high. In the United States, cataract surgery is the most frequently performed surgical procedure in the Medicare program, with about 1.35 million cataract operations done each year at a cost of approximately 3.4 billion dollars. The identification of modifiable risk factors or interventions that affect the development of cataract could have a large economic impact and reduce rates of blindness and visual impairment throughout the world. The Age-Related Eye Disease Study (AREDS), sponsored by the NEI, is an ongoing multi-center study of the natural history of cataract and age-related macular degeneration. Data were collected at entry on a wide range of possible risk factors for cortical and nuclear cataracts, two of the most common types of cataract. Results from the study reinforce a growing consensus that smoking increases the risk of development of nuclear cataract and that higher levels of sunlight exposure increase the risk of cortical cataract. The identification of these potentially modifiable risk factors for cataract reinforces public health recommendations to avoid smoking and decrease exposure to sunlight.

**Glaucoma**

Glaucoma is a group of eye disorders that share a distinct type of optic nerve damage that can lead to blindness. Approximately three million Americans have glaucoma, and as many as 120,000 are blind from this disease. Most of these cases can be attributed to primary open angle glaucoma, an age-related form of the disease. Elevated intraocular pressure is frequently, associated with glaucoma, but definitive evidence supporting a casual effect has not been demonstrated experimentally. Scientists now have evidence that increases in intraocular pressure have a profound effect on ganglion cell survival. Optic nerve fibers from retinal ganglion cells
connect to neurons in a part of the brain called the lateral geniculate nucleus (LGN). Neurons from the LGN relay information to the visual cortex for processing. Using a primate model of glaucoma, scientists showed that relatively moderate elevations of intraocular pressure cause loss of LGN neurons over an extended period of time. These data demonstrate that chronic elevation of intraocular pressure has a neurodegenerative effect on neurons critical for the integration and transmission of visual information.

**Low Vision Education Program**

On October 19, 1999, the NEI announced the formal launch of its Low Vision Education Program. Low vision is broadly defined as a visual impairment, not corrected by standard glasses, contact lenses, medicine, or surgery, that interferes with the ability to perform everyday activities. Most people develop low vision because of eye diseases, such as cataracts; glaucoma; diabetic retinopathy; or age-related macular degeneration, the leading cause of severe visual impairment and blindness in Americans 60 years of age and older. Low vision primarily affects the growing population of people over age 65 and other higher risk populations, including Hispanics and African Americans who are likely to develop low vision at an earlier age. While lost vision usually cannot be restored, many people can learn to make the most of the vision that remains. The Low Vision Education Program will include a multimedia public service campaign and a traveling exhibit that will be displayed in shopping malls around the country. The program will provide communities nationwide with materials and technical support to increase awareness of local low vision services and resources.

**Office of Research on Women's Health**

During 1999 and 2000, the Office of Research on Women's Health (ORWH) supported a number of research activities with the NIA and other NIH ICs that specifically address the health of older Americans, including:

**Study of Women's Health Across Nation II: (SWAN II)**

The goal of this research is to determine menopause-specific physiological changes and their predictors and the impact of menopause on subsequent disease. SWAN consists of both cross sectional and longitudinal studies on the natural history of menopause and a characterization of endocrinology/physiology of premenopause. Five ethnic groups are included - Caucasian, African American, Hispanic, Chinese, and Japanese.

**Black Rural and Urban Caregivers Mental Health Functioning**

The purpose of this study is to assess the mental health and social functioning of rural and urban African-American women who provide unpaid care to an elder (65 years and older) by using a cross-sectional research design and random sample of elders.

**Continuous Low-Dose Hormone Replacement Therapy (HRT) Combined with Alendronate (ALN) in Postmenopausal Women**

The primary outcome measures from this research are spine bone mineral density and total hip bone mineral density as a result of
receiving low-dose HRT, ALN, and both low-dose HRT and ALN. Total body bone mineral content and forearm bone mineral content will also be measured.

**Comprehensive Treatment for Older Breast Cancer Patients**

The hypothesis of this study is that a comprehensive geriatric intervention integrated with oncological treatment may preserve the independence and quality of life of older breast cancer patients.

**Exercise and Quality of Life in Older Women with Breast Cancer**

The primary aims of the study are to determine if: 1) A moderate exercise program, as compared to enhanced usual care, significantly improves the physical function and quality of life in older women with breast cancer; and 2) A psycho-educational program, as compared to usual care, significantly improves physical functioning and quality of life in older women with breast cancer.

**Gender Differences in Pain Responses of the Elderly**

This research will develop future strategies for pain treatment in elderly patients by increasing our understanding of the role of gender and hormone replacement on pain perception.

**Menopausal Depression: Chronobiologic Basis**

This research is designed to provide information on possible mechanisms mediating the effects of reproductive hormones on mood and behavior and deriving relevant clinical treatment guidelines for menopausal women from this research. This proposal represents an extension of the investigators' previous work that led to the development of new hypotheses and treatment strategies.

**NAS Panel on Risk and Prevalence of Elder Abuse and Neglect**

This panel evaluates the potential for pilot studies needed to develop instruments that can detect abusive behavior. The panel will also discuss issues related to confidentiality and data sharing, and make recommendations regarding the scope of a national research effort on elder abuse and neglect which will include institutionalized victims of abuse and neglect and issues related to data collection on victims suffering from dementia.

**Estrogen and Cholinergic System Interactions in Aging**

The studies contribute important information on the mechanistic link between estrogen, cognition, and Alzheimer's disease in older women, and promote further interest in designing better therapeutic strategies.

**Postmenopausal Estrogen Influences on Olfaction**

This study tests the hypothesis that hormone replacement therapy (HRT) is associated with higher olfactory and cognitive functioning in postmenopausal women. If HRT were found to benefit olfaction and cognition in postmenopausal women, improvements in both nutritional and functional status could result.
Vascular Gene Expression in Aging Women

The central hypothesis of the study is that estrogen inhibits the initiation and progression of atherogenesis in part through direct estrogen receptor-dependent effects on vascular gene expression. This study provides insights into the progression of the disease as well as potential therapies to prevent this age-related disease.

Progestogens vs Phytoestrogens: An Adjunct to ERT

Postmenopausal estrogen replacement therapy (ERT) reduces morbidity and mortality from coronary heart disease (CHD). There is a continuing concern, however, that the concurrent use of a progestogen to protect the endometrium may reduce the cardiovascular benefits of ERT. This research explores whether soy phytoestrogens may be an effective alternative approach to progestogen therapy.

Hormone Replacement and Cerebral Glucose Metabolism

There is evidence that estrogen replacement therapy (ERT) in postmenopausal women may preserve and improve cognition in non-demented women. This study explores whether ERT may produce an increase in global cerebral metabolic rate of glucose utilization (CMRglc) in humans or whether there are specific regional CMRglc increases that may modulate enhanced cognitive functioning.

Selective Estrogen Receptor Modulator (SERMs) Workshop

The overarching objective of the workshop was to identify pivotal questions and formulate future projects in SERM research that cross disease boundaries and potentially incorporate multiple disease endpoints up front.

Older Adults, Health Information and the World Wide Web Conference

The conference provided information on how to develop senior-friendly web sites and offered hands-on opportunities for exploring various sites. A variety of new collaborative activities were established among the participants.

Phytoestrogens and Healthy Aging: Gaps in Knowledge

This workshop examined the relationship between phytoestrogens and cardiovascular health, cancer, bone disease, and menopausal symptoms. The participants suggested areas of research to be included on the agenda for future investigation.

Graylyn Conference on Women's Health

The purpose of the conference was to review and integrate the body of knowledge concerning the effects of estrogen on both arterial and venous thrombosis and its effects on vascular inflammation.
The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) supports basic and clinical research in several major diseases that disproportionately affect older Americans. These include type 2 diabetes, end-stage renal disease, osteoporosis, and prostate cancer.

**Diabetes**

The risk of type 2 diabetes, the most common form of the disease, increases dramatically in middle age. For the elderly with diabetes, life poses major problems. Of the nearly 16 million Americans who have type 2 diabetes, over 6 million are aged 65 or older. Among Americans over age 65, over 18 percent have type 2 diabetes, with the highest prevalence occurring in minority populations (African Americans, Hispanic Americans, and Native Americans).

**Primary Prevention:** The most important risk factors for type 2 diabetes are obesity, insulin resistance, physical inactivity, impaired glucose tolerance, and a history of gestational diabetes or a family history of diabetes. The Diabetes Prevention Program (DPP), a clinical trial under way in 26 medical centers nationwide, seeks to determine whether type 2 diabetes can be prevented with diet and exercise, or medication. The study is designed to determine whether lowering blood glucose levels in people with impaired glucose tolerance can prevent or delay development of type 2 diabetes. Nearly 21 million Americans are affected by impaired glucose tolerance, a precursor to diabetes. These individuals have high blood glucose levels, but not high enough to be diagnosed as having diabetes. The DPP has met its recruitment goals ahead of schedule. Over 3,000 patients have been recruited with nearly 20 percent of them over 60 years of age.

**Obesity:** Another important clinical trial is designed to study if interventions to produce sustained weight loss in obese individuals with type 2 diabetes will improve health. This trial is expected to recruit a patient population which reflects the prevalence rates for diabetes in the United States, and plans to include individuals over age 70. The NIDDK is spearheading this trial with support from the National Heart, Lung and Blood Institute, the National Institute of Nursing Research, the National Center for Minority Health and Health Disparities, the NIH Office of Research on Women's Health, and the Centers for Disease Control and Prevention.

**Complications:** Diabetes is a major risk factor for cardiovascular disease which accounts for 80 percent of mortality in people with type 2 diabetes. The NIDDK is co-sponsoring two major clinical trials with the National Heart, Lung and Blood Institute to address issues of optimal management of glucose, blood pressure and lipids in people with type 2 diabetes. The NIDDK also supported a multicenter clinical trial in patients with type 2 diabetes, the United Kingdom Prospective Diabetes Study, which demonstrated the importance of good blood sugar control in slowing the eye, nerve, and kidney damage caused by diabetes. These findings further reinforce the results of the nationwide Diabetes Control and Complications Trial, which showed similar benefits in type 1 diabetes.
Genetics: Type 2 diabetes is thought to arise from genetic factors, combined with environmental factors, such as obesity. More than one genetic alteration or mutation is probably necessary for the development of type 2 diabetes, which is therefore considered a "complex" genetic disease. Researchers have now found a gene on chromosome 2 calpain 10 which predisposes to type 2 diabetes in a population of Mexican Americans and individuals studied in Finland where there is a high rate of diabetes. In addition, several other groups of investigators have identified genes important in the development of rare forms of diabetes findings that may shed light on type 2 diabetes. The NIDDK has established and fostered an ongoing international consortium on the genetics of type 2 diabetes, and will continue to capitalize on these remarkable advances in genetics, which could provide the means to stem or even reverse the increasing incidence of this devastating disease.

Beta Cell Biology: Type 2 diabetes is a consequence of both insulin resistance and impairment of the insulin-producing beta cells of the pancreas, such that sufficient insulin cannot be produced to compensate for the resistance to its action. Among the new NIDDK research initiatives important to type 2 diabetes in older Americans are the establishment of a Beta Cell Biology Consortium, that can be expected to yield new knowledge about the molecular events involved in glucose sensing and insulin secretion, and a Functional Genomics of the Endocrine Pancreas Consortium, that will identify all genes expressed in the beta cell at various stages of development.

Diabetes Mellitus Interagency Coordinating Committee: In cooperation with the National Institute on Aging, and the Diabetes Mellitus Interagency Coordinating Committee (DMICC), the NIDDK is holding a meeting on “Diabetes and Aging: From Basic Biology to Clinical Care.” The purpose of this meeting is to bring together researchers in the genetic, environmental, phenotypic, and pathogenic causes of type 2 diabetes during the aging process. Also included are researchers looking at diabetes health care among the elderly, including disparities in diabetes treatment among minority groups during the aging process. Federal Agencies which are members of the DMICC will participate in this scientific conference and then meet the following day to share information on current initiatives and report on their efforts in the treatment and clinical management of older Americans with type 2 diabetes.

Osteoporosis

Osteoporosis is characterized by low bone mass and bone deterioration, leading to fragile bones and an increased risk for fractures of the hip, spine and wrist. According to the National Osteoporosis Foundation, more than 28 million Americans, 80 percent of them women, have osteoporosis or are at increased risk of developing the disease. Osteoporosis has been reported in people of all ethnic backgrounds. In addition, of the population over age 50, one in two women and one in eight men will experience an osteoporosis-related fracture in his or her lifetime.

The NIDDK has a strong program on bone and mineral research, focused on the hormones that are major regulators of bone mass and on nutritional aspects of osteoporosis, particularly calcium and
vitamin D intake and metabolism. This program encompasses both basic and clinical research. In December 1999, the NIDDK, together with other institutes with an interest in osteoporosis, issued a research solicitation on receptors and signaling in bone health and disease.

Alterations in hormone levels, such as loss of normal estrogen production in post-menopausal women, is a major contributor to bone loss with aging. Limited clinical trials have determined that hormone replacement can partially mitigate or reverse the osteopenia associated with menopause. The use of estrogen/progesterone hormone replacement therapy has gained wide acceptance in peri- and post-menopausal women, through not without undesired side effects. The development and use of Selective Estrogen Receptor Modulators (SERMs) has the potential to lessen the side effects, while giving some degree of protection against post-menopausal bone loss. Still other hormonal therapeutic agents, such as parathyroid hormone, have recently shown great promise as new approaches to treatment of osteoporosis. These clinical studies are a direct outgrowth of a longstanding NIDDK-supported basic research program on hormonal regulation of bone. Additional studies are needed to evaluate the role of these newer therapies in combination with established therapies for osteoporosis.

The NIDDK co-sponsored an NIH Consensus Development Conference on Osteoporosis Prevention, Diagnosis and Therapy on March 27–29, 2000. The panel’s recommendations for future research included identifying and intervening in disorders that can interfere with peak bone mass in children of ethnic diversity; improving diagnosis and treatment of secondary causes of osteoporosis; collecting the data necessary to establish guidelines for testing for osteoporosis; developing quality-of-life measurement tools; conducting randomized trials of combination therapies; and developing a paradigm for the management of fractures.

**End-Stage Renal Disease**

Irreversible kidney failure known as end-stage renal disease or ESRD is a serious health problem in older Americans, who require either lifelong dialysis or kidney transplantation to survive. While ESRD affects persons of all ages, the peak incidence is in the sixth decade of life. Over the last decade there has been a worrisome growth in the incidence of ESRD, and incidence rates have grown more rapidly for individuals over age 75. In most instances, ESRD develops as the consequence of progressive damage to the kidney that occurs over a decade or more. A number of underlying diseases can cause progressive renal failure, most importantly diabetes mellitus, which in 1997 accounted for 42 percent of incident cases of ESRD, and hypertension, which was responsible for 26 percent of incident cases.

The NIDDK supports several initiatives to combat ESRD through the generation of fundamental insights into kidney abnormalities and their progression to kidney failure, and through research aimed at improving therapies, as well as developing prevention strategies. Some examples of major initiatives include:

**Hemodialysis Vascular Access Clinical Trials Consortium**: Vascular access has been called the “Achilles heel” of hemodialysis. A
very sizable portion of costs of care of dialysis patients are attributable to problems with vascular access. This newly created clinical consortium will conduct a series of multicenter, randomized studies of strategies to reduce the failure and complication rate of arteriovenous grafts and fistulas in hemodialysis patients over a five-year period.

Prospective Cohort Study of Chronic Renal Insufficiency: In FY2000 the NIDDK is initiating a new longitudinal cohort study to understand the epidemiology of chronic renal disease. The goals of the study are two-fold: To determine the risk factors for accelerated decline in renal function, and to determine the incidence and identify risk factors for cardiovascular disease. Because of the relative and increasing importance of diabetes as a cause of ESRD, approximately one-half of the study participants in the cohort study will be diabetic.

The United States Renal Data System (USRDS): Since its creation in May 1988, USRDS has pursued the collection, analysis, and distribution of information on the incidence, prevalence, treatment, morbidity, and mortality of ESRD in the United States. The USRDS monitors outcomes for dialysis and transplant patients. USRDS data are publicly available on the NIDDK World Wide Web site (http://www.niddk.nih.gov).

Long-Range Plan: In 1999, the NIDDK, in collaboration with the Council of American Kidney Societies, released a long-range plan for research to improve the treatment and prevention of kidney disease and kidney failure. The strategic plan reflects the consensus of more than 100 researchers, members of kidney societies, and of patients regarding research needs, opportunities for advances, and barriers to progress.

Healthy People 2010: Healthy People 2010 contains the first-ever chapter on Chronic Kidney Disease, a major contributor to ESRD. It includes scientific background, specific objectives, and current and future challenges to improving the Nation's kidney health.

Prostate Disease

The NIDDK supports an active portfolio of basic and clinical investigations on benign prostatic hyperplasia and prostate cancer, both of which disproportionately affect older men.

BENIGN PROSTATIC HYPERPLASIA

Benign prostatic hyperplasia (BPH) is an enlargement of the prostate gland that can interfere with urinary function in older men. It causes blockage by squeezing the urethra, which can make it difficult to urinate. Men with BPH frequently have other bladder symptoms including an increase in frequency of bladder emptying both during the day and at night. Most men over the age of 60 have some BPH, but not all have problems with blockage.

Medical Therapy of Prostate Symptoms (MTOPS): This multicenter clinical trial is assessing the effect of two different pharmacological agents on the prevention of progression of symptomatic BPH, and correlating those clinical effects with molecular and genetic actions on prostate biopsy tissue from participants in the study.
Minimally Invasive Surgical Therapies Treatment Consortium for Benign Prostatic Hyperplasia: This new initiative, in collaboration with the National Cancer Institute and the National Institute of Environmental Health Sciences, is establishing a group of collaborative Prostate Evaluation and Treatment Centers and a Biostatistical Coordinating Center to develop and conduct randomized, controlled clinical trials of the long-term efficacy and safety of the major "minimally-invasive" approaches for the treatment of symptomatic benign prostatic hyperplasia.

PROSTATE CANCER

In the United States, prostate cancer has become the most frequently diagnosed cancer, and the second leading cause of cancer mortality in men after lung cancer. Its incidence rate has continued to increase rapidly during the past two decades especially in men over the age of 50 years.

Molecular Epidemiology of Prostate Carcinogenesis: This new initiative is encouraging molecular epidemiologic studies for advancing understanding of prostate cancer development and progression. The purpose is to stimulate development and application of biological markers of prostate cancer risk and tumor aggressiveness and for utilization in chemoprevention studies. Of special interest are studies of markers to elucidate multiethnic differences in prostate cancer susceptibility.

Role of Hormones and Growth Factors in Prostate Cancer: This initiative is encouraging studies to explore the underlying mechanism(s) of action of hormones and growth factors in the regulation of prostate development, growth, and tumor development.

Biology, Development, and Progression of Malignant Prostate Disease: This initiative, in collaboration with the National Cancer Institute, the National Institute on Aging, and the National Institute of Environmental Health Sciences, is encouraging a range of fundamental biological issues considered critical for progress in defeating prostate cancer. The purpose is to support studies focusing on the biology that underlies the development and progression of malignant prostatic disease.

NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES

Researchers supported by the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) use powerful research tools to acquire and apply new knowledge to studies of some of the most challenging diseases affecting older Americans today. Many of these diseases have troubled patients and their health care providers for decades, but each year significant discoveries have brought researchers closer to fully understanding, diagnosing, treating, and ultimately preventing these common, disabling, costly and chronic diseases, which greatly compromise quality of life. These disorders include the many different forms of arthritis and numerous diseases of joints, muscles, bones, and skin.
Rheumatoid Arthritis

Rheumatic diseases such as rheumatoid arthritis and osteoarthritis affect people of all races and ages, and are the leading cause of disability among adults age 65 and older in the United States. It is estimated that by the year 2020, nearly 60 million Americans will be affected by arthritis and other rheumatic conditions. These diseases may cause pain, stiffness, and swelling in joints and other supporting structures of the body such as muscles, tendons, ligaments, and bones. The NIAMS funds a broad array of research studies across the spectrum from basic to clinical to translational, in an effort to better understand what causes these conditions and how best to treat and prevent them. Such investments include support for studies of target organ damage in rheumatoid arthritis (RA), an inflammatory disease of the lining of the joint, and of new imaging technologies in animal models of RA. Other scientists funded by the NIAMS have launched a multicenter clinical trial to test the oral administration of a small peptide for RA treatment.

The Institute is also building the research infrastructure needed to stimulate additional innovative studies of arthritis and other rheumatic conditions. Such efforts include support for a consortium that is searching for genes that predispose individuals to RA, with the overall scientific goal of developing better diagnostic and treatment methods; funding of a new research registry on RA in the African American population; and support for specialized centers of research in both RA and osteoarthritis, which is a degenerative joint disease. In the NIAMS intramural research program, we continue to support studies designed to understand the genetic and cellular bases of arthritis, as well as novel therapeutic trials involving targeted biologic agents. Finally, the NIAMS is committed to disseminating science-based health information on arthritis and related conditions. For that purpose, the Institute published a bilingual brochure, in Spanish and English, entitled “Do I Have Arthritis?” and developed a primer for patients on new medications for RA and OA.

Osteoarthritis

The NIAMS is pursuing a multipronged approach to the challenge that osteoarthritis (OA), a degenerative joint disease that is the most common form of arthritis, poses as the U.S. population ages. This approach includes efforts to create a public-private partnership to identify biomarkers and surrogate endpoints that can facilitate clinical trials and enhance drug development for OA; the initiation of a major research contract, in collaboration with the National Center for Complementary and Alternative Medicine, to study the efficacy of the dietary supplements glucosamine and chondroitin sulfate for the treatment of knee OA; and the recent publication of a handout on health on OA for affected patients, family members, health care providers, and health educators. Scientists supported by the Institute have made a number of important contributions in the field of OA in recent years, including investigations to develop specific chemical compounds that prevent the expression of enzymes that cause cartilage degradation, and studies to determine the genetic predisposition of daughters whose
mothers have knee OA in the hopes of identifying susceptible individuals as early as possible.

These projects complement other efforts supported by the Institute that range from basic studies to examine biomechanical signaling mechanisms in cartilage, to tissue engineering work that includes the use of animal models to develop joint scaffolds and test surgical approaches for engineered joints, to novel imaging studies designed to better identify joint disorders and assess their progression. We are also supporting several pilot projects to test the feasibility of new methodologies to understand the causes of, and develop novel treatments for, OA. Furthermore, we recently funded a number of new grants to identify and evaluate chondroprotective agents that prevent cartilage destruction, or facilitate its repair. In addition, the NIAMS is building on the insights gained at a scientific conference on OA held in the summer of 1999 by issuing a new solicitation for research on the onset, progression, and disability associated with OA, in conjunction with other interested Institutes.

**Osteoporosis**

Osteoporosis, a disease characterized by low bone mass and structural deterioration of bone tissue, is the leading cause of bone fractures in postmenopausal women and older people in general. The NIAMS leads the Federal research effort on osteoporosis and related bone diseases, and supports research ranging from very basic studies to clinical and translational projects, as well as early intervention and prevention efforts. Significant advances in the prevention and treatment of osteoporosis are available today as the direct result of research focused on determining the causes and consequences of bone loss at cellular and tissue levels, assessing risk factors, developing strategies to maintain and even enhance bone density, and exploring the roles of such factors as hormones, calcium, vitamin D, drugs, and exercise on bone mass. For example, scientists at a NIAMS-funded specialized center for research on osteoporosis recently reported that giving lower doses of estrogen and progesterone during hormone replacement therapy (HRT), in combination with calcium and vitamin D, spares older women significant osteoporotic bone mass loss while limiting HRT’s more negative side effects.

In 1999, the Institute funded two new core centers for research on musculoskeletal disorders. The first is concentrating on studies of skeletal integrity, which encompasses biological, chemical, and mechanical influences on bone. The second core center focuses on basic bone biology and bone diseases. The work at these core centers will boost the critical mass of talented scientists working on problems of bone growth and disease. In addition, in 2000, the NIAMS issued a request for applications for additional specialized centers for research in osteoporosis. Such centers are supported by the NIAMS to further the translation of basic research findings to clinical applications that will help affected patients. Furthermore, in the spring of 2000, the Institute sponsored a major consensus development conference on osteoporosis at which national and international experts presented the latest research findings on this disorder, and developed recommendations to enhance future diag-
nosis, prevention, and treatment approaches. Finally, the NIAMS and several other NIH components support the Osteoporosis and Related Bone Diseases National Resource Center to promote the dissemination of science-based health information to patients, health care providers, and the general public.

**NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE**

NCCAM is dedicated to exploring complementary and alternative healing practices in the context of rigorous science; educating and training complementary and alternative medicine (CAM) researchers; and disseminating authoritative information to the public and professionals. CAM use spans the spectrum of conditions and diseases confronting the American public as a whole, however, it is especially associated with chronic conditions. Consequently, a large component of the NCCAM research portfolio, addresses dementia, arthritis, cancer, cardiovascular disease, and pain conditions affecting the quality of life and longevity of our nation’s elderly. Key examples from our portfolio are described below.

**CAM Use by the Elderly**

Contemporary studies of CAM practices estimate that 42 percent of all adults in the United States use some form of CAM. New findings from an NCCAM-supported survey of senior citizens confirm that the extent of their CAM use closely mirrors that of the population at large. Results from this study of Medicare beneficiaries found that more than 40 percent reported using CAM. Of those using CAM, some 80 percent maintained that they experienced substantial benefit from it. However, the majority did not disclose their use of CAM therapies to their physicians. These findings underscore the need for conventional physicians to inquire about CAM use by their elderly patients.

**Dementia**

For centuries, extracts from the leaves of the *Ginkgo biloba* tree have been used as Chinese herbal medicine to treat a variety of medical conditions. In Europe and Asia, standardized extracts from ginkgo leaves are routinely taken to treat a wide range of neurocognitive symptoms, including those of Alzheimer’s disease. Little is known, however, about the safe dosage levels of *Ginkgo biloba* extract, let alone its actual effectiveness in preventing Alzheimer’s disease. NCCAM, in collaboration with the National Institute on Aging (NIA), the National Heart, Lung and Blood Institute (NHLBI), and the National Institute of Neurological Disorders and Stroke (NINDS), may help resolve these questions through a six-year, multi-center effort to study the efficacy of *Ginkgo biloba* extract in preventing dementia, a cognitive decline in memory and other intellectual functions, in older individuals. This study, the largest of its kind ever conducted on *Ginkgo biloba*, includes four clinical centers and an enrollment of almost 3,000 people. Participants who take *Ginkgo biloba* are being compared to a second group of individuals who are taking a placebo.
**Osteoarthritis**

Osteoarthritis (OA), or degenerative joint disease, is a common type of arthritis caused by the deterioration of cartilage, the connective tissue that cushions the ends of bones and permits their surfaces to slide smoothly across one another within the joint. Arthritic diseases are major public health problems affecting the quality of life for a large segment of the older American population. In 1995, it was reported that 32 million Americans were afflicted with this disease. Estimated medical costs for people with arthritis total $15 billion annually. Accordingly, the first U.S. multi-center study to investigate the dietary supplements glucosamine and chondroitin sulfate for knee OA has been funded by the NCCAM in collaboration with the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS). Glucosamine and chondroitin sulfate are two natural substances, found in and around the cells of cartilage, and commonly used today as nutritional supplements. The study is expected to verify their clinical safety and effectiveness alone or in combination in reducing joint pain and improving mobility. The study involves nearly 1,600 OA patients at 13 study centers across the country.

**Cardiovascular Disease**

Cardiovascular disease, (CVD) accounts for more than 40 percent of all U.S. deaths and is the leading cause of death in African-Americans. NCCAM supports a Specialty Research Center for CAM, Minority Aging, and CVD at the Maharishi University of Management in Iowa. In collaboration with traditionally black universities and medical schools, the Center is testing the efficacy of Vedic medicine, an ancient Hindi system of healing, for reducing mortality and morbidity associated with CVD in high risk, older African-Americans.

NCCAM has also established a CAM Research Center for Cardiovascular Diseases to focus on the investigation of CAM modalities to treat and prevent CVD. The Center is employing a double-blind, placebo-controlled, randomized trial of a standardized extract of the plant *Crataegus* (Hawthorn) in patients who, despite optimal conventional medical therapy, continue to experience symptomatic heart failure. The goal is to obtain a comprehensive understanding of the potential role of Hawthorn in the treatment of heart failure. This study is also testing the effectiveness of Reiki treatment for sub-acute stroke inpatients. The randomized trial employs three arms: Reiki plus standard care, a placebo plus standard care and standard care alone. Additionally, the center stresses CAM education and promotion of validated CAM treatments for cardiovascular well-being.

**Cancer**

More than 175,000 women will have been diagnosed with breast cancer in the year 2000; nearly 30 percent will ultimately die of the disease. Studies show that support group participation improves breast cancer survival rates. NCCAM and the National Institute of Nursing Research (NINR) are supporting the investigation of strategies of self-transcendence among support group members to improve well-being and immune function and to increase understand-
ing of the relationship between survival rates and support group participation.

In 2000 NCCAM funded two Specialty Research Centers for Cancer dedicated to studying the safety and effectiveness of several popular CAM therapies. One of these centers is examining the antioxidant effects of herbs in cancer cells and the safety and efficacy of PC–SPES, a popular mixture of Chinese herbal medications, in men with prostate cancer.

Finally, in conjunction with the National Cancer Institute, (NCI) NCCAM is supporting a Phase III clinical trial of shark cartilage in over 700 lung cancer patients in the United States and Canada.

**Menopause**

In collaboration with the NIH Office of Dietary Supplements (ODS), NCCAM funds four Centers for Dietary Supplement Research with an emphasis on botanicals. The Centers serve to identify and characterize botanicals, assess bioavailability and activity, explore mechanisms of action, conduct preclinical and clinical evaluations, establish training and career development, and help select the products to be tested in randomized controlled clinical trials. In one of these centers, an multidisciplinary team of investigators studies the clinical safety and efficacy of botanicals for menopause. Additional studies will address identification of active compounds, characterization of metabolism, and pharmacokinetics of active species contained in these botanicals.

**Prostate Enlargement**

Benign prostatic hyperplasia (BPH), or enlargement of the prostate, is the most common benign tumor found in men. Anecdotal reports suggested that the botanical product saw palmetto is effective in decreasing the swelling associated with BPH. To determine the validity of these observations, NCCAM, in collaboration with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), is supporting a large, rigorously designed, placebo-controlled, prospective study to evaluate the effect of saw palmetto extract on symptoms and quality of life in men with moderate-to-severe prostate swelling.

**Parkinson's Disease**

The NCCAM's multi-site, double blind study compares the effects of the nutritional supplement, melatonin, given at two different doses, and placebo on nocturnal sleep. The study allows for assessment of any adverse events associated with melatonin related to its safety and tolerableness. This research may lead to the development of safer, more physiologic therapies for treating sleep disturbances in patients with Parkinson's Disease.

**NATIONAL INSTITUTE ON DEAFNESS AND OTHER COMMUNICATION DISORDERS**

**Genetic Association and Age-Related Causes for Hearing Loss**

Scientists are determining if different mutations in the same genes that cause profound hereditary hearing impairment also cause age-related hearing loss (presbycusis), a common problem for
older Americans. It has been presumed for some time that presbycusis may be inherited and that genetic factors may influence the rate and severity of hearing loss. An NIDCD-supported study involving a large population of related and non-related individuals has demonstrated that a clear genetic component exists for age-related hearing loss. The investigators were able to demonstrate a genetic component by measuring several different hearing thresholds at specific frequencies that are most commonly affected in presbycusis. In fact, estimates for the amount of a genetic component to age-related hearing loss were greater than, or comparable to, those seen for blood pressure or cholesterol levels. With the ability to predict who is at increased risk, better strategies to minimize or delay hearing loss within the aging population can be developed.

In another project, NIDCD-supported scientists are conducting basic and clinical research on the structural and molecular changes in the aging auditory system. Information from these studies should form the rationale for designing pharmacological and gene-based therapies for treating presbycusis and preventing or reducing its prevalence.

**Hearing Aid Clinical Trial Yields Important Results**

The prevalence for hearing impairment significantly increases with age, and hearing aids are the most common means of assistance for persons with hearing loss. The NIDCD and the Department of Veterans Affairs conducted a multi-center trial, which included elderly volunteers, to compare the effectiveness of three commonly used hearing aid circuits. Data from the trial showed minimal performance differences among the three hearing aid circuits. Of greater importance, the trial demonstrated that each circuit improved speech recognition under both quiet and noisy listening conditions, improved the quality of speech for soft and conversational speech levels, and reduced the frequency of problems encountered with using hearing aids in verbal communication. NIDCD remains committed to support research leading to smaller and better hearing aids, capitalizing on bioengineering advances in microelectronics.

**Vestibular Disorders in the Elderly**

Disorders of balance and the vestibular system affect a large proportion of the population, particularly the elderly. Disorders of balance and spatial orientation are common conditions. Based on an NIDCD analysis of the 1994–1995 Disability Supplement of the National Health Interview Survey, an estimated 6.2 million Americans reported chronic problems of dizziness and/or balance. These problems were self-reported in approximately nine percent of individuals ages 65 years and older. Furthermore, balance-related falls account for a large proportion of fractures, including hip fractures, and accidental deaths in the elderly. Loss of body stabilizing information across the senses will result in problems with balance and gait. Scientists supported by the NIDCD are studying the mechanisms that control posture and equilibrium in stance and gait to better understand disorders of the vestibular system and the other body stabilizing systems. The scientists are determining how indi-
Individuals with loss of vestibular function substitute sensory information from touch and muscle/joint sensations to maintain balance. This research will reveal information on how the somatosensory and the vestibular systems contribute to movement and stance, with aims in developing better rehabilitative strategies for individuals with balance disorders.

**Molecular Mechanisms Governing Our Sense of Taste**

In humans, the loss of taste sensation can contribute to the loss of appetite and poor nutrition, a particularly common problem for older Americans. Although scientific advances have resulted in a better understanding of the basic mechanism of taste, there is still much to be learned about the cellular and molecular mechanisms critical for taste perception. The molecular pathway resulting in perception of taste is initiated when a sweet, bitter, salty, or sour substance binds to specific taste receptors found on the outer surface of taste cells on the tongue. In a collaboration between investigators supported by the National Institute of Dental and Craniofacial Research and NIDCD, scientists have discovered a large family of genes that encode taste receptors that bind bitter substances. The family consists of about eighty genes that code for receptor proteins in certain taste cells on the tongue. This vast array of receptors explain why structurally diverse molecules produce the same perception of bitter taste. These ground-breaking studies are crucial towards understanding the mechanisms underlying the sense of taste.

**Aphasia**

Language deficits in the elderly are most frequently associated with aphasia as a result of stroke or head injury or with the onset of central nervous system diseases, such as Alzheimer’s or Parkinson’s disease. A language deficit may affect employment and social status and can result in isolation from family and friends. Aphasia results when the portions of the brain that are responsible for language are damaged. This disorder usually occurs suddenly and impairs both expression and understanding of language, as well as reading and writing.

For many years, it was thought that brain activity associated with human language function was restricted to the left side of the brain. Studies of individuals with aphasia and other types of disorders of language function have revealed that other regions in the brain also participate in language function. Using functional magnetic resonance imaging (fMRI), NIDCD-supported scientists have documented reorganization of brain activity after treatment for acquired reading disorders following stroke. The neuroimaging performed during a reading task before and after treatment indicated a shift in brain activation from one area to another, showing that it is possible to alter brain activity patterns with therapy for acquired language disorders.

**NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (NHLBI)**

Many research areas supported by the National Heart, Lung, and Blood Institute (NHLBI) are closely related to the health of older people. The following paragraphs describe some recent
NHLBI-supported research results of special relevance to older Americans.

**Older (and Cheaper) Blood Pressure Drug Holds Its Own**

Although newer, more expensive, antihypertensive drugs do a good job of lowering blood pressure and are being prescribed widely by physicians, their ability to reduce cardiovascular events such as heart attacks has not been demonstrated. A large clinical trial that is comparing a diuretic with three types of newer drugs, including an alpha-adrenergic blocker, recently showed that the diuretic was superior to the alpha-adrenergic blocker in terms of its ability to reduce the overall incidence of cardiovascular disease events, and particularly the incidence of congestive heart failure, in patients over 55 years of age. This finding provides valuable information for physicians seeking to prescribe the best and most cost-effective drugs for their patients, particularly as the incidence of congestive heart failure increases as the population ages.

**Antibiotic Inhibits Key Enzyme Responsible for Abdominal Aortic Aneurysm.**—Scientists recently identified MMP-9 as the key enzyme responsible for the development of abdominal aortic aneurysm (AAA), a bulging or ballooning of a weak area in the main artery, the aorta, as it runs from the heart down through the abdomen. More important, the investigators determined that the antibiotic doxycycline inhibits MMP-9 production. Aneurysms tend to grow and can eventually rupture, causing profuse internal bleeding that usually results in death. AAA is projected to affect more and more people, since up to 9 percent of those over 65 have AAA and since the U.S. population continues to age. No drug treatment is currently available to prevent small aneurysms from developing into larger, life-threatening ones. The identification of MMP-9 as the key enzyme in AAA development and the recognition that doxycycline inhibits it should lead to new strategies for managing AAA. Additionally, results suggest that doxycycline has potential for preventing aneurysm growth in patients, thereby reducing the need for risky and expensive surgery.

**Researchers Identify a Potential Therapeutic Compound for Reducing Stroke Damage**

Modern treatment of many strokes includes use of a natural compound, tissue-type plasminogen activator (tPA), that helps to reestablish blood flow by dissolving clots in the blood vessels of the brain. However, tPA can cause serious complications if it leaks from the blood vessels into the brain cells. Additionally, studies in animal models indicate that the brain produces its own tPA in response to traumas such as stroke although, paradoxically, the expression of tPA has been positively associated with increased brain damage in such models. Scientists recently concluded that brain cells can reduce damage from tPA by producing an inhibitor called neuroserpin. Experiments in rats revealed that injecting neuroserpin immediately after a stroke reduces brain cell injury and death, indicating that neuroserpin has potential as a therapeutic agent to reduce the risks of hemorrhage and brain damage associated with tPA treatment.
**Combination Therapy to Reduce Risk of Coronary Artery Disease in Women**

Research suggests a new approach for treating healthy post-menopausal women who are at increased risk of developing coronary artery disease by virtue of elevated cholesterol levels. A recent study found that the addition of estrogen replacement therapy to treatment with a cholesterol-lowering drug has an extra protective effect against heart disease for such women. Results showed that combining the two therapies was more effective than either treatment alone at lowering the level of harmful low-density lipoprotein cholesterol and raising the level of the beneficial high-density lipoprotein cholesterol. In addition, among women who also received estrogen the investigators observed an improved capacity of the blood vessel wall to break down blood clots and to resist inflammation, two processes important for impeding the progression of atherosclerosis. By reducing the risk of developing atherosclerosis, this combination therapy could reduce the risk of heart attacks and strokes, thereby resulting in improved quality of life and monetary savings from fewer hospitalizations and less need for surgery.

**New Advice for Inhaled Corticosteroids to Help COPD Patients**

A recent study suggests that inhaled corticosteroids have a modest benefit in terms of lessened airway reactivity and respiratory symptoms in patients with chronic obstructive pulmonary disease (COPD), but have no effect on the rate of decline of lung function in people with mild to moderate COPD. COPD is a result of accelerated decline in lung function and is thought to be caused by inflammatory changes in the lung that can be initiated by cigarette smoke. Although corticosteroids have been widely prescribed for COPD because of their anti-inflammatory properties, their benefit has been questioned. Researchers suggest that inhaled corticosteroids should be used only for reducing symptoms rather than as agents to modify the long-term course of the disease.

**Blood Clot Risk Increases with Old Age**

The potential for developing blood clots, which can lead to heart attacks and strokes, increases throughout adulthood, but until now little has been known about the mechanisms responsible for this normal aging phenomenon. Researchers recently identified two elements that are responsible for age-regulation of the human gene for blood coagulation factor IX. Using a mouse model, they determined that one element (called AE5'), is responsible for age-stable expression of the gene and the second element (designated AE3') controls the age-related elevation of expression. These findings provide a new avenue for understanding age-related physical disorders and determining potential target sites for new therapeutics for thrombotic disorders.

**Insights into Human Cell Aging**

Researchers have used the ras gene, normally associated with many cancers, to study the process of aging in human cells. By adding an active form of the gene to human cells being grown in laboratory culture, investigators were able to induce rapid cellular aging. This occurred because the gene dramatically increased the
intracellular levels of highly reactive forms of oxygen known as free radicals, which can function as oxidants and are known to be capable of damaging various cellular components. The investigators also determined that the chief sources of free radical production were mitochondria, which are small structures found scattered throughout the cell. Furthermore, these scientists have preliminarily identified a class of chemical compounds that appear to significantly inhibit the level of mitochondrial free-radical production without being toxic to the cells, suggesting that an approach using inhibitors of free radicals may have potential as one possible strategy for slowing the aging process.

THE NATIONAL INSTITUTE OF NURSING RESEARCH

The National Institute of Nursing Research (NINR) supports studies that address health issues of the older population, including prevention of illness and disability; health promotion strategies; management of the symptoms of chronic diseases, including pain; interventions for family caregivers to help them maintain their own health as well as that of their ill relatives; and end-of-life issues to ensure that dying patients receive compassionate and life-affirming health care that promotes comfort and dignity.

Below are examples of findings during 1999–2000.

• Nursing research has developed a successful arthritis self-management program in Spanish. To test the effectiveness of the program, the investigator analyzed the results of a 6-week course led by lay community members involving 219 participants and 112 controls originating from Mexico and Central and South America. The mean age was 62 and a half, and about 85 percent were women. Four months after the program, there were notable improvements among those who took the course in range of motion exercise, degree of disability, relief of pain, and self efficacy. A year after the course, participants showed significant improvements in these areas and in self-reported health status and depression. Not only was this hard-to-reach Spanish language population recruited and retained for the course and its evaluation, but they provided important research information and showed continued improvement in their health.

• Research has been conducted in a population of women aged 55 through 75 before coronary artery bypass surgery and one year after. Although they experienced weight loss following surgery, 58 percent of the women continued to be obese, and their dietary intake of fat and cholesterol remained above recommended levels. Blood pressures significantly increased, and 54 percent of patients continued to exhibit hypertension one
year after surgery. One-third exceeded recommended levels for triglycerides, 78 percent for total cholesterol, and 92 percent for low-density lipoproteins. These findings indicate a high risk for future coronary heart disease for these women and a need for healthcare professionals to design prevention strategies for the women's lives after surgery.

- A study of genetic influences for obesity and weight loss has identified variants in PPAR-gamma-2 and LPL genes that can serve as potential indicators of obesity and successful weight loss among older, postmenopausal women. These women were placed on a regimen of moderate, regular exercise and a heart-healthy diet. Those with the LPL Pvull variant of a gene pair had higher total cholesterol, low-density lipoprotein cholesterol and fasting glucose than women with the normal LPL Pvull gene, thus placing them at increased risk for atherosclerosis. Further, although women with the PPAR gamma-2 variant of a gene pair were highly successful in losing weight, their ability to maintain weight loss was far less successful than women with two normal copies of the gene. They had a nearly two-fold rate of weight regain at 18 months after the intervention was completed. They also had a larger body mass index and a greater increase in insulin sensitivity, which may contribute to their more rapid weight gain. This finding adds important information for development of weight management strategies.

- It is important that caregiver health, as well as that of the patient, be assessed by health care professionals. Research has shown that caregivers who themselves have physical problems are at greater risk for psychological distress. An intervention that better prepares them for their tasks can minimize this distress in the long term and improve the well being of both caregiver and patient. Research comparing a home care intervention using oncology nurse clinical specialists with standard home care found that patients showed 32 percent less distress. Sixteen percent of patients improved function for up to six weeks longer than patients receiving standard care. After the patients died, spouses who were followed for 13 months showed 28 percent less psychological distress. The oncology nursing intervention included providing caregivers with skills training in assessing and monitoring problems, managing symptoms, and taking care of themselves.

- In the absence of specific advance directives, health care providers must rely on decisions made by the patient's family or friends when the patient can no longer communicate adequately. At issue is whether the choices these surrogates make are in tune with what the patient would wish. Researchers looked at how closely these decisions are reflective of the patient's decision by posing three hypothetical clinical scenarios (permanent coma, small chance of survival, severe dementia) to dying patients and their surrogate decisionmakers. Researchers found that 66 percent of the time, the surrogates predicted accurately the patients' wishes - under the coma scenario, they made accurate predictions with 84 percent accu-
racy. Among those whose decisions differed from the patient, there was no trend either for or against treatment.

**NATIONAL CENTER FOR RESEARCH RESOURCES**

The National Center for Research Resources (NCRR) creates, develops, and provides a comprehensive range of human, animal, technological, and other resources to enable biomedical research advances in aging research. NCRR serves as a "catalyst for discovery" for NIH-supported investigators by supporting resources in four areas: Biomedical Technology, Clinical Research, Comparative Medicine, and Research Infrastructure.

**Growth Patterns in the Developing Brain Using Continuum Mechanical Tensor Maps**

The dynamic nature of growth and degenerative disease processes requires the design of experimental protocols to detect, track, and quantify structural changes in the brain. Researchers at UCLA have created complete four-dimensional (x,y,z, and time) maps of growth patterns in the developing human brain. A new tensor mapping strategy allows much greater spatial detail and sensitivity than was previously obtainable. A major finding of the research was that different parts of the brain grow at markedly different rates during the development of a normal child. The researchers also found that the same areas of the brain that grow fastest in children degenerates fastest during the early stages of Alzheimer's disease. The sensitivity of the new experimental protocol may offer advantages in tracking the effects of various treatments for Alzheimer's disease. This approach can also be extended to evaluating the effect that treatments have on other age-related diseases affecting the brain such as dementia.

**Detection of Neuritic Plaques in Alzheimer's Disease by MR Microscope**

Researchers at Duke University Medical Research Center have used Magnetic Resonance Microscopy as a means to identify neuritic plaques, the neuropathological hallmark of Alzheimer's Disease, in autopsy tissue specimens. Experimental parameters were identified to supply sufficient contrast in the magnetic resonance microscopy signal to visualize the plaques in vitro and correlate them with histological samples. Future and ongoing efforts are focused on applying this technology in vivo, for example in transgenic rodents overexpressing amyloid protein. The ability to detect and follow the early progression of amyloid-positive brain lesions will greatly aid and simplify the many possibilities to intervene pharmacologically in Alzheimer's disease. Ultimately, results gained from such studies would benefit humans afflicted with Alzheimer's disease and related neurodegenerative disorders associated with aging.

**Proton Emission Tomography (PET) Scans in Aged Monkeys**

Aged rhesus monkeys were used in studies at the California Regional Primate Research Center to assess safety and survival of intracranial grafts. Fibroblastic cells containing a gene for the expression of nerve cell growth factor were implanted into the cere-
brum and were monitored by PET imaging. The initial studies suggest that such an approach could be successfully used as a potential treatment for Alzheimer's disease. This delivery of nerve cell growth factor might prevent the death of crucial neurons and ameliorate the effects of aging on the central nervous system.

**Cognitive studies of aging monkeys**

All of the Regional Primate Research Centers have significant populations of aging nonhuman primates, principally rhesus macaques, which are being studied to determine the behavioral, physiologic and pathologic events which occur during aging in a controlled and closely monitored setting. The NCRR cooperates with a program of the NIA to study the effects of dietary restriction on the aging process which shows that, as in rodent studies, caloric restriction is effective in retarding the aging process. Investigators at the Oregon, Tulane, Wisconsin, Emory and California Regional Primate Centers are conducting cognitive research on aging monkeys. Studies at the Yerkes Center at Emory are examining the neural substrates of cognitive decline in aging rhesus to identify the specific cell populations which are important in this decline. At the same center, the effects of age and stress are being examined in the female rhesus monkey population.

**Less Estrogen May Be Just As Effective in Preventing Post-menopausal Osteoporosis**

Osteoporosis, a dangerous thinning of the bones, affects millions of Americans, 80 percent of whom are women. Millions also suffer from low bone mass, an early warning sign of the disease, which can lead to painful, debilitating breaks. Osteoporosis is associated with a decrease in estrogen after menopause. Replacing estrogen with supplements can slow the erosion of bone, as can a number of drugs. Researchers at the University of Connecticut General Clinical Research Center compared three daily doses of the estrogen estradiol—0.25 mg, 0.5 mg, 1 mg, the typical treatment dose,—and placebo in women age 65 and over. To gauge how well the treatments worked, the scientists looked for markers related to bone turnover at regular intervals over the three-month study. All doses of estrogen helped control bone destruction, but the 0.25 mg dose yielded essentially the same response as the 1.0 mg dose. However, the women taking the 0.25 mg dose of estrogen reported less breast tenderness, and only one woman in the 0.25 mg group had bleeding or spotting, compared with eleven in the 0.5 and 1 mg groups. And, while women taking 1 mg had a marked increase in the thickness of the womb tissue, those in the 0.25 mg and placebo groups did not. It appears that a lower dose of estrogen may prevent osteoporosis as well as the usual, higher dose, but with fewer side effects and potentially less risk of uterine and breast tumors.

**Risk for Alzheimer's Disease in Ethnic Minorities**

The ε4 allele of the apolipoprotein E gene (APOE) is the chief known genetic risk factor for Alzheimer's disease (AD), the most common cause of dementia late in life. At the Columbia University General Clinical Research Center in New York, an ongoing series of studies is examining the interaction of genetic factors and eth-
nicity on AD risk. A major previous finding was that the relative risk of AD associated with one or more copies of the $\epsilon 4$ allele was significantly increased in whites, but not in African Americans or Hispanics. A more recent study of familial aggregation of AD confirms that genetic factors, but not necessarily the same ones, contribute to AD in ethnically diverse communities. The total magnitude of the genetic risk component of AD seems to be the same in whites, African Americans, and Hispanics. However, in light of the weaker contribution of the $\epsilon 4$ allele to AD risk in African Americans and Hispanics compared with whites, other (as yet unknown) genetic risk factors must be present in these groups.

**Relationship of Parkinson's Disease and Rebound Burst Firing in Rat Subthalamic Neurons**

The subthalamic nucleus (STN) of the basal ganglia is important in both normal movement and movement disorders. Lesioning or deep-brain stimulation of the STN can alleviate resting tremor in Parkinson's disease. Electrophysiologic data and therapeutic effect of inactivating the STN strongly indicate that this structure is involved in the origin of parkinsonian tremor in Parkinson's disease patients. Reciprocally connected glutamatergic subthalamic and GABAergic globus pallidus neurons have recently been proposed to act as a generator of low-frequency oscillatory activity in Parkinson's disease. The investigators results suggest that synchronous activity of pallidal neuron inputs could underlie rhythmic bursting activity of subthalamic neurons which results in tremor in Parkinson's disease.

**Aging and Central Interleukin-1 Beta Control of Glucose Homeostasis**

Impaired glucose metabolism has long been associated with aging. Investigators funded through the Institutional Development Award Program (IDeA) have found that injection of interleukin-1beta (IL-1b) into the brain causes inhibition of insulin secretion and that this inhibition occurs in the presence of elevated plasma glucose levels. The investigators propose that increased levels of IL-1b within the brain of old rats compared to younger rats are responsible for altered regulation of insulin secretion. The control of insulin secretion by brain levels of IL-1b could be a contributing factor in age-related insulin resistance and non-insulin dependent diabetes mellitus.

**NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT**

The National Institute of Child Health and Human Development (NICHD) supports a broad research portfolio that has far-reaching implications for human development throughout the entire life-span. Listed below are some examples of the Institute's recent initiatives that may be most directly related to issues of human aging.

**Potential Avenue for Treating Aging or Damaged Brains**

Information gained from neurobiological research is challenging old theories about the functioning of the central nervous system—specifically, whether old or damaged nerve cells can eventually be regenerated or repaired. Once thought to be fixed at birth, the
number of nerve cells in an individual's brain may in fact change to help maintain stability later in life, and may be responsive to signals outside the cell. NICHD-supported researchers have discovered that, instead of decreasing, the number of brain cells is actively maintained throughout life. They also found that a specific protein, basic fibroblast growth factor, not only regulates, but stimulates nerve cell growth. Ultimately, treatment with growth factors may help slow the onset of neuronal damage, help repair injured brain cells, and stimulate replacement of nonfunctional or dead brain cells, offering hope to patients with Alzheimer's disease and acute injuries due to stroke and trauma.

Older Women's Health

The transition to menopause encompasses a wide ranging set of changes for women. For at least half of their adult lives, most women will be affected by decreased levels of the hormone estrogen that accompany menopause. Recently, NICHD-supported researchers provided important new information about cognitive function in postmenopausal women and the possible benefit of hormone replacement therapy. They used functional magnetic resonance imaging to study the effects of estrogen replacement on women's brain activation patterns, finding that estrogen actually changed those patterns. These findings indicate that the memory systems of mature women are not fixed or immutable as previously believed and are responsive to external stimuli.

In another clinical study funded by NICHD, researchers found that nearly two-thirds of women who experienced premature ovarian failure (POF) had increased risk for hip fracture due to bone loss. Of all bone injuries, hip fractures pose the greatest threat, leading to death in some cases and significant disability in others. Because estrogen replacement therapy alone has been ineffective at stemming bone loss for some of these women, researchers are now investigating whether adding small amounts of testosterone to the estrogen therapy will help.

Through a Small Business Innovation Research Grant, NICHD investigators have developed a new approach to correct urinary incontinence. This condition affects nearly twice as many women as men; "stress incontinence," in particular, often occurs in women due to weakening of the muscles after childbirth or menopause. Using recombinant DNA technology, scientists developed special polymers that strengthen damaged muscles after injection. This discovery holds promise for restoring independence and improving quality of life for millions of women.

Heart Disease

One of NICHD's areas of major emphasis involves the scientific search for ways to predict adult disease, which in turn can often lead to premature aging or death. In one effort, scientists examined children's blood levels of the amino acid homocysteine to determine if it was associated with their parents' history of coronary heart disease. They found that significant differences in these levels were associated with differences in parents' history of coronary heart disease and high blood pressure. Thus, homocysteine levels in
Obesity is one of the most widely known risk factors for a range of adult diseases. In one study, NICHD researchers found that certain "homeobox" genes control the origin of fat cells. Homeobox genes are the "master genes" that determine the pattern in which embryos develop and direct the formation of specialized body genes. The researchers identified 10 different genes that direct early cells to transform themselves into fat cells. Further studies may help determine how these processes can be altered or blocked.

On a related front, the prevalence of obesity is increasing so rapidly in children of minority populations that an epidemic of Type 2 diabetes is appearing in Hispanic and Native American adolescents, far earlier than usual. Obesity, Type 2 diabetes, and fat metabolism disorders have their origins in the interaction of an individual's genes and the intrauterine and post-birth environments. In a trans-NIH effort, NICHD will support grants to identify variations in coding sequences and regulatory regions of genes that may contribute to obesity and related chronic diseases.

Initiatives To Help Seniors Access Health Information

The National Library of Medicine joined the National Heart, Lung, and Blood Institute, the Office of Research on Women's Health, and the Department of Health and Human Service's Health Care financing Administration to release findings of a jointly sponsored project to "train trainers" of senior citizens from around the country in how to access health information on the Internet. Results of the project indicate that training had a positive impact on seniors' confidence in using computers and the Internet, in conducting consumer health information searches online, and in sharing health care information with doctors, families and friends. The report also found that seniors can learn to use the Internet and don't want to be left behind on the information superhighway. Two-thirds of those who search for health information on the Internet talked about it with their doctors, and more than half indicated they were more satisfied with their treatment as a result of their search. The findings suggest that the "train the trainer" approach may be used successfully to enable older adults to access credible medical information on the Internet. The report, "Internet Train-the-Trainer Program for Older Adults," may be requested from the Library's Office of Communications and Public Liaison.

To make the "Train the Trainer" program more widely available, the National Library of Medicine is supporting the development of an online training curriculum which will be tested by trainers in senior centers in selected states nationwide. This project is administered by the SPRY (Setting Priorities for Retirement Years) Foundation in Washington, D.C. SPRY is a nonprofit national organization devoted to research and education efforts on senior citizens health and retirement issues.
Development Of A Health Website for Older Americans.—The National Library of Medicine recognizes that more and more older people are using the Internet as a source of health information. A survey conducted by Microsoft and the American Society on Aging found that 24 percent of seniors age 60 or older use computers, and that number is growing daily. Many older Americans who log on for health information turn to the websites of the National Institutes of Health, where they know they can receive free, reliable, comprehensive, and timely information. To better serve this population, NLM and the National Institute on Aging (NIA) will continue their development of a website designed for older Americans during 2001. A jointly sponsored NLM/NIA pilot to determine the usability of this new website is underway in several senior centers in Maryland and the District of Columbia. Upon the pilot's completion, the website will incorporate recommended improvements and add topics of primary interest to senior citizens. This new website will serve as an entry point to MEDLINEplus for seniors as well as a distance learning site specifically geared to older populations and their caregivers. Web-based courses will not only contain information seniors want and need, they will be designed based on NIA-funded research about cognitive function, computer use and technological interface among senior populations.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

The National Institute of Allergy and Infectious Diseases (NIAID) supports and conducts basic and clinical research on several diseases and conditions that affect the health of older Americans. Several research initiatives are yielding advances in the understanding and treatment of these disorders.

Shingles

Shingles (zoster) is caused by the same virus, varicella-zoster (VZV) that causes chickenpox (varicella). Primary infection with VZV manifests as chickenpox; after a latent period, reactivation of the virus leads to shingles. Current research is aimed at preventing shingles and shingles-associated pain in otherwise healthy older Americans.

Every year, 600,000 to one million Americans are diagnosed with shingles. A person has a one-in-five chance of developing shingles in his or her lifetime. More than half of shingles cases occur in persons 60 years or older, and the incidence and severity of shingles and its complications increase with increasing age. During the next 30 years, as the number of American seniors continues to increase, the need for a shingles vaccine will grow.

The Shingles Prevention Study (SPS) is a national trial of an experimental vaccine for the prevention of shingles and its complications in people 60 years or older. The SPS is being conducted by the Department of Veterans Affairs in scientific collaboration with NIAID and Merck & Co., the vaccine's developer. The SPS will enroll 37,200 volunteers across the United States. The vaccine being studied is a more potent form of the same vaccine routinely given to children to prevent chickenpox.
Pneumococcal Disease

Streptococcus pneumoniae, also called pneumococcus, is a bacterium that infects the upper respiratory tract and can spread to the blood, lungs, middle ear, or nervous system. In the United States, S. pneumoniae causes 40,000 deaths, 7 million middle ear infections (otitis media), 500,000 cases of pneumonia, 50,000 blood stream infections (bacteremia), and 3,000 cases of meningitis annually. Pneumococcal disease kills more Americans each year than all other vaccine-preventable diseases combined. Adults 65 years old and older are among the people disproportionately affected by pneumococcal disease. Pneumococcal disease can be difficult to treat because it has become more resistant to drug treatment. This makes prevention of the disease through vaccination even more important. NIAID has conducted and supported research on pneumococcal vaccine development for more than 30 years.

Two Phase I/II trials will be conducted in a high risk population to determine what impact a multivalent pneumococcal conjugate vaccine has on safety and immunogenicity when administered to elderly individuals. Multiple injections of a 9-valent and an 11-valent pneumococcal conjugate vaccine in addition to a propriety adjuvant will be given to study participants using several different vaccine schedules. Due to the large number of vaccinations, vaccine safety will be closely monitored. One trial has begun, and the second trial is scheduled to begin within the next couple of months.

Immune Response in the Elderly

Several of the most common afflictions of the elderly involve the immune system, directly or indirectly. Historically, the aging of the immune system has not received research attention equal to that of other aspects of immunology. The effects of aging on the immune system have not been widely appreciated by immunologists until fairly recently. Several ongoing NIAID research projects should add to the body of knowledge about the effects of aging on the immune system.

A Program Project titled “Molecular Aspects of Human Lymphopoiesis” is uniting four investigators in studies of the development of the immune system. Two of the projects focus on the effects of aging on B cell development. The combined efforts of these investigators should yield new insights into the molecular events in human lymphocyte development and abnormalities which lead to immunodeficiencies, autoimmunity, and malignancies in the elderly.

A project titled “Costimulatory Interactions During the Aging Process” will examine CD4 T cells, which play a pivotal role in immunity, primarily by directing responses of other lymphoid cells. It is generally accepted that CD4 T cell function in aged individuals is diminished, although the reasons and mechanisms responsible for this are not clear. This study explores several potential explanations for the decrease in CD4 T cell function as people age. This research also may provide novel findings with regard to T cell-antigen presenting cell interactions during the aging process and may highlight ways in which hyperresponsiveness can be corrected.
The National Institute of Neurological Disorders and Stroke (NINDS) supports research on disorders of the nervous system, which includes the brain, spinal cord, and nerves of the body. Many nervous system diseases present special problems or are markedly prevalent among older people. These include not only the classical neurodegenerative diseases of aging, such as Parkinson's and Alzheimer's, but also chronic pain, epilepsy, trauma, and many other disorders. For this reason, much of the research that NINDS supports is relevant to problems of aging.

In order to more effectively carry out its mission, NINDS has embarked on a strategic planning process, engaging the efforts of more than 100 of the nation's experts in clinical and basic neuroscience. This process produced a five-year strategic plan for the Institute, *Neuroscience at the New Millennium*. One immediate outcome of the planning process was the reorganization of the Institute's extramural programs into seven cross-cutting areas of research emphasis that follow our current understanding of the nervous system and disease. One of these, Neurodegeneration, reflects the increasing recognition that common mechanisms contribute to the many neurodegenerative disorders that are caused by the progressive death of neurons, such as Alzheimer's and Parkinson's diseases. Another focus area, *Clinical Trials*, will help improve both the number and quality of clinical trials that are supported by the Institute. Neurodegenerative diseases are an obvious target of many of these trials, as are other disorders, such as stroke, that have a disproportionate impact on older individuals. Other planning activities are underway that complement this initial effort. These activities, and selected research highlights of particular significance to the field of aging research, are described below.

**Parkinson's Disease**

To complement its strategic planning activities, which emphasize cross-cutting themes, NINDS has also begun planning efforts focused on specific disorders. The first of these, targeting Parkinson's disease, was initiated in January 2000 with a major planning conference that included NIH staff, researchers, clinicians, and advocacy group representatives. Based on the recommendations from this meeting, NINDS, along with several other institutes, developed a five-year NIH Parkinson's Disease Research Agenda, which was released in March 2000. This agenda outlines a number of strategies that the NIH will utilize in enhancing research progress in this area.

To help carry out the Parkinson's Agenda, NINDS has developed a Parkinson's Disease Implementation Committee that includes Institute staff, extramural researchers, and members of the advocacy community. This Committee monitors progress and suggests new directions for implementation in response to new findings. NINDS has taken several actions to make progress on the plan as rapidly as possible. In March 2000, the Institute convened representatives of the 11 currently funded Morris K. Udall Parkinson's Disease Research Centers of Excellence to discuss research being conducted at each center and to coordinate ongoing and future collaborations.
NINDS has awarded supplements to Udall centers for critical projects highlighted in the agenda such as expediting drug discovery, identifying Parkinson's genes, and investigating Parkinson's disease in minority populations. Other NINDS actions include a Request for Applications (RFA) on parkin, a protein implicated in the early-onset forms of Parkinson's, an RFA on the role of mitochondria in neurodegeneration, and the funding of several projects in response to an RFA on deep brain stimulation. Deep brain stimulation is a novel therapy that holds promise for providing symptomatic treatment for some Parkinson's patients. A follow-up RFA will focus on other aspects of this form of therapy. Other program activities in the planning stages include an RFA for a large-scale clinical trial on neuroprotective agents to slow the progress of Parkinson's. Lastly, Parkinson's disease was highlighted in two recent meetings sponsored by the Institute, the first a workshop on Gene Therapy, and the second a meeting of the Therapeutic Opportunities in Parkinson's Disease Working Group, both held in late 2000. Both will guide the Institute in further efforts in these areas.

Over the past several years, NINDS-supported researchers have made several significant findings, including:

- Demonstration of the potential of stem cell transplantation in animal models of Parkinson's disease, and the development of a technique to stimulate cultured embryonic stem cells in mice to develop into large numbers of dopamine neurons that may someday be useful in cell replacement therapies in Parkinson's patients.

- Generation of a new rodent model of Parkinson's disease using exposure to the pesticide rotenone. The cellular changes that take place in this model of Parkinson's bear such a close similarity to the changes that take place in the human brain as a result of Parkinson's, that this model should prove exceedingly useful in studying both the cellular basis of the disease and in evaluating treatments at the preclinical stage.

- Demonstration that the delivery of specific growth factors in a primate model of Parkinson's disease can be successfully achieved using gene therapy, and that this technique can slow the disease progression in these animals. This was a critical final step before this approach can be initiated in human patients.

- Characterization of the genes that cause Parkinson's in different forms of the disease. These studies suggest that important similarities exist between genetic changes in early-onset and late-onset forms of Parkinson's. Other research has expanded our knowledge about how multiple genetic events, each impacting a different protein family, may be involved in the degeneration of affected neurons.

Alzheimer's Disease

In efforts coordinated with other institutes at NIH, NINDS provides support for a broad range of studies in the area of Alzheimer's disease. To foster the transition from preclinical findings to human testing as efficiently as possible, the Institute, along with the NIMH and NIA, issued two joint Program Announcements (PAs) encouraging the submission of Alzheimer's Disease Pilot
Clinical Trial Planning Grants and Clinical Trial grant applications in early 1999. In addition, an RFA was released in December 2000, in the area of vaccine and immune therapies for Alzheimer’s disease. The ultimate effect of these program initiatives will not be known for some time, but the goal of these activities is to accelerate the development of therapies for Alzheimer’s disease towards clinical testing. NINDS continues to coordinate these, and other, research activities in Alzheimer’s disease with all other institutes working in this field, including NIA and its Alzheimer’s Disease Center Program.

Recent research highlights in NINDS-supported Alzheimer’s disease research include:

- Characterization of the mechanisms by which changes in amyloid beta protein, a cellular hallmark of Alzheimer’s disease, lead to neuronal cell damage. A recent study suggests that the conversion of this protein to a fibrillar form may lead to abnormal, and ultimately toxic, interactions with the cell membrane of affected neurons.
- Discovery of a novel mutation in the amyloid precursor protein gene, which may play a role in the development of early-onset Alzheimer’s.
- Validation of the theory that the presenilins play an important role in the cleavage and ultimate buildup of amyloid beta protein, confirming that these proteins are an appropriate therapeutic target in Alzheimer’s research.
- Demonstration that improved magnetic resonance imaging techniques may be useful in identifying early cognitive changes in individuals at risk for Alzheimer’s disease.

Stroke

Stroke research is a high priority of NINDS because of the enormous public health burden and the opportunities science presents for progress against stroke. As with Parkinson’s and Alzheimer’s, increasing age is also a risk factor for stroke. It has been reported that the chance of having a stroke more than doubles for each decade of life after age 55. NINDS is engaged in a broad range of activities, from targeted programs of public education and prevention, to the design of large-scale clinical trials of therapeutic agents, and fundamental research on how stroke damages brain cells. To enhance these efforts, the Institute is now developing a five-year plan for stroke research, which will identify topics in need of additional study and strategies to improve stroke prevention and develop new therapies. The initial organizational phase is underway with a planning workshop anticipated by late 2001. NINDS will collaborate with other NIH institutes and voluntary health organizations in this effort, as it has in many stroke related activities in the past.

In the past two years NINDS-supported researchers have made several significant research findings in the area of stroke research, including:

- The development of a vaccine that, in animal models of stroke and epilepsy, is capable of reducing damage to the brain caused by these disorders. The vaccine causes the body to produce antibodies to a specific neurotransmitter receptor that has been implicated previously in neuronal cell death.
• The identification of a novel method of introducing genes into the nervous system, across the blood-brain barrier (BBB). The BBB has traditionally acted as an obstacle in the delivery of therapeutic agents to the central nervous system.
• The discovery that individuals experiencing transient ischemic attacks (TIAs) have a much greater risk of experiencing a full-blown stroke shortly after the attack. Intervention with agents such as blood thinners or surgery after a TIA may be useful in preventing subsequent strokes, if patients can be identified and treated rapidly.

Over the past few years, NINDS has also been involved in a number of broad-based stroke education activities, including:
• Creation of a multi-faceted communication effort to raise awareness of the signs of stroke, the need for urgent action, and the possibility of a positive outcome with timely hospital treatment.
• Collaboration with the Brain Attack Coalition (BAC), a group of professional, voluntary, and government groups dedicated to reducing the occurrence, disabilities, and death associated with stroke. Recent accomplishments of this collaboration include the distribution of a stroke symptom list that is now used by all participating BAC organizations, publication of the first clearly defined set of recommendations for hospitals to update their stroke treatment strategies, and creation of a web-based resource for healthcare professionals to provide the latest tools for diagnosis and treatment of stroke.
• Development of a series of public education materials including: airport dioramas jointly sponsored with the National Stroke Association, billboard displays, consumer education brochures, exhibits, and new television and radio public service announcements, all designed to increase awareness of stroke.
• Involvement in a number of community-based stroke awareness activities, both locally and in other regions of the country.

THE NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES

The National Institute of Environmental Health Sciences (NIEHS) explores the environmental factors that contribute to human disease, especially the interaction between environment, susceptibility, and time over the age span. Understanding of these interactions is a key step in promoting seniors' health, which manifests the influences of a lifetime of environmental exposures. Research on the effects of the environment on aging and diseases of aging has been increasing for the past few years at the NIEHS. Various NIEHS research activities in the area of aging are highlighted below.

Parkinson's Disease

During 1999–2000 the NIEHS released two requests for applications (RFAs) associated to an age-related ailment, Parkinson's disease. Parkinson's disease is a neurologic disorder marked by a progressive loss of motor function resulting from the degeneration of neurons in the area of the brain that controls voluntary movement. The average age of the onset of this disease is 57. The prevalence
of Parkinson's disease (PD) is estimated to be approximately 500,000 in the general population, with about 50,000 new cases appearing each year. Recent evidence has shown that genetics plays less of a role and environmental factors play a potentially greater role than previously thought in the progression of late-onset PD. The purpose of one RFA was to stimulate the career development of physician-scientists engaged in research on the factors that cause PD. The other RFA was to encourage research aimed at revealing the role of the environment in the occurrence of Parkinson's disease. The results of these investigations will contribute to clarifying the part environmental factors play in the development of this disease.

Cancer

The NIEHS also has a number of intramural researchers who are studying aspects of the aging process and certain diseases associated with them. An NIEHS investigator is addressing the problem of cancer in the elderly. By studying aging at the molecular level this scientist hopes to uncover factors that influence the development of cancer that create major health problems for the aged. More importantly this research may offer new insights on how to treat or prevent cancer. Another researcher is expanding a technique that will help to better study chemical exposures and brain development. This research will examine how these chemicals disrupt neurological functions and help determine how these exposures affect cognitive function later in life. Other intramural researchers are studying various components of the aging process to better understand how the environment may cause certain diseases or cause them to progress faster thereby producing destructive health effects later in life. All of these studies should help to better understand the aging process and develop better intervention and prevention strategies.

Additionally, NIEHS grantees are working to determine how various environmental exposures affect the development of assorted diseases in the later stages of life. For example, in three separate studies researchers are examining the effects of lead, methylmercury, and aluminum exposure and the development of chronic diseases such as hypertension and decreased cognitive functioning. Determining the consequences of these exposures, especially related to cognitive function through the aging process, will help understand how to provide therapies and intervention strategies to reduce harmful health impacts.

HEALTH RESOURCES SERVICES ADMINISTRATION

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 health care in health professional shortage areas. The BPHC provides services to older Americans through BPHC-supported Health Centers, Migrant Health Centers, Health Care for the Homeless Program sites, Pub-
lic Housing Primary Care Program sites, the National Health Service Corps, and the Division of Federal Occupational Health.

In April 2000, the Health Resources and Services Administration approved BPHC's establishment of the “Healthy Aging Initiative.” BPHC named Marion E. Primas, Ph.D., M.S., Director of this initiative and she is located in the Division of Programs for Special Populations. A number of activities have been launched including internal and external infrastructure building around the following areas of focus:

1. Reimbursement (dual Medicare and Medicaid health coverage)
2. Outreach (improved methods to bring older persons into care)
3. Quality (appropriate health care specific to client needs)
4. Modeling of effective approaches for adaptation in other communities

Partnerships are being developed with Primary Care Association Members and Primary Care Offices throughout the Nation. We are collaborating with other Department of Health and Human Services programs, (e.g., the Administration on Aging, the National Institutes of Health's National Institute on Aging and the National Cancer Institute) and the Department of Education’s Office of Special Education and Rehabilitation Services. Collaborating organizations also include the American Association of Retired Persons, the Helen Keller National Center, the American Foundation for the Blind, the National Center and Caucus on Black Aging, Inc., the National Asian Pacific Center on Aging, and the National Council of Hispanic Aging.

CONSOLIDATED HEALTH CENTERS

On October 11, 1996, the President signed the Health Centers Consolidation Act of 1996. This Act consolidates the Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs under a single statutory umbrella that revised section 330 of the Public Health Service (PHS) Act. Health Center programs are designed to promote the development and operation of community based primary health care service systems in medically underserved areas for medically underserved populations. Legislation governing this program can be found in section 330 the PHS Act, as amended (42 U.S.C. 254b). The Health Centers Consolidation Act of 1996, under section 330(a)(1) of the PHS Act, defined the term “health center” as an entity that serves medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing.

The Consolidated Health Centers Programs entered into fiscal year 2000 with 826 grantees and a total of approximately $1.0187 billion covering over 3,000 sites, located in medically underserved areas throughout the United States and its territories. The Consolidated Health Centers Programs entered into fiscal year 2001 with an estimated 850 grantees and $1.1687 billion covering approximately 3,600 sites.

Health centers provide access to case-managed, family-oriented, culturally sensitive preventive and primary health care services for
people living in rural and urban medically underserved areas. The medical services include: preventive health and dental services, acute and chronic care services, and appropriate hospitalization and specialty referrals. Health centers also provide essential ancillary services such as laboratory tests, X-ray, environmental health and pharmacy services. In addition, many centers provide such enabling health and community services as transportation, health education, nutrition, counseling, and translation. Case management—the coordination of the center’s services appropriate to the needs of the patient (social, medical, or economic)—is emphasized.

Health centers target medically underserved, disadvantaged populations. These populations include: minorities, women of childbearing age, infants, persons with HIV infection, substance abusers and/or homeless individuals and their families. In fiscal years 1999–2000, the Health Center Program served more than 9,500,000 patients annually. Of this total, 7 percent were age 65 or older.

The BPHC has implemented clinical performance measures related to the primary and preventive care of elderly users. The measures include: (1) a functional assessment of activities of daily living; (2) an inventory of prescription and nonprescription drug use; and, (3) pneumococcal and influenza immunization administration.
EXHIBIT A.—Breakdown by program and age cluster of the number of elderly persons who received health care services from BPHC-supported programs for the years 1999–2000.

<table>
<thead>
<tr>
<th>Program</th>
<th>Age 65+Years</th>
<th>Total Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community &amp; Migrant Health Center</td>
<td>Females: 395,517</td>
<td>Medical: 7,809,390</td>
</tr>
<tr>
<td></td>
<td>Males: 240,229</td>
<td>Dental: 1,235,992</td>
</tr>
<tr>
<td></td>
<td>Total: 635,746</td>
<td>Total: 9,045,382</td>
</tr>
<tr>
<td>Homeless Program</td>
<td>Females: 4,826</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Males: 6,534</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total: 11,360</td>
<td>473,057</td>
</tr>
<tr>
<td>Public Housing</td>
<td>Females: 1,137</td>
<td></td>
</tr>
<tr>
<td>Primary Care Program</td>
<td>Males: 921</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total: 2,058</td>
<td>42,969</td>
</tr>
<tr>
<td>Total</td>
<td>649,164</td>
<td>9,561,408</td>
</tr>
</tbody>
</table>
EXHIBIT B.—Breakdown by program and age cluster of the number of elderly persons who received health care services from BPHC for the year 1999–2000.

<table>
<thead>
<tr>
<th>Program</th>
<th>AGE 65–74</th>
<th>AGE 75–84</th>
<th>AGE 85+</th>
<th>Subtotal Elderly</th>
<th>Total Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999/2000 CLUSTER</td>
<td>372,749</td>
<td>198,912</td>
<td>70,948</td>
<td>642,609</td>
<td>9,017,325</td>
</tr>
</tbody>
</table>

**THE NATIONAL HEALTH SERVICES CORPS**

The National Health Service Corps (NHSC) places primary care physicians, nurse practitioners, physician assistants, certified nurse midwives, dental and mental health professionals in health professional shortage areas. There are now 4,400 clinicians serving communities and populations of greatest need (53 percent rural and 47 percent urban). Older Americans with special health care needs benefit from the proximity of dedicated primary care clinicians that provide high quality health care. The NHSC works closely with Bureau-supported health centers, other primary care delivery systems, and the Indian Health Service to provide assistance in recruiting and retaining health personnel for the poorest, the least healthy, and the most isolated of our fellow Americans, including the aging population.

**DIVISION OF FEDERAL OCCUPATIONAL HEALTH**

The Division of Federal Occupational Health 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 generic issues that are regularly addressed in educational seminars and employee assistance programs.

**BUREAU OF HEALTH PROFESSIONS**

The Bureau of Health Professions (BHPPr) provides national leadership, sets policies, and administers programs to assure a health professions workforce that meets the health care needs of all Americans. The Bureau’s five strategic functions include:

1. Enabling access to health care through improved health professions distribution.
2. Enabling culturally competent health care through improved racial and ethnic diversity and cultural competence in the health professions workforce.
3. Ensuring adequate information, analysis and planning to strategically enable national health professions workforce development.
4. Enabling ongoing improvement in the quality of health professions education through demonstration, education research, innovation and dissemination; and of health professions practice through innovations in financing and regulation.
5. Providing public information and technical assistance relating to health professions.

Additionally, the Bureau has three areas of emphasis: geriatrics, genetics, and diversity. These areas are promoted throughout the Bureau’s training programs. The geriatric emphasis will help ensure that health care workers are trained and become knowledge-
able about the aging process, diseases and common conditions of the elderly, and older people's special problems and needs.

The strategies defined by these functions and areas of emphasis are implemented through a variety of collaborative public and private efforts and programs supported and operated by the Bureau. Programs include: education and training grant programs for institutions such as health professions schools and health professions education and training centers; loan and scholarship programs for individuals, particularly those from disadvantaged backgrounds; the Vaccine Injury Compensation Program; the National Practitioner Data Bank; the Healthcare Integrity and Protection Data Bank; the Ricky Ray Program; and the Children's Hospitals Graduate Medical Education Program. In addition, BHP\textsuperscript{r} administers several education-service network multidisciplinary and inter-disciplinary programs such as the Area Health Education Centers (AHECs), the Geriatric Education Centers (GECs), and Rural Inter-disciplinary Training Programs.

The multi- and inter-disciplinary programs:
- Train health professional to deliver cost-effective, high-quality health care in medically underserved areas;
- Stimulate curricula improvements so that health education reflects the needs of vulnerable populations and changes in health care financing; and
- Improve racial and cultural diversity in the health professions, which results in greater access to health care by minority and lower-income Americans.

The Bureau also supports the Council on Graduate Medical Education, which reports to the Secretary and the Congress on matters related to graduate medical education, including the supply and distribution of physicians, shortages, or excesses in medical and surgical specialties and subspecialties, foreign medical graduates, financing medical educational programs, and changes in types of programs. It also supports the National Advisory Council on Nurse Education and Practice which provides advice and recommendations to the Secretary concerning policy matters relating to nurse workforce, education, and practice improvement.

The National Vaccine Injury Compensation Program, administered by BHP\textsuperscript{r}, became effective October 1, 1988. It 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.

BHP\textsuperscript{r} maintains a federally sponsored health practitioner data bank on all disciplinary action and malpractice claims. The National Practitioner Data Bank (NPDB) was created by The Health Care Quality Improvement Act of 1986, Title IV of P.L. 99–660, as amended November 1986. The Act authorized the Secretary of Health and Human Services to establish a data bank to ensure that unethical or incompetent medical and dental practitioners do not compromise health care quality. The NPDB is a central repository of information about: malpractice payments made on behalf of physicians, dentists, and other licensed health care practitioners;
licensure disciplinary actions taken by State medical boards and State boards of dentistry against physicians and dentists; and adverse professional review actions taken against physicians, dentists, and certain other licensed health care practitioners by hospitals and other health care entities, including health maintenance organizations, group practices, and professional societies. The NPDB began operation on September 1, 1990.

The Secretary of the U.S. Department of Health and Human Services, acting through the Office of Inspector General was directed by the Health Insurance Portability and Accountability Act of 1996 to create the Healthcare Integrity and Protection Data Bank (HIPDB). The HIPDB is a national health care fraud and abuse data collection program for the reporting and disclosure of certain final adverse actions taken against health care providers, suppliers and practitioners. Health plans and Federal and State programs and officials (including licensing agencies, certification agencies, criminal prosecutors, government attorneys participating in civil cases, and agencies taking program exclusion actions) are required to report to the data bank all final adverse actions (such as revocations, suspensions, exclusions, criminal convictions and civil judgments) against health care providers, suppliers and practitioners. Federal and State agencies and health plans are permitted to query the data bank. It began full operation on March 2000.

The Ricky Ray Hemophilia Relief Act of 1998 established in the Treasury of the U.S. a trust fund to be known as the “Ricky Ray Hemophilia Relief Fund”, to provide compassionate payments for individuals with blood-clotting disorder, such as hemophilia, who contracted HIV from contaminated antihemophilic factor between July 1, 1982 and December 31, 1987. A former legal spouse, who was a legal spouse and contracted HIV through transmission from their spouse, and an individual who acquired infection through perinatal transmission from either of the individuals listed above are also eligible for compassionate payments under the program. The Act specifies that the Fund shall terminate upon the expiration of the 5-year period beginning on the date of enactment of the Act.

The Children's Hospitals Graduate Medical Education Program provides a more adequate level of support for health professions training in U.S. children's teaching hospitals that have a separate Medicare provider number (“free-standing” children's hospitals). These hospitals receive very small amounts of from Medicare for graduate medical education (GME) and other health professions training, while children’s hospitals that share Medicare provider numbers with other teaching hospitals receive more typical amounts of GME from Medicare. As managed care organizations become increasingly unwilling to pay for GME, free-standing children's teaching hospitals are at a competitive disadvantage, in the absence of a similar level of support from Medicare that other hospitals receive, and are coming under increasing pressure to reduce their level of residency training. Children's hospitals train over 25 percent of all U.S. general pediatric residents, the majority of pediatric subspecialty residents, and about 4 percent of all medical residents. The goal of this program is to make the level of Federal GME support more consistent with other teaching hospitals, in-
excluding children's hospitals which share Medicare provider numbers with other teaching hospitals.

**DIVISION OF MEDICINE AND DENTISTRY**

The Division of Medicine and Dentistry (DMD) continues to support, through its grant and cooperative agreement programs, significant educational and training initiatives in geriatrics.

For FYs 1999 and 2000, predoctoral grantees indicated that they were actively involved in the development, implementation, and evaluation of their geriatrics curriculum and training. There are eleven predoctoral grantees that received funds totaling $285,340 for geriatric activities.

Residency program grants were awarded with a focus on geriatrics, emphasizing the interdisciplinary approach, home visits, and nursing home visits. There were nine residency primary care grantees that received funds totaling $221,463 for geriatric activities.

Faculty development programs instituted training activities, enhanced primary care research training, and developed strategies for career development in geriatrics. These programs also placed an emphasis on the instruction of, "Teaching Geriatrics." There were twelve faculty development grantees that received funds totaling $725,000 for geriatric activities.

The majority of academic administrative units developed a research infrastructure in support of primary care research with an emphasis on the elderly, palliative care, and geriatric education. There are five academic administrative unit grantees that received funds, for FY2000, totaling $239,200 for geriatric activities.

One physician assistant training program grantee continued participation in the Rural Elderly Assessment Project and received funds totaling $30,000 for geriatric activities.

Podiatric primary care residency programs supported training which emphasized geriatric health. Two podiatric grantees that emphasized geriatric training received funds totaling $167,920.

Title VII funded training programs in the general and pediatric practice of dentistry provide a favorable Special Consideration for applicants that propose to prepare practitioners to care for underserved populations and high risk groups such as the elderly and patients of long term care facilities. In addition, applicants may also propose innovative projects that encourage curriculum enrichment or unique resident experiences in the area of geriatric dentistry. In FY1999, twenty-three dental training programs provided care to the elderly in nursing homes, clinical settings, and geriatric treatment centers. For FY2000, twenty training programs utilizing over a hundred and twenty residents provided much needed care and treatment for this population in various settings throughout the nation.

The Society of Teachers of Family Medicine (STFM) was awarded a four-year contract to develop a faculty resource manual to assist medical school faculty with the inclusion of geriatrics into the curriculum for medical students over the entire four years of medical school. This project will define new competencies for medical students that also include palliative and end-of-life care. This grantee received approximately $25,000, for FY2000, for geriatric activities.
The Undergraduate Medical Education for the 21st Century (UME–21) and Partnerships for Quality Education (PQE): Collaborative Faculty Development Program in Managing Patient Care with Harvard Pilgrim Health Care, Boston, Massachusetts, was initiated in 1999. This 18 month contract was created to develop, implement, and evaluate a set of two faculty development workshops for physician faculty of UME–21 and PQE programs centering on two content areas of managing patient care. The purpose is to develop faculty competencies in the basics of curriculum development and teaching methodology appropriate for medical students in UME–21 and residents in PQE. These competencies will be learned within the context of two content areas selected from among those common to UME–21 and PQE; namely, evidence-based and population-based medical care; healthy systems finance, economics and delivery; ethics; patient-provider communication skills; leadership; quality measurement including cost-effectiveness and patient satisfaction; systems-based care; medical informatics; and wellness and prevention. The focus population for UME-21 and PQE range from pediatric to geriatric. The final phase of this faculty development program involves dissemination of results and instructional materials.

DIVISION OF NURSING

In FY1999, the Division of Nursing awarded grants through four programs: (four grants) Advanced Nurse Education, (two grants) Nurse Practitioner/Nurse Midwifery, (three grants) Nursing Special Projects and (four grants) Professional Nurse Traineeships. The Professional Nurse Traineeship Program provides funds to schools that allocate these funds to individual full-time master's and doctoral students preparing to be nurse practitioners, nurse-midwives, nurse educators, public health nurses, or other clinical nurse specialists. Geriatric Nurse Practitioners and Geriatric Clinical Nurse Specialists are among those benefitting from the Traineeship Program.

In FY2000, the Division of Nursing legislation changed, resulting in the renaming of the four FY1999 grant programs. The Advanced Nurse Education Program and the Nurse Practitioner/Nurse Midwifery Program were combined and are now entitled Advanced Education Nursing. The Professional Nurse Traineeship Program was changed to Advanced Education Nursing Traineeship Program and expanded traineeship eligibility to include part-time students. The Nursing Special Projects Grant Program was changed to the Basic Nurse Education and Practice Program.

In FY1999, the Advanced Nurse Education Program supported four projects totaling $894,049. In FY2000, the Advanced Education Nursing Program supported three projects totaling $547,470. All of these projects supported gerontological nursing programs leading to a master's or doctoral degree. Graduates of these programs are prepared broadly to meet a wide range of health needs relative to the elderly in many settings, but are particularly prepared to deal with the older individual with multiple health care needs. In addition, the program prepares nurses who can teach and offer consultation in this important field.
In FY1999, the Nurse Practitioner and Nurse-Midwifery Program, supported six master's or post-master's geriatric nurse practitioner (GNP) program grants totaling $598,955. In FY2000, three master's or postmaster's GNP program grants totaling $492,978 were supported. In addition, seven Adult Nurse Practitioner (ANP) programs were supported in FY1999 for a total of $712,961, and five Family Nurse Practitioner (FNP) programs were supported for a total of $735,498. In FY2000, the Advanced Education Nurse Program supported five Geriatric Nurse Practitioner grants totaling $805,261, and five Adult Nurse Practitioner grants totaling $708,825.

GNPs, ANPs, and FNPs all provide primary care services to older adults. As nurses with advanced academic and clinical preparation, 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 homes. They provide nursing care and clinical management of common acute and chronic health problems, including health promotion and maintenance, disease prevention, health assessment, and long-term management of chronic health problems. Emphasis is placed on teaching and counseling the elderly to actively participate in their own care and to maintain optimal health.

In FY1999, the Nursing Special Projects Grant Program supported five Long-Term Care Fellowships for Paraprofessional projects in four institutions totaling $1,057,564. These fellowships supported approximately 88 individuals employed by nursing facilities, including long-term care facilities or home health agencies as paraprofessionals and enrolled in approved nursing program. The agencies assist the fellows financially to obtain further education in nursing.

In FY1999, the Nursing Special Project Grant Program supported three nursing centers providing services specifically for elderly populations received support totaling $371,503. In FY1999, an additional thirteen nursing centers providing services to elders in housing and other community sites received support totaling $2,229,950.

In FY2000, the Basic Nurse Education and Practice Program supported six nursing centers providing services to elders in clinics in rural and urban underserved areas, receiving support totaling $1,312,287. In addition, one nursing center project (University of Maryland) provided services specifically to the geriatric population, receiving $231,089. All of these centers demonstrate methods of improving access to primary health care in medically underserved communities.

The nursing center project at the University of Maryland, Baltimore, Maryland, now in the first year of a three year grant period, is designed to provide a community-based continuum of senior services. The Senior Care Center offers three programs: (1) Comprehensive Geriatric Assessment; (2) Geriatric focused primary care and (3) Wellness Programs. In addition, faculty and students are conducting a community needs assessment that will form the basis for the design of structured wellness programs that can be implemented at a new senior housing facility in Baltimore. This project also provides clinical experiences for graduate and undergraduate
students which will prepare them to provide the specialized care needed by older adults.

DIVISION OF INTERDISCIPLINARY, COMMUNITY-BASED PROGRAMS

The Division of Interdisciplinary, Community-Based Programs was created in FY2000 in response to the Health Professions Partnership Act of 1998 (Part D of Title VII of the Public Health Service Act). Programs supported by the Division are designed to “carry out innovative demonstration projects for strategic workforce supplementation activities as needed to meet national goals for interdisciplinary, community-based linkages.” Supported programs include Area Health Education Centers, Health Education and Training Centers, Education and Training Related to Geriatrics, and Rural Interdisciplinary Training Grants.

The Division (DICP) supports the training of health professionals in geriatric care through three principal programs—Geriatric Education Centers; Faculty Training in Geriatrics for Physicians, Dentists, and Behavioral and Mental Health Professionals; and Geriatric Academic Career Awards. Authorized by the Public Health Service Act, as amended, Sections 753 (a), (b), and (c) respectively, these three programs focus on preparing the health care workforce to serve an aging population. The AHEC program supports continuing education in geriatrics. The Quentin R. Burdick Rural Interdisciplinary Training program promotes rural health care practice which may include geriatrics.

Geriatric Education Centers (GECs).—GEC grants help accredited health professions schools collaborate with health care facilities to train health professions students, faculty and practitioners in the diagnosis, treatment, disease and disability prevention, and other health problems of the aged. Projects must involve at least four health disciplines one of which must be medicine. These Centers are educational resources providing multidisciplinary and interdisciplinary geriatric training for health professions faculty, students, and professionals in medicine, dentistry, pharmacy, nursing, occupational and physical therapy, podiatric medicine, optometry, social work, and related allied and public or community health disciplines. They provide comprehensive services to the health professions education community within designated geographic areas. Grants may support geriatric residencies, traineeships or fellowships; development and dissemination of curricula; training and retraining of faculty; continuing education of health professionals; and clinical training in geriatrics in various care settings. Grantees may be single institutions or consortia of institutions.

At the State and National level, the GECs comprise a comprehensive educational system, serving as the primary coordinating body for the preparation of faculty, health professions students, and health care personnel to better serve the Nation’s elderly. GECs use ambulatory care centers, hospitals, long-term care facilities and senior centers to provide appropriate educational experiences to health professions students and providers, to prepare them to deliver humane and dignified care and to be responsive to older individuals whose ability to care for themselves has been reduced by physical and/or mental disorders. Over 40,000 health care pro-
professionals received education and training through the GECs in FY1999–2000.

Of the 43 GECs Geriatric Education Centers that make up the membership of the National Association of Geriatric Education Centers, 34 received BHPPr funding in both FY1999 and FY2000. In FY1999, there were 27 consortia and 7 single institution awards. In FY2000, there were 26 consortia and 8 single institution awards. Awards were made to the following institutions in FY1999 and FY2000:

**GERIATRIC EDUCATION CENTERS**

<table>
<thead>
<tr>
<th>Consortia:</th>
<th>FY1999</th>
<th>FY2000</th>
</tr>
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<tbody>
<tr>
<td>University of California, Los Angeles, Univ. of California, Davis, Univ. of California, San Francisco, UCLA School of Medicine, California State University at Fresno</td>
<td>$258,323</td>
<td>$319,028</td>
</tr>
<tr>
<td>New York University, Columbia University, Hunter College</td>
<td>312,422</td>
<td>162,990</td>
</tr>
<tr>
<td>University of Pittsburgh, Pennsylvania State University, Temple University</td>
<td>159,982</td>
<td>263,733</td>
</tr>
<tr>
<td>University of Miami, Barry University, Florida A&amp;M, Florida International University</td>
<td>252,565</td>
<td>23,673</td>
</tr>
<tr>
<td>St. Louis University, U. of Missouri, School of Optometry, Washington U., Occupational Therapy, St. Louis College of Pharmacy, Kirkbible College of Osteopathic Medicine</td>
<td>323,245</td>
<td>160,283</td>
</tr>
<tr>
<td>University of Kentucky, East Tennessee State Univ., U. of Ohio Cincinnati</td>
<td>313,236</td>
<td>160,365</td>
</tr>
<tr>
<td>University of Kansas Medical Center, Aging Research Institute, University of Missouri-Kansas City</td>
<td>161,891</td>
<td>269,991</td>
</tr>
<tr>
<td>University of Medicine &amp; Dentistry of NJ, Rutgers University School of Social Work</td>
<td>324,807</td>
<td>161,997</td>
</tr>
<tr>
<td>University of Oregon, Portland State University</td>
<td>261,847</td>
<td>290,058</td>
</tr>
<tr>
<td>University of Iowa, University of Osteopathic Medicine and Health Sciences</td>
<td>270,000</td>
<td>324,000</td>
</tr>
<tr>
<td>Baylor College of Medicine, University of Texas, Houston HSC, Univ. Texas, Medical Branch, Univ. of North Texas, Univ. of Texas-Pan AM, Texas Southern Univ., Univ. of Houston, Texas A&amp;M University</td>
<td>322,720</td>
<td>162,000</td>
</tr>
<tr>
<td>George Washington University, Georgetown University, Howard University</td>
<td>321,653</td>
<td>0</td>
</tr>
<tr>
<td>Case Western Reserve University, Ohio University college of Osteopathic Medicine, Bowling Green State University, Northeastern Ohio Universities College of Medicine</td>
<td>319,440</td>
<td>161,200</td>
</tr>
<tr>
<td>Marquette University, Univ. of Wisconsin-Madison, Univ. of Wisconsin-Milwaukee, Milwaukee Area Technical College, Medical College of Wisconsin, Geriatrics Inst.of Sinai Samaritan Medical Center</td>
<td>162,000</td>
<td>268,821</td>
</tr>
<tr>
<td>Michigan State University, Wayne State University, Michigan Primary Care Association, St. Lawrence Hospital</td>
<td>269,592</td>
<td>324,000</td>
</tr>
<tr>
<td>University of New Mexico, New Mexico State University, New Mexico Highlands University, National Indian Council on Aging, Indian Health Service, Sisters of Charity Health System</td>
<td>248,832</td>
<td>312,292</td>
</tr>
<tr>
<td>University of Pennsylvania, Geisinger Medical Center, Lehigh Valley Hospital, Philadelphia College of Pharmacy</td>
<td>235,490</td>
<td>321,191</td>
</tr>
<tr>
<td>University of Rhode Island, Rhode Island College, Brown University, Rhode Island Hospital</td>
<td>161,997</td>
<td>269,999</td>
</tr>
<tr>
<td>Meharry Medical College, Alabama A&amp;M University, Tennessee State University</td>
<td>269,971</td>
<td>313,616</td>
</tr>
<tr>
<td>University of North Carolina-Chapel Hill, Program on Aging, Rural Health Group, Inc, Area L Area Health Education Center</td>
<td>161,821</td>
<td>204,516</td>
</tr>
<tr>
<td>Stanford University, San Jose State University, On Lok, Senior Health Services</td>
<td>266,219</td>
<td>315,707</td>
</tr>
<tr>
<td>University of Oklahoma</td>
<td>211,809</td>
<td>315,887</td>
</tr>
<tr>
<td>University of Texas San Antonio HSC, University of Texas at El Paso</td>
<td>162,000</td>
<td>270,000</td>
</tr>
<tr>
<td>University of Rochester, Ithaca College, Cornell University, Nazareth College</td>
<td>270,070</td>
<td>149,971</td>
</tr>
<tr>
<td>University of West Virginia, Rural Health Education Partnership, West Virginia State Community and Technical College, West Virginia School of Osteopathic Medicine</td>
<td>194,043</td>
<td>161,454</td>
</tr>
<tr>
<td>University of Minnesota, Arrowhead Regional Development Commission, Central Minnesota Council on Aging, Rochester Community and Technical College, Mankato State University</td>
<td>324,000</td>
<td>162,000</td>
</tr>
<tr>
<td>Harvard Medical School, Maine Geriatrics/Gerontology Education</td>
<td>310,220</td>
<td>160,495</td>
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<thead>
<tr>
<th>Single Institution:</th>
<th>FY1999</th>
<th>FY2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Hawaii</td>
<td>215,760</td>
<td>107,934</td>
</tr>
<tr>
<td>University of Puerto Rico</td>
<td>215,760</td>
<td>107,934</td>
</tr>
<tr>
<td>University of Washington</td>
<td>161,206</td>
<td>215,975</td>
</tr>
<tr>
<td>University of South Florida</td>
<td>216,000</td>
<td>108,000</td>
</tr>
<tr>
<td>University of Nevada</td>
<td>158,809</td>
<td>214,013</td>
</tr>
<tr>
<td>University of Arkansas</td>
<td>106,258</td>
<td>157,063</td>
</tr>
</tbody>
</table>
FACULTY TRAINING IN GERIATRICS FOR PHYSICIANS, DENTISTS, AND BEHAVIORAL MENTAL HEALTH PROFESSIONALS

Faculty Training Projects in Geriatric medicine, dentistry and behavioral/mental health grants are awarded to public and private nonprofit schools of allopathic or osteopathic medicine, teaching hospitals, and graduate medical education programs. The grants support fellowships and other training efforts that assist health professionals who plan to teach geriatrics. Funded projects support two-year fellowships and one-year retraining programs.

Projects emphasize primary care and enable health professionals who plan to teach geriatrics to care for elderly people at different levels of wellness and functioning and from a range of socio-economic and racial and ethnic backgrounds. They offer service rotations such as geriatric consultation, acute care, dental care, psychiatry, day and home care, rehabilitation, extended care, ambulatory care as well as community care for older people with mental retardation. No programs were funded in FY1999. In FY2000, a total of $1.6 million was awarded to five new programs.

GERIATRIC ACADEMIC CAREER AWARDS (GACAS)

The Bureau of Health Professions made awards for the first time under the newly established Geriatric Academic Career Award (GACA) Program in September 1999. Intended to support the development of newly trained geriatric physicians into first rate teachers of geriatrics, GACAs provide five years of support for academic career development. The awards require and allow the recipients to devote the bulk of their academic careers to teaching geriatrics to a wide range of health care professionals. The career development plans of the first cohort of awardees show a strong commitment to the development of best practices in the care of older patients. They have chosen a wide range of topics to devote their time to developing, including direct service projects such as mobile geriatric assessment clinics for older people living in rural areas, home-based geriatric assessment, and geriatric rehabilitation, all aimed at restructuring and facilitating delivery of care to the elderly; interdisciplinary care for the chronically ill and the development of chronic disease state “glide paths;” effective clinical
teaching of palliative care for the elderly; geropharmacy and nutrition; acute care of the elderly; culturally competent care of the elderly; infection control interventions in long-term care; development of resource materials on organ system normative aging; hospice care; special issues in the delivery of rural health care by family practitioners; and the design and implementation of community-based programs which allow the frail elderly remain in their homes. The program contributes not only to the training of physicians but to many other health professionals who have responsibility for the care of the elderly. As specified in the statutory language, awards were made directly to individuals who were required to obtain the commitment of their employing institution for a period of five years.

**Geriatric Academic Career Awards**

<table>
<thead>
<tr>
<th></th>
<th>FY1999</th>
<th>FY2000</th>
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</thead>
<tbody>
<tr>
<td><strong>Total Awarded</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$818,400</td>
<td>$795,645</td>
</tr>
</tbody>
</table>

**Rural Interdisciplinary Training**

The Quentin R. Burdick Rural Health Interdisciplinary Program promotes rural health care practice by providing support for the interdisciplinary training of health professions students. The program requires two or more applicant organizations to apply together in order to foster collaborative efforts to promote and retain health professionals in rural areas. Specific programs demonstrate innovation in interdisciplinary training and curriculum development, and forge linkages among academic health training institutions and rural health care agencies and practice facilities, State health departments, and health professionals who practice in rural areas. Though not limited to training in geriatrics, some projects focus prominently on geriatric care. In FY1999, one project focused primarily on geriatric care, and in FY2000, two projects focused on geriatrics.

<table>
<thead>
<tr>
<th></th>
<th>FY 1999</th>
<th>FY 2000</th>
</tr>
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<tbody>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$147,165</td>
<td>$373,377</td>
</tr>
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**Area Health Education Centers (AHEC) CE Programs in Geriatrics**

The Area Health Education Centers (AHEC) is an active provider of continuing education (CE) for primary health care providers with nearly every Federally funded AHEC program within 40 States providing a wide array of topics. CE Programs in Geriatrics is one of the most frequently requested and offered topics. During FY99, a summary of the AHEC CE offerings in geriatrics were as follows: a total of 478 programs was offered, 118 were offered via distance education methodologies, 12,445 CE participants attended these geriatric programs, and 1157 were distance participants in the CE programs.
GERIATRIC EDUCATION FUTURES PROJECT

In 1994–1995, the Bureau of Health Professions sponsored a major assessment of the state of workforce development in geriatrics. The effort resulted in the production of A National Agenda for Geriatric Education with specific recommendations for action in eleven broad areas. In Fiscal Year 2000, the Bureau is beginning a follow-up to the National Agenda. Through various efforts, the Bureau will track where health professions training is in relation to the earlier recommendations and where workforce development activities need to go in light of progress-to-date and recent changes in health care delivery systems.

PUBLICATIONS


OFFICE OF RURAL HEALTH POLICY

The Office of Rural Health Policy (ORHP) was established in 1987 at the urging of the Senate Special Committee on Aging in order to address severe shortages of health services in rural areas, where one quarter of the Nation’s elderly live. Aging-related issues are of particular importance to the Office, since rural counties have, on average, a higher percentage of individuals over 65 years of age than urban counties; and these residents are often poorer, sicker, and more isolated than their urban counterparts.

To strengthen support for health services in rural areas, the office plays a collaborative role throughout the Department and with the States and the private sector. For example, it informs 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 and the Assistant Secretary on Aging on the affects that Medicare and Medicaid programs have on rural health care, on the shortage of health care providers, the viability of rural hospitals, and the availability of primary care and also emergency medical services to elderly and other rural residents.
The Office supports local and States initiatives to build rural health care services through almost $39 million in grants to rural communities, themselves, and a $3 million program of matching grants to the States to support States offices of rural health, which can recruit rural providers and assist their rural communities in developing more local health services.

The ORHP also promotes informed policy making by administering a $3.0 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. For example, one study currently underway looks at quality differences between rural and urban nursing homes to examine the consequences of a lower skill-mix of staff in rural areas. Another is estimating the Medicare-Choice threshold payment rate which will attract and retain Medicare managed care plans in rural areas. Also under study is an examination of the impact on rural elderly of different approaches for restructuring Medicare.

The Office also administers a $25 million grant program to States to help them implement the Medicare Rural Hospital Flexibility Program. Under this program, rural hospitals that convert to a smaller Rural Critical Access Hospital can receive cost-based payments from the Medicare. The grants help States and rural communities plan and implement the conversion of rural hospitals and promote the development of new local networks of care.

In collaboration with other Federal agencies such as the Health Care Financing Administration, the Department of Agriculture, the Department of Transportation, and the National Institute on Aging, ORHP sponsors workshops and seeks public advice on a range of rural health needs. These issues may included such issues as emergency medical services, managed care options for Medicaid and Medicare clients, physician recruitment, and rural economic development.

To provide health care professionals, researchers, community officials, and the public with an efficient source of information and referral, the office sponsors the Rural Information Center Health Service, or RICHS. This service is operated in cooperation with the USDA and its National Agricultural Library. It is available toll-free at 1-800-633-7701. Internet information is available at: http://www.nal.usda.gov/ric/richs.

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.

OFFICE OF THE INSPECTOR GENERAL

INTRODUCTION

The Office of Inspector General (OIG) was established by the Inspector General Act of 1978. The OIG's mission is to identify ways to improve effectiveness and promote economy and efficiency in HHS programs and operations, and protect them against fraud, waste, and abuse. This is accomplished by conducting independent and objective audits, evaluations, and investigations which provide
timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public. In carrying out its mission, the OIG partners with the Department and its operating divisions, the Department of Justice (DOJ), other Federal and State agencies, and the Congress to bring about systemic improvements in HHS programs and operations, and successful prosecutions and recovery of funds from those who defraud the Government. The OIG is comprised of the following components:

The Office of Audit Services (OAS) conducts and oversees audits of HHS programs, operations, grantees, and contractors; identifies systemic weaknesses that give rise to opportunities for fraud, and abuse; and makes recommendations to prevent their recurrence. The OAS also provides overall leadership and direction in carrying out the responsibilities mandated under the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994 relating to financial statement audits.

The Office of Evaluation and Inspections (OEI) seeks to improve the effectiveness and efficiency of departmental programs by conducting program inspections that provide timely, useful, and reliable information and advice to decision makers. These inspections are program and management evaluations that focus on specific issues of concern to the Department, the Congress, and the public. The results of these inspections generate accurate and up-to-date information on how well HHS programs are operating and offer specific recommendations to improve their overall efficiency and effectiveness.

The OIG's Office of Investigations (OI) conducts investigations of fraud and misconduct to safeguard the Department's programs and protect the beneficiaries of those programs from individuals and activities that would deprive them of rights and benefits. Working with Federal and State law enforcement agencies, OIG investigators seek criminal, civil, and exclusion actions against those who commit fraud or who thwart the effective administration of HHS programs.

The Office of Counsel to the Inspector General (OCIG) coordinates the OIG's role in the resolution of health care fraud and abuse cases, including the litigation and imposition of administrative sanctions, such as program exclusions, civil monetary penalties, and assessments; the global settlement of cases arising under the Civil False Claims Act; and the development of corporate agreements for providers that have settled their False Claims Act liability with the Federal Government. It also develops and promotes industry awareness of models for corporate integrity and compliance programs and monitors ongoing integrity agreements. The OCIG also provides all administrative litigation services required by OIG, such as patient dumping cases and all administrative exclusion cases. In addition, OCIG issues special fraud alerts and advisory opinions regarding the application of OIG's sanction statutes and is responsible for developing new, and modifying existing, safe harbor regulations under the anti-kickback statute. Finally, OCIG counsels OIG components on personnel and operations issues, subpoenas, audit and investigative issues, and other legal authorities.

The Office of Management and Policy (OMP) provides support services to the OIG, including congressional relations; public af-
fairs; strategic planning and budgeting; financial and information resources management; and preparation of the OIG's semiannual and other reports.

ACCOMPLISHMENTS

During Fiscal Years 1999 and 2000, the OIG reported more than $890 million in fines and restitutions deposited into the Medicare Trust Fund. More than 6,320 individuals and entities were excluded from doing business with Medicare, Medicaid, and other Federal and State health care programs. The OIG's 1999 and 2000 accomplishments included 815 convictions of individuals or entities that engaged in crimes against departmental programs.

The OIG reported savings of $28.2 billion for Fiscal Years 1999 and 2000. This is comprised of $26.1 billion in implemented legislative or regulatory recommendations and actions to put funds to better use; $393 million in audit disallowances, and $1.6 billion in investigative receivables. The savings that result from OIG recommendations that are implemented into law or regulation represent the dollars that will not be spent.

HEALTH CARE

In recent years, Medicare has been a major focus of OIG work. Approximately 75 percent of OIG resources in the past two years were dedicated to Medicare audits, evaluations, and enforcement activities. OIG work continues to show that Medicare is not always a prudent purchaser of health care goods and services and is inherently vulnerable to making improper payments. In discharging its responsibilities, the OIG responds both reactively and proactively to counteract these problems and is pleased to report that measurable progress is being made. For example, through a statistically valid sample of FY1999 Medicare fee-for-service payments, OIG estimated that the overall dollar value of claims paid in error had decreased 42 percent since FY1996.

A key element of HHS/OIG's prevention efforts has been the development of compliance program guidance to encourage and assist the private health care industry to fight fraud and abuse. The guidance, developed in conjunction with the provider community, identifies steps that health providers may voluntarily take to improve adherence to Medicare and Medicaid rules. In 1999 and 2000, the OIG developed and released final compliance program guidance for third party medical billing companies, hospices, durable medical equipment (including prosthetics and orthotics, and suppliers), Medicare+Choice organizations offering coordinated care plans, nursing facilities, and individual and small group physician practices.

Some of the significant OIG work involving the elderly, during this reporting period, includes the following:

Quality of Care in Nursing Homes.—The OIG has focused on the quality of care in nursing homes in a number of inspection reports. Topics include: deficiency trends, survey and certification system capacity, public access to deficiency information, ombudsman program complaints and overall capacity, medical necessity and quality of care of physical and occupational therapy in nursing homes,
nursing home vaccination, effect of the prospective payment system on access to skilled nursing facilities, and the effect of financial screening and distinct part rules on access to nursing facilities.

Home Health Care.—Under the interim payment system, in effect prior to the start of the prospective payment system on October 1, 2000, home health agencies had an incentive to stay below the new payment limits by reducing the number of visits per patient and limiting the number of potentially high-cost patients. Because of this, concerns were raised as to whether this system so adversely affected home health agencies that they were unable to care for all Medicare patients needing home health services. In a number of studies, we found that these concerns are not well supported. Hospital discharge planners reported that almost all Medicare beneficiaries can be placed into home health care. In addition, an OIG follow-up to an earlier review revealed that improper Medicare payments for home health services had been significantly reduced, down from 40 to 19 percent.

Withdrawal of Managed Care Organizations From Medicare.—In the last several years, a number of managed care organizations (MCO) left the Medicare program or reduced their service areas. We recently examined the impact of these withdrawals on beneficiaries, including the adequacy of notification, the availability of other health care options, and the extent of costs to beneficiaries associated with these changes. We found that the 1999 MCO withdrawals affected fewer beneficiaries than did the 1998 withdrawals (about 300,000 in 1999 versus about 400,000 in 1998); however, a greater percentage of beneficiaries were left without an MCO option in 1999. As a related issue, OIG’s body of work during this period finds that MCOs receive more than an adequate amount of funds to deliver the Medicare package of covered services, i.e., those services received by 85 percent of Medicare beneficiaries (those in the Medicare fee-for-service program).

Managed Care Marketing Materials.—We examined how well informed Medicare beneficiaries were of the choices available to them under the managed care option. In one study we found that the Health Care Financing Administration (HCFA) did not completely meet its goals to expedite the marketing material review process; reduce resubmissions of material; ensure uniform review across the Nation; and, most importantly, provide beneficiaries with accurate and consumer-friendly marketing materials to help them make informed health care choices. Some of the marketing materials that we examined were difficult to understand. We also looked at the influence of “extra” benefits offered by managed care plans on beneficiaries’ decisions to join Medicare+Choice MCOs.

Medicare Payments for Mental Health Services.—We examined Medicare payments for mental health services across a variety of settings. One such setting is community mental health centers, where payments for partial hospitalization services increased almost five-fold between 1993 and 1997. Although partial hospitalization consists of an intensive program of outpatient services for acutely ill beneficiaries in order to prevent inpatient hospitalization, both OIG and HCFA reviews found that Medicare was paying for services to beneficiaries with no history of mental illness and for beneficiaries who suffered from conditions that would preclude
their benefitting from the program. Our five-State review found that over 90 percent ($229 million of $252 million) of such payments in this setting were unallowable or highly questionable. In a similar review, we examined Medicare charges in 10 States for outpatient psychiatric services provided at acute care hospitals. Here our statistical sample estimated that 58 percent ($224 million of $382 million) of such services in these States were unallowable or unsupported.
The Department of Housing and Urban Development is committed to providing America's elderly with decent affordable housing appropriate to their needs. The Department's goal is to provide a variety of approaches so that older Americans may be able to afford their housing costs, maintain their independence, remain as part of the community, and live their lives with dignity and grace.

The Department is committed to meeting the needs of our elderly citizens. This report provides a brief overview of the programs and activities undertaken by the Department to assist the elderly with their housing needs during FY1999 and 2000.

I. OFFICE OF HOUSING

A. SECTION 202—CAPITAL ADVANCES FOR SUPPORTIVE HOUSING FOR THE ELDERLY AND SECTION 811 SUPPORTIVE HOUSING FOR PERSONS WITH DISABILITIES

The National Affordable Housing Act of 1990 authorized a restructured Section 202 program while separating out and creating the new Section 811 program for Housing for Persons with Disabilities. Funding for both programs is provided by a combination of interest-free capital advances and project rental assistance. Project rental assistance replaces Section 8 rent subsidies. The annual project rental assistance contract amount is based on the cost of operating the project. The 30 percent maximum tenant contribution remains unchanged.

Since the passage of the National Affordable Housing Act of 1990, there have been 63,023 units approved under the Section 202 program and 17,494 units approved under the Section 811 program. Of those amounts 7,142 Section 202 units and 1,801 Section 811 were approved in Fiscal Year 1999. In FY2000, there were 6,518 additional units approved under Section 202 for $493,274,200 and 1,483 more units approved under Section 811 for $109,588,400.

B. SECTION 221(d)(3) AND (4)—MORTGAGE INSURANCE PROGRAM FOR MULTIFAMILY HOUSING

Sections 221(d)(3) and (4) authorized the Department to provide insurance to finance the construction or substantial rehabilitation of market rate rental or cooperative projects. The programs are available to non-profit and profit-motivated mortgagors as alternatives to the Section 231 program. While most projects under the
programs have been developed for families with children, projects insured under Section 221 may be designed for occupancy wholly or partially for the elderly, and the mobility impaired of any age. In FY1999, a total of 31,880 additional units in 198 projects were approved under Section 221(d)(3) and (4) for $2.1 billion. In FY2000, 28,707 units in 155 projects were approved for $1.7 billion.

C. SECTION 232—MORTGAGE INSURANCE FOR NURSING HOMES, INTERMEDIATE CARE FACILITIES, BOARD AND CARE HOMES, AND ASSISTED LIVING FACILITIES

The Section 232 program authorized the Department to offer financing for the construction and rehabilitation (or purchase or refinance of existing projects) of nursing homes, intermediate care facilities, board and care homes, and assisted living facilities by providing mortgage insurance to finance these facilities. The vast majority of the residents of such facilities are the frail elderly. In FY1999, HUD insured 155 projects worth $896 million consisting of 76 nursing homes, 53 assisted living facilities, and 26 board and care homes. In FY2000, HUD insured 159 projects at $979 million (100 nursing homes, 49 assisted living facilities, and 10 board and care homes.)

D. SECTION 8—NEW CONSTRUCTION

The Section 8 program sponsored the new construction of housing for families and for the elderly by attaching subsidies to the units being developed. That way the landlord would guarantee the ability to make payments and operate the developments. The new construction program was active from 1974 until it was repealed by Congress in 1983. No new units have been approved since 1983 but units approved prior to that may still receive a subsidy. The maximum term of the housing assistance payments vary from 20 to 40 years, depending on how the project was financed. There are 1.4 million private, project-based Section 8 units, about 50 percent of which serve elderly households. About 193,000 of these 658,000 units were built under the Section 202 program before the restructuring of that program in 1990. That means that about 465,000 units developed with Section 8 project-based assistance serve elderly households. The Section 8 new construction program is no longer used to subsidize new development.

E. SERVICE COORDINATORS IN ASSISTED HOUSING

The National Affordable Housing Act authorized funding for service coordinators under the Section 202 program in 1990. Eligibility was expanded to cover Sections 8, 221(d)(3), and 236 projects in 1992. A service coordinator is a social service staff person who is part of the project’s management team. The service coordinator is responsible for ensuring that the elderly individuals and persons with disabilities living in the project are linked with the supportive services they need from agencies in the community to assure that they can remain independently in their homes as long as possible and avoid premature and unnecessary institutionalization.
In FY1999, HUD awarded $5,000,000 in service coordinator grants to 51 projects, 33 of which were Section 202 projects; the remainder were Section 8, 221(d)(3) or 236.

In FY2000, HUD funded 259 projects for $28,579,665 in new grants, 170 of which were 202s, 42 were Section 8, and 47 were Section 221(d)(3) or Section 236.

In FY1999 and 2000, HUD also provided one-year extension funds to expiring Service Coordinator contracts. These extensions enable the Service Coordinator programs to continue operating without breaks. In FY1999, HUD made extensions to 150 contracts at a cost of $4,069,376. In FY2000, the Department extended 329 contracts with $9,168,441 in funding.

Funding for service coordinators in public housing is discussed below.

F. THE CONGREGATE HOUSING SERVICES PROGRAM

The Congregate Housing Services Program (CHSP), initially authorized in 1978 and revised in 1990, provides direct grants to States, Indian tribes, units of general local government and local non-profit housing sponsors to provide case management, meals, personal assistance, housekeeping, and other appropriate supportive services to frail elderly and non-elderly disabled residents of HUD public and assisted housing, and for the residents of Section 515/8 projects under the Department of Agriculture's Rural Housing and Community Development Service.

In FY1999, HUD extended 80 existing grantees for an additional year at a cost of $9,774,859. In FY2000, HUD extended 63 existing grantees for an additional year at a cost of $6,156,306. There were no funds appropriated for new grants in FY1999 or FY2000.

G. FLEXIBLE SUBSIDY AND LOAN MANAGEMENT SET ASIDE (LMSA) FUNDING

The Flexible Subsidy Program (FLEX) is comprised of two components: (1) the Operating Assistance Program (OAP), which is designed to provide temporary funding to replenish project reserves, cover operating costs, and pay for limited physical improvements. The Operating Assistance (OA) is provided in the form of a non-amortizing "contingent" loan; of major capital improvements when funding such improvements cannot be done with project reserves. CILP assistance is provided in the form of an amortizing loan. Both programs are designed to restore or maintain the physical and financial soundness of eligible projects at the lowest possible cost to the Federal government. Because of the limited funding, however, Flexible Subsidy funds are strictly reserved for the emergency needs of 202 projects. Such projects must have been in occupancy for at least 15 years and have emergency health and safety needs. In FY1999, $13,716,999 was disbursed to over 20 projects. In FY2000, Flexible Subsidy funding was awarded to 30 projects, totaling $17,195,115.

The Loan Management Set Aside (LMSA) Program provides Project-based Section 8 funding to HUD-insured and HUD-held projects and projects funded under the 202 program which need additional financial assistance to preserve the long term fiscal health
of the project. Funding has not been available for this program for several years.

H. MANUFACTURED HOME PARKS

The Housing and Urban-Rural Recovery Act (HURRA) of 1983 amended Section 207 of the National Housing Act to permit mortgage insurance for manufactured home parks exclusively for the elderly. The program has been operational since the March 1984 publication of a final rule implementing the legislation, although HUD insures very few manufactured home parks.

I. TITLE I PROPERTY IMPROVEMENT LOAN INSURANCE

Title I of the National Housing Act authorizes HUD to insure lenders against loss on property improvement loans made from their own funds to creditworthy borrowers. The loan proceeds are to be used to make alterations and repairs that substantially protect or improve the basic livability or utility of the property. There are no age or income requirements to qualify for a Title I loan. HUD funded 30,689 loans in FY1999 and 18,387 loans in FY2000.

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. HUD funded 350 loans in FY1999 and 313 in FY2000.

K. HOME EQUITY CONVERSION MORTGAGE INSURANCE PROGRAM

The Department has implemented a program to insure Home Equity Conversion Mortgages (HECM), commonly known as “reverse mortgages.” The program is designed to enable persons aged 62 years or older to convert the equity in their homes to monthly streams of income and/or lines of credit. HUD funded 7,921 loans in FY1999 and 6,641 loans in FY2000.

L. SECTION 231—MORTGAGE INSURANCE FOR HOUSING FOR THE ELDERLY

Section 231 of the National Housing Act authorized HUD to insure lenders against losses on mortgages used for construction or rehabilitation of market rate rental accommodations for persons aged 62 years or older, married or single. Nonprofit as well as profit-motivated sponsors are eligible under this program. The program is largely inactive and produced no units in FY1999 or FY2000.

II. OFFICE OF PUBLIC AND INDIAN HOUSING

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.

About 15 percent of Section 8 certificate and voucher recipients are being used by the elderly. As of January 2001, this represented 213,000 occupied units.

B. ELDERLY/DISABLED SERVICE COORDINATORS

Section 673 of the Housing and Community Development Act of 1992 authorized the Department to fund service coordinators in public housing developments to ensure that the elderly and non-elderly disabled residents have access to the services they need to live independently. From FY 1994 to 1998, the Department awarded 227 grants totaling approximately $62.8 million for public housing authorities to hire service coordinators for their elderly and non-elderly disabled residents to provide general case management and referral services, connect residents with the appropriate services providers, and educate residents on service availability. Service coordinator grants that were previously awarded are being renewed annually to maintain the level of services for elderly residents and residents with disabilities. In FY1999 approximately $13 million in renewal grants were awarded. Because funds are still available from FY1999, service providers who had not applied for funds were asked to submit applications. HUD staff are currently reviewing these applications and may award additional funds. In FY2000 approximately $12 million in grants were awarded.

C. TENANT OPPORTUNITY PROGRAM

Section 20 of the U.S. Housing Act of 1937, as amended, authorized the Tenant Opportunities Program (TOP). The program enables resident entities to establish priorities and training programs for their specific public housing communities that are designed to encourage economic development, stability, and independence. The program began in 1988 and to date has awarded about 986 grants totaling approximately $80 million. Public housing developments with elderly residents are eligible to participate and perhaps 7 percent are primarily elderly grantees.

As part of the implementation of Section 538 of the Public Housing Reform Act, the TOP program was consolidated into the Resident Opportunities and Self Sufficiency (ROSS) program. Section 538 authorizes a program to link services for public housing residents to promote self sufficiency and economic empowerment. Many of the activities previously eligible under TOP are eligible under ROSS.

D. PUBLIC HOUSING DEVELOPMENT PROGRAM

The Public Housing Development Program was authorized by Sections 5 and 23 of the U.S. Housing Act of 1937 to provide adequate shelter in a decent environment for families that cannot afford such housing in the private market.

In 1999, 4 additional units of public housing for the elderly were reserved, 25 started construction, and 261 became available for occupancy. In 2000, 36 units were reserved, 36 started construction, and 775 became available for occupancy. As of February 2001,
there were approximately 404,860 elderly low income persons residing in public housing:

III. OFFICE COMMUNITY PLANNING AND DEVELOPMENT

A. COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) ENTITLEMENT COMMUNITIES PROGRAM

The CDBG Entitlement Communities program is HUD’s major source of funding to large cities and urban counties for a wide range of community development activities. These activities primarily help low- and moderate-income persons and households, however, they can also be used to help eliminate slums and blight or meet other urgent community development needs.

The Department normally does not ask grantees to report CDBG program beneficiaries by age. The Department estimates, that grantees spent about 1 percent of their CDBG program funds (about $35 million in 1999 and $34 million in 2000) for public services that were specifically targeted to senior citizens. In addition, HUD staff are aware that senior citizens frequently benefit from local housing rehabilitation programs that are funded by CDBG. What is not known is how many of those benefiting from rehabilitation projects are elderly.

B. CDBG STATE-ADMINISTERED AND HUD-ADMINISTERED SMALL CITIES PROGRAMS

The CDBG State-administered program (and its predecessor, the HUD-administered Small Cities program, which still operates in Hawaii) is HUD’s principal vehicle for assisting communities with populations under 50,000 that are not central cities of metropolitan areas. States provide grants to small cities, counties and other units of local government, which use the CDBG funds to undertake a broad range of activities. (HUD makes grants directly to counties in Hawaii.) As is also true with the Entitlement Communities program, these activities must primarily help low- and moderate-income persons and households; however, they can also be used to help eliminate slums and blight or meet other urgent community development needs.

The Department has no specific information on the extent of benefit from these programs for the elderly, however HUD staff are aware that elderly persons and households who live in these small cities and counties are benefiting from CDBG-funded activities. The extent of benefit to the elderly in the State CDBG program may be similar to that in the Entitlement CDBG program, since many small communities and rural areas have high concentrations of elderly persons.

C. HOME INVESTMENT PARTNERSHIPS (HOME) PROGRAM

The HOME Program continues to serve as a major resource for elderly housing assistance, particularly for the rehabilitation of deteriorating properties of low-income elderly homeowners, allowing them to remain in their own homes and keep those homes in standard condition. The figures below represent the number of HOME-assisted units that participating jurisdictions reported were com-
completed and occupied by elderly residents during calendar years 1999 and 2000 and the percentage of units in that category that this figure represents.

<table>
<thead>
<tr>
<th>Tenure type</th>
<th>Calendar 1999–2000</th>
<th>Elderly Cumulative</th>
<th>Total Units Completed</th>
<th>Percentage Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeowner Rehabilitation</td>
<td>10,391</td>
<td>36,054</td>
<td>86,974</td>
<td>42.9%</td>
</tr>
<tr>
<td>Rental Units</td>
<td>11,589</td>
<td>20,193</td>
<td>125,173</td>
<td>16%</td>
</tr>
<tr>
<td>New Homebuyers</td>
<td>1,624</td>
<td>3,911</td>
<td>145,234</td>
<td>3%</td>
</tr>
<tr>
<td>Total elderly units</td>
<td>23,604</td>
<td>60,158</td>
<td>357,381</td>
<td>17%</td>
</tr>
</tbody>
</table>

To date, HOME has assisted 60,158 low-income elderly households. This constitutes an investment of over $1,027,000,000 in HOME funds, which have leveraged another $1,406,000,000 in private investment and other non-HOME funds (which includes Federal, State and local funds) to provide housing for the elderly (estimates based on a weighted average of $17,072/per unit HOME subsidy for production, and conservative estimate of $1.37 per $1.00 of HOME as leverage).

For data collection purposes, the HOME Program defines elderly as 62 or older. Therefore the above numbers do not reflect projects which are designed for seniors between 55 and 62.

D. EMERGENCY SHELTER GRANTS PROGRAM

The Emergency Shelter Grants (ESG) Program provides funds to States, metropolitan cities, urban counties, Indian tribes, and territories to improve the quality of emergency shelters, make available additional shelters, meet the cost of operating shelters, provide essential social services to homeless individuals, and help prevent homelessness.

According to a recent Federal study entitled HOMELESSNESS: Programs and the People They Serve, about 2 percent of homeless persons are 65 years or older. While about 1 percent of the ESG funds go to seniors-only facilities for the homeless, this population often receives emergency housing and services at other shelter facilities that are not reported in the ESG program. Shelters normally serve all homeless adults of any age, unless they have a particular family or single person focus.

E. SUPPORTIVE HOUSING PROGRAM

The Supportive Housing Program (SHP) funds may be used to provide: (1) transitional housing designed to enable homeless persons and families to move to permanent housing within a 24 month period, which may include up to 6 months of follow-up services after residents move to permanent housing; (2) permanent housing provided in conjunction with appropriate supportive services designed to maximize the ability of persons with disabilities to live as independently as possible within permanent housing; (3) innovative supportive housing; or (4) supportive services for homeless persons not provided in conjunction with supportive housing.
IV. OFFICE OF FAIR HOUSING AND EQUAL OPPORTUNITY

A. THE FAIR HOUSING ACT

The Fair Housing Act prohibits discrimination in housing based on race, color, religion, sex, national origin, handicap, or familial status. The Act exempts from its provisions against discrimination based on familial status “housing for older persons.” The statutory exemption of “housing for older persons” comprises three categories of housing: (1) housing provided under any State or Federal program that the Secretary of HUD determines is specifically designated and operated to assist elderly persons; (2) housing intended for and solely occupied by residents 62 years of age and older; and (3) housing intended and operated for occupancy by at least one person 55 years of age or older per unit, provided various other criteria are met.

B. THE HOUSING FOR OLDER PERSONS ACT OF 1995

The Housing for Older Persons Act (HOPA) of 1995 amends the “55 and older” housing exemption to the Fair Housing Act’s prohibition against discrimination based on familial status. HOPA eliminates the requirement that housing “55 and older” have significant facilities and services and establishes a good faith reliance defense from monetary damages for individual real estate professionals on a legitimate belief that the housing was entitled to an exemption. In order to qualify for the “55 and older housing” exemption a housing community or facility must: (1) have at least 80 percent of its occupied units occupied by at least one person 55 years of age or older; (2) publish and adhere to policies and procedures which demonstrate an intent by the owner or manager to provide housing for persons 55 and older; and (3) comply with the rules issued by the Secretary for verification of occupancy through reliable surveys and affidavits.

The Department published the HOPA final rule on April 2, 1999 with an effective date of May 3, 1999.

C. AGE DISCRIMINATION ACT

The Age of Discrimination Act of 1975 prohibits programs or activities receiving Federal financial assistance from directly or through contractual, licensing, or other arrangements, using age distinctions or taking any other actions which have the effect, on the basis of age, of: excluding individuals from, denying them the benefits of, or subjecting them to discrimination under a program or activity receiving Federal financial assistance; or denying or limiting individuals their opportunity to participate in any program or activity receiving Federal financial assistance. The Department’s regulations implementing the Age Discrimination Act became effective on April 10, 1987, and are codified at 24 CFR Part 146.

During FY1999, the Department received 16 complaints alleging age discrimination, all of which were referred to the Federal Mediation and Conciliation Services (FMCS). One of these complaints were successfully mediated and agreements was reached. Of the remaining cases, 3 were unsuccessfully mediated, 1 is pending mediation, and in 11 cases mediation was canceled due to the failure
to attend the mediation meeting. These 15 cases may be administratively closed out at a later date.

**D. DESIGNATED HOUSING**

The 1992 Housing and Community Development Act authorized HUD to approve Public Housing Authority plans to designate mixed population housing units (serving elderly and persons with disabilities) for elderly families only, disabled families only, or elderly and disabled families, if the plans met certain statutory requirements outlined in Section 7 of the United States Housing Act. The Housing Opportunities Program Extension Act of 1996 simplified and streamlined those requirements, but continued to require HUD to review and approve or disapprove designated housing plans.

For FY2000, 26 housing authorities received approval to designate 4,450 units for elderly families.

**V. OFFICE OF POLICY DEVELOPMENT AND RESEARCH**

**A. AMERICAN HOUSING SURVEY**

The American Housing Survey for the United States, Current Housing Report Series Number H150 for the year 1999 contains special tabulations on the housing situations of elderly households in the United States. Chapter 7 of the regular report provides detailed demographic and economic characteristics of elderly households, detailed physical and quality characteristics of their housing units and neighborhoods and the previous housing of recent movers, and their opinions about their house and neighborhood. The data are displayed for the four census regions, and for central cities, suburbs, and non-metropolitan areas, and by urban and rural classification. The non-elderly chapters (total occupied, owner, renter, Black, Hispanic, central cities, suburbs, and outside MSAs) also contain data on the elderly. In addition, Current Housing Report Series Number H170 contains data on the elderly for the 47 largest metropolitan areas that are individually surveyed over four- to six-year cycles.

An elderly household is defined as one where the householder, who may live alone or head a larger household, is aged 65 years or more. Special information in these publications is provided on households in physically inadequate housing or with excessive cost burden, and on households in poverty.

**B. EVALUATION OF THE CONGREGATE HOUSING SERVICES PROGRAM (CHSP)**

The New Congregate Housing Services program was authorized under the National Affordable Housing Act of 1990 and amended by the Housing and Community Development Act of 1992.

The Congregate Housing Services Program (CHSP) provides a combination of housing and support services to frail elderly and non-elderly disabled persons living in federally subsidized apartment developments. CHSP services include service coordination and non medical supportive services, such as housekeeping, congregate meals, personal care, and transportation.
The main purpose of CHSP is to promote and encourage maximum resident independence within a home environment, and to improve housing management's ability to assess eligible residents' service needs and provide or ensure the delivery of needed services to them. HUD pays up to 40 percent of the costs of CHSP; the grantees pay 50 percent or more, and the remaining 10 percent is paid by fees from participating residents. CHSP services are subsidized through grants to public housing authorities, Section 202 and other developments that serve frail elderly and disabled residents (project based model).

Data for the evaluation was collected over a two-year period. The final report, which was Congressionally mandated, was transmitted to Congress in September 2000.

**FINDINGS**

The number of residents served in different developments ranges from fewer than 10 to more than 100, with a median in 1996 of 24 participants. Services are targeted to residents who have functional limitations that meet eligibility requirements, and are income-eligible for subsidized housing. CHSP participants are typically elderly (average age 81 years) white women who live alone. In their age and race/gender composition, the group served by CHSP is similar to other frail elderly populations receiving supportive services. Although they live alone, they are not socially isolated: 84 percent have at least one family member living nearby, and more than half (58 percent) see family at least once a week. Also, most have contact with friends (63 percent see friends at least once a week).

Most participants (75 percent) report 3 more activities of daily living (ADL) limitations and half have 6 or more ADLs. Areas in which more than half of CHSP participants report ADL limitations include: doing housework (81 percent); shopping (72 percent); getting in or out of a tub or shower (59 percent); preparing meals (56 percent); and getting in or out of a bed or chair (54 percent). Comparison shows that CHSP participants are more impaired than the overall population of U.S. elderly.

Half of CHSP participants studied were still in the program 24 months after the baseline survey; about 14 percent had died; and about 9 percent had left the program because they were no longer eligible; were dissatisfied, or obtained services from another source. Among residents who remained in CHSP over the 24 month study period, about half (48 percent) showed the same ADL level over the period and 29 percent experienced decline.

Annual per-participant costs of CHSP services and associated housing were estimated and compared with costs for assisted living and nursing homes. These show that the costs per participant for housing plus CHSP services ($8,900 to $11,000 per year) are substantially lower than the costs for assisted living ($15,000 to $20,000) or a nursing home ($41,000). This supports the view that CHSP provides a cost effective means of providing housing and supportive services for the frail elderly.

Several conclusions from the evaluation are specially relevant: (1) CHSP has been successful in delivering supportive services to frail, low-income elderly residents of subsidized housing; (2) HUD
funds have been important for grantees in leveraging funds from other sources; (3) the CHSP data show that housing and supportive services can be delivered in subsidized housing at costs below those for assisted living and nursing home care; and (4) the kinds and levels of service can be changed as individual residents needs change over time.

C. EVALUATION OF THE HOPE FOR ELDERLY INDEPENDENCE DEMONSTRATION PROGRAM—HOPE IV

The final report on the evaluation of the HOPE for Elderly Independence Program was released in February 1999.

HOPE IV combines HUD Section 8 rental assistance with case management and supportive services to low-income elderly persons (62 and older) with limitations in three or more personal care and home management activities, such as bathing, dressing, and housekeeping. The purpose of HOPE IV, administered by local Public Housing Agencies (PHAs), is to expand access to Section 8 rental assistance by frail elderly tenant populations and help participants avoid nursing home placement or other restrictive settings when home and community-based options are appropriate. In addition to rental assistance, as vouchers for private-market housing, HUD pays 40 percent of the supportive services costs, the grantees pay 50 percent, and participants, except for those with very low incomes, pay 10 percent.

The vast majority of HOPE IV participants are widowed, white females, consistent with the profile of frail elderly Americans overall. In addition, approximately half of the participants are age 75 and over, have less than a high-school education, and receive incomes under $8,000 per year. Over half of the participants, however, are between 62 and 74 years old, but with few exceptions and in spite of their relatively young age, these persons have similar levels of frailty as their counterparts above age 75.

Most HOPE IV participants have several factors that are highly correlated with frailty and risk of institutionalization in national studies—low-income, low level of education, minority status, and living alone. HOPE IV participants are much frailer than non-institutionalized elderly persons in the general population, and they are considerably less frail than elderly persons in community-based programs (nursing home eligible) or persons receiving nursing home care. During the two-year period between the baseline and follow-up survey, the percentage of participants and comparison group (control group) members reporting an ADL limitation increased for all activities of daily living. However, the comparison group reported fewer increases than the participants.

Many HOPE IV participants are not isolated, participate in activities outside the home, and enjoy their social contact. However, the patterns of both in-person and telephone contact showed that most participants have either a great deal of contact or little contact at all, with surprisingly few cases in between.

Participants in the HOPE IV program received a significantly higher level of supportive services than the comparison (or control) group, and this disparity in access to care remained over time. For example, at follow-up (2 years after baseline), nearly one-third (32 percent) of the comparison group reported receiving no services at
all despite high levels of frailty, versus seven percent of the participants. In addition, receipt of services has a significant correlation with range of positive outcomes, across multiple domains of functioning. For example, service recipients scored significantly higher in four major mental health dimensions, social functioning, vitality, and other measure of social well-being. However, there were no statistically significant differences between the participants and the comparison group members in the rates of nursing home placement, mortality, or remaining in Section 8. This finding is consistent with the results of prior studies that show the impacts of similar programs address quality of life and care, rather than changing such overt outcomes as death, institutionalization, or otherwise having to leave one's home due to frailty.

Over the two-year period of the study, 40 percent of the participants left the HOPE IV program, including Section 8. This consisted of 15 percent who died, 9 percent who went into a nursing home or other similar setting, 9 percent who moved to another location, and 7 percent who left HOPE IV and Section 8 for other or unspecified reasons. Sixty percent of the participants remained in assisted housing, including 7 percent who left HOPE IV but retained their Section 8 rental assistance. Over the same two-year period, 38 percent of the frail elderly comparison group left Section 8, including 13 percent who died, 8 percent who went into a nursing or related care home, 9 percent who moved to another location, and 8 percent who left for other or unspecified reasons.

An overwhelming 85 percent of participants at baseline, and an even higher 91 percent at follow-up (2 years later), reported they were very satisfied with HOPE IV; 11 percent and 6 percent, respectively, said they were somewhat satisfied. Only one respondent indicated active dissatisfaction with the program at either point in time, while a very few were uncertain or did not say.

**Comparison of HOPE IV and CHSP**

This report compares the effectiveness of providing assistance under the Congregate Housing Services program (CHSP) and the HOPE for Elderly Independence Demonstration (HOPE IV) program as requested in the 1990 Cranston-Gonzales National Affordable Housing Act (Public Law 101–625). HOPE IV and CHSP combined HUD housing assistance with case management and supportive services for low-income elderly persons (62 and older) with limitations in personal care and home management activities, such as bathing, dressing, and housekeeping. The report was released in June 2000.

The purpose of HOPE IV and CHSP was to expand existing housing assistance programs to an elderly population often deprived of access to them due to frailty and to help these participants avoid nursing home placement or other restrictive settings when home and community-based options were appropriate. In addition to the housing assistance, HUD paid 40 percent of the supportive services costs, the grantees paid 50 percent, and participants, except for those with very low incomes, paid 10 percent of total program costs.
The Departmental Office for Equal Opportunity (OEO) is responsible for enforcing a variety of Federal anti-discrimination laws that guarantee equal employment opportunity and nondiscrimination in all aspects of the Department of the Interior's (DOI) operations. OEO serves as the focal point for ensuring nondiscrimination on the basis of age in all aspects of DOI's operations including its employment practices, federally conducted education programs, and in all programs and activities receiving Federal financial assistance. In calendar years 1999 and 2000, OEO promoted and oversaw an array of proactive diversity initiatives to ensure nondiscrimination in DOI's employment practices, i.e., diversity training for bureau and office managers, diversity presentations, and listening sessions on diversity workforce issues. Each of these diversity initiatives covered age discrimination matters and quality of life issues that generally affect older DOI job applicants and employees. DOI continues to provide equal employment opportunity (EEO) counseling services through collateral duty personnel who have been specifically trained to address age discrimination issues that may affect DOI job applicants and employees. DOI has a "Zero Tolerance Policy" in place that is aimed at prohibiting discriminatory employment policies and practices based on age. DOI's age discrimination policy is prominently proclaimed to the public and its employees through a variety of approaches.

In 1999, DOI processed a total of 117 civil rights complaints of which two were age discrimination complaints. In 2000, out of a total of 132 civil rights complaints received by DOI, as in 1999 only two complaints alleged discrimination on the basis of age. These complaints were filed against State and local government agencies who received Federal financial assistance from DOI. Generally, the complaints did not relate to discriminatory age based policies, rather these complaints alleged instances of maltreatment and inaccessible programs encountered by older people with disabilities. In calendar year 1999, experts from the U. S. Department of Health and Human Services, the lead Federal agency for providing government wide guidance in enforcement of the Age Discrimination Act of 1975, provided comprehensive civil rights training to key DOI equal opportunity personnel on the requirements of the Act. (The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in federally assisted programs.) This training was provided to all DOI bureaus and offices that administer Federal financial assistance programs. During the period, policy guidance and
procedural information were developed on how to conduct age discrimination complaint investigations filed against recipients of Federal financial assistance. Technical assistance was routinely provided by OEO to bureaus having responsibility for addressing age discrimination complaints. Comprehensive guidance was issued on DOI's civil rights public notification requirements which are intended to inform the public of DOI's nondiscrimination policy and the procedures for filing age discrimination complaints. Additionally, compliance reviews of DOI's federally assisted programs were conducted that covered age discrimination issues. These reviews were conducted to ascertain, in part, whether or not DOI's recipients of Federal financial assistance were in compliance with the requirements of the Act. DOI's bureaus and offices have established continuous civil rights compliance and enforcement programs that provide for conducting civil rights compliance reviews, complaints processing, training, and the provision of technical assistance in DOI's most service-delivery oriented Federal assistance programs. All of these particular processes cover the requirements of the Act.

DOI continues to have a complaints processing system in place that facilitates prompt investigations of age discrimination complaints against DOI recipients of Federal financial assistance. DOI's complaint processing procedures incorporate routine determinations as to whether a complaint is within DOI's jurisdiction and covered by the Act. Complaints received by DOI that contain sufficient information which identify the recipient, the location of the program or activity, the policy or issue in question, and the approximate date the alleged discrimination occurred are routinely referred to the Federal Mediation and Conciliation Service as required by Departmental regulation.

During the period, DOI also initiated work life assessments to ascertain the needs and wants of its employees with the older worker in mind. These assessments were accomplished in terms of improving conditions in DOI's workplace for all workers. These work life assessments resulted in the re-opening of DOI's health center and a refurbished fitness center which substantially benefits DOI's aging employees. Older workers can now take advantage of family support rooms that have been established in DOI facilities. In addition, DOI's aging employees, on an as needed basis, can avail themselves of DOI sponsored wellness programs including free physical examinations, flexi-time work schedules, telecommuting, retirement planning programs, and alternative work schedules.

**BUREAU OF INDIAN AFFAIRS**

The Bureau of Indian Affairs (BIA) administers initiatives and programs to benefit aging American Indians and Alaskan Natives. More specifically, BIA provides and finances adults with custodial and protective care services. These services have been provided in homes, group homes and nursing care facilities for elderly persons who lack financial, physical and mental capability to care for themselves. Other aging citizens have received protective and counseling services without custodial care payments. BIA coordinates intensive nursing care services for aging residents through referrals to other Federal, state or local agencies. The Division of Social Services recently established standards that focuses on upgrades for
homemakers and custodial care services. On January 22, 2001, BIA published in the *Federal Register*, guidance that addresses the handling of financial matters for adults with disabilities including the elderly. The BIA administers a Housing Improvement Program that provides for repairs and home improvements, and the construction of new homes on Indian reservations or in Indian communities. The Housing Improvement Program is a Federal financial assistance program designed to improve housing standards for Native Americans who are ineligible for such aid under conventional housing assistance programs. Program participants are selected from weighted criteria that favor low income individuals, people with disabilities, and the elderly. Furthermore, Tribal governments are authorized to use "638 Contracts" as a means to meet the housing needs of elderly Native Americans. In addition, the BIA continues to enforce the Age Discrimination in Employment Act. The Act prohibits discrimination in employment on the basis of age in the BIA's employment practices.

**OFFICE OF SURFACE MINING RECLAMATION AND ENFORCEMENT**

The Office of Surface Mining Reclamation and Enforcement (OSM) is committed to ensuring that all persons are provided equal opportunity in all employment matters. For calendar years 1999 and 2000, an equal employment opportunity policy statement from the Director was in effect. This policy governs OSM's employment practices. The policy states that "(in the OSM) discrimination based on age (40 and older) will not be tolerated." Older workers are represented in most of OSM's occupational workforce series. In fact, over half (69.6%) of OSM's workforce will have reached retirement eligibility within the next 5–10 years.

OSM continuously keeps abreast of what is important to its workers and their quality of workplace issues. In 1999 and 2000, OSM sponsored a series of seminars on retirement, breast cancer, prostate cancer, the Thrift Savings Plan, and social security. These seminars were chosen because of their direct or indirect impact on OSM's aging workforce. Moreover, service awards for 25, 30, and 35 years of service were awarded to many OSM employees during calendar years 1999 and 2000. For further information regarding OSM's policies and practices, please contact Diane Wood on (202) 208–2997.

**BUREAU OF LAND MANAGEMENT**

The Bureau of Land Management (BLM) offered retirement training to its employees. The training was provided to BLM employees who were at retirement age. The training was attended mostly by employees age 50 and over.

The BLM has established a family room in its Washington Office. This room is used by employees who have elderly parents requiring close attention especially in cases where there is no one at home to care for them. The room is equipped with a computer and other office amenities to allow employees to perform their duties while taking care of their parents.

BLM employs thousands of senior citizens in volunteer jobs in the States of Alaska, Arizona, California, Colorado, Idaho, Mon-
tana, the Dakotas, Idaho, Nevada, New Mexico, Oregon, Utah, and Wyoming. These volunteers perform tasks as diverse as clearing public lands, collecting data on raptor populations, maintaining fish habitat, serving as campground hosts, monitoring and protecting caves and other related resources, conducting archeological inventories, nurturing plant species growing on public lands from Eastern Florida to Western Oregon, and teaching kids and adults about natural resources.

Volunteers are recognized during the Earth Day celebrations. A group of the best volunteers is recognized by the Secretary of the Interior every year in Washington, DC. In 1999, 17,300 persons participated in the BLM volunteers program. We do not have the report for 2000 as of this date. A high percentage of these volunteers are older citizens.

The BLM Nevada State Office has an established Elder Care Program for BLM families caring for older parents. Senior Resource Guides are distributed to BLM Nevada State employees to assist them in providing care and support for their aging parents. The guide contains information regarding transportation, counseling services, and support groups, i.e., grandparents raising grandchildren, protective services for elderly persons, centers for independent living, "meals-on-wheels," nursing homes, companion care, educational programs, employment opportunities and volunteer programs for senior citizens. The Nevada State Office participates regularly in the Children's Cabinet, a public service program that affords volunteer and employment opportunities to older Americans. The program also offers advice to BLM employees who are in need of day care services for their elderly parents. Free meeting facilities are provided for employee support group meetings. Telephone numbers for elder care services located outside of the State of Nevada are routinely provided to BLM employees who need assistance in finding reputable elder care services for their parents or grandparents.

The BLM participates in the Senior Community Service Employment Program (SCSEP). SCSEP is a program that affords part-time employment and basic entry level job training opportunities to persons 55 years of age and older who meet established Federal low income guidelines. An enrollee's duties in the program others similar to those performed by others already employed by the BLM. A SCSEP person is not considered a Federal employee within the context of the laws administered by the Office of Personnel Management. Hence, they do not have Federal employee status, except for the purpose of the Tort Claims Act and Federal Employee Compensation Act. The objective of the program is to help older Americans to get into or return to private sector jobs. The pay for a SCSEP employee is the Federal minimum wage or if they live in a state where the minimum wage is higher they get paid the higher wage. BLM's SCSEP employees receive one hour of excused leave for every 20 hours they work. They are paid for Federal holidays that occur during their scheduled tour-of-duty. SCSEP employees do not receive Federal health benefits. However, they are covered by the Federal Workman's Compensation Act for injuries that occur while working on the job.
The Bureau of Reclamation's mission is to manage, develop, and protect water and related resources in an environmentally and economically sound manner, in the interest of the American public. The Bureau of Reclamation offers extensive career opportunities for diverse individuals with a wide variety of education and work backgrounds. In order to ensure diversity, the Bureau of Reclamation instituted a Workforce Diversity Implementation Plan in 1999. This was in response to the Department of the Interior's Strategic Plan for Improving Diversity. The plan outlines five separate and distinct goals, all of which impact the aged population. The five goals are cited in the following section of this report.

Recruit a workforce that reflects the diversity of the nation.—As an equal opportunity employer, the Bureau of Reclamation continues to recruit individuals from all age groups. However, examples of specific opportunities for aged applicants is re-employed annuitants to perform special projects or provide assistance in specialized technical areas of work, since they are able to offer invaluable experience and expertise to these assignments. For example, one office hired an annuitant for an employee relations specialist position. Other offices have volunteer and work trainee programs specifically designed for seniors. In Farmington, New Mexico, the county provides names of volunteer seniors to perform receptionist and clerical duties at the Reclamation Construction Office. In addition, the Pacific Northwest Region utilizes senior volunteers as “Park Hosts” every summer. They also utilize volunteer referrals from organizations such as the local Easter Seals for a variety of worker trainee positions, from thinning forests to office automation.

Retain a workforce that reflects the diversity of the nation.—In 1995, the Bureau of Reclamation established a Work and Family Team (WAFT) to implement the Presidential directive on Family-Friendly Federal Work Arrangements. Initiatives taken on behalf of older Americans and their families include:

- **Human Resource Centers** located in seven geographically dispersed regions which are designed to be “one stop shopping centers.” Aside from job information, they also provide resources and seminars on work and family issues, such as child and elder care, as well as health maintenance. The WAFT regularly updates its web page, which covers a wide range of topics and allows employees to send questions about work and family policies, such as the Family and Medical Leave Act. A **WAFT Handbook** is also available to employees in all offices.

- The Bureau of Reclamation conducts many activities throughout the year which affect senior citizens. The Bureau of Reclamation's Human Resources Offices maintain contact and provide services to many retirees who need advice or have questions concerning their retirement and health benefits. The Bureau of Reclamation also makes available to its retirees and their spouses annual health insurance fairs that are attended by reputable health insurance carriers. Several regional offices of the Bureau of Reclamation continue to mail out a highly regarded monthly newsletter to all retirees as a way of keeping in touch. Additionally, pre-retirement seminars are held for all
interested employees who are within five years of retirement eligibility.

Ensure accountability at the Secretarial and bureau levels for improving diversity.—Bureau of Reclamation offices are required to provide quarterly updates of their activities and progress in attaining and maintaining a diverse workforce.

Educate managers, supervisors and employees regarding diversity.—Training is provided on a continuous basis to all employees of the Bureau of Reclamation regarding the value of maintaining a diverse workforce. In addition, observances that focus on the contributions of contemporary and historic individuals, particularly women, minorities, and people with disabilities are featured periodically throughout the year. Other relevant seminars cover such topics as U. S. Census Data, which highlight demographic shifts and raise awareness of the nation's aging population.

There will be zero tolerance for discrimination, harassment or hostile work environments.—This goal assures that all operations are conducted without discrimination including, but not limited to, age discrimination. Moreover, the Bureau of Reclamation has responsibilities in assuring equal access to employees and the public through its federally conducted and federally assisted programs. The Bureau of Reclamation is committed to serving the diverse populations of this country by improving work and public environments, consistent with its mission of managing water resources. Tasked with meeting legal responsibilities, the Bureau of Reclamation has developed a corporate approach to providing accessible opportunities for people with disabilities. The Bureau of Reclamation believes that these equal opportunity policies and practices will continue to have a positive impact on our nation's seniors.

NATIONAL PARK SERVICE

The National Park Service (NPS) continues to ensure that a broad range of services is provided to the visiting public including senior citizens. The NPS hosts the Senior Community Employment Program. This activity is implemented in cooperation with a number of parks with the National Park system and the U. S. Forest Service, U. S. Department of Agriculture. The program seeks to provide supplemental income to seniors in general and in rural communities.

The Summer Seasonal Employment Program hires and employs a number of retirees to perform duties in those parks where the visitation rates have increased and the workload of the permanent workforce requires hiring of seasonal employees.

The Golden Age Passport, for individuals 62 or older, is a lifetime entrance pass to the majority of the 384 park sites in the National Park system with entrance fees. The passport permits the holder and accompanying passengers to be admitted to these sites.

The NPS Accessibility Office provides park and recreation services to special populations including senior citizens and individuals with disabilities. The office develops and implements comprehensive approaches for ensuring that the park sites are accessible. The office also provides training and technical assistance to these sites.

Volunteers are vital in meeting the NPS's mission. In turn, having a meaningful experience while helping to preserve and protect
America’s national treasures is vital to NPS’s volunteers. The National Park Service Volunteers-In-Parks program provides opportunities that are mutually beneficial to volunteers and parks.

In an effort to expand these opportunities and tap what has been a somewhat untapped resource in the past, the NPS developed the idea of a Volunteer Senior Ranger Corps. The original idea, conceptualized two years ago, was to create a cadre of seniors with specialized skills who would work with parks on specific projects projects that might not get the level of attention required without the help of volunteers.

Within the last year, the National Park Foundation was presented with an opportunity to receive grant money from the United Parcel Service (UPS) Foundation. The UPS Foundation’s Volunteer Impact Initiative was a perfect way to implement the Volunteer Senior Ranger Corps. The grantor’s requirement for this initiative involved a strong youth component. The National Park Foundation, the NPS, and the Environmental Alliance for Senior Involvement partnered together in creating a proposal which incorporated a strong intergenerational component where seniors would work with youths on park projects as well as sharing experiences and building stewardship.

The UPS Foundation is very excited about the NPS being a part of their Volunteer Impact Initiative. As one of four grantees, the National Park Foundation and its partners are in the process of implementing the Volunteer Senior Ranger Corps.

U. S. GEOLOGICAL SURVEY
1999

The U. S. Geological Survey (USGS) provides opportunities to individuals of all ages in all areas of the USGS’s operations. The USGS ensures that the skills of older individuals are utilized through special programs and employment opportunities.

In 1999, USGS employed a total of 9,889 individuals in permanent and temporary jobs. During this period, 6,750 (68.3%) USGS employees were age 40 and over. Of USGS employees age 40 and over, there were 475 (7%) employees who were 60 years of age and older, and two employees over 80 years old.

The majority of USGS’s mission related occupations, which include occupations such as hydrologists, geologists, cartographers, and biologists, are in the professional category. Of the 6,750 USGS employees age 40 and over, there were 3,612 (53.5%) in professional positions, 277 (7.7%) of whom were age 60 or over, and two employees over 80. Other demographic information regarding USGS employees age 40 and over are as follows:

- 1,046 (15.5%) were in “Administrative” positions with 49 (4.7%) of them age 60 and over;
- 1,645 (24.4%) were in “Technical” positions with 112 (6.8%) of them age 60 and over;
- 309 (4.6%) were in “Clerical” positions with 31 (10%) of them age 60 and over;
- 18 (0.3%) were in “Other” positions with none of them age 60 and over; and
• 120 (1.8%) were in “Wage Grade” positions with eight (6.7%) 60 and over.

There were two employees over the age of 80, one geologist and one wildlife biologist, both of whom worked full time.

In 1999, USGS selected participants for the following career development activities:
• Women's Executive Leadership Program: six participants, four were age 40 and over; and
• Federal Executive Institute: 18 participants, 17 were over the age of 40. There were 6 complaints filed based on age during this period.

2000

In 2000, USGS employed a total of 10,050 individuals in permanent and temporary jobs. There were 6,859 (68.2%) USGS employees who were age 40 and over. Of USGS employees age 40 and over, there were 506 (7.4%) employees who were 60 years of age and older, and there were three employees over the age of 80.

The majority of USGS' mission related occupations, which include positions such as hydrologists, geologists, cartographers, and biologists, are in the professional category. Of the 6,850 USGS employees age 40 and over, there were 3,673 (53.6%) in professional positions, 294 (8%) of whom were age 60 and over, and two employees over the age of 80. Other demographic information regarding USGS employees who were age 40 and over are as follows:
• 1,080 (15.7%) were in “Administrative” positions with 56 (5.2%) of them age 60 and over;
• 1,661 (24.2%) were in “Technical” positions with 119 (7.2%) of them age 60 and over;
• 307 (4.5%) were in “Clerical” positions with 29 (9.4%) of them age 60 and over;
• 23 (0.3%) were in “Other” positions with none of them age 60 and over; and
• 115 (1.7%) were in “Wage Grade” positions with eight (7%) age 60 and over.

There were three employees over 80 years of age, a geologist, a wildlife biologist, and a clerk typist. All three were full time employees.

In FY2000, USGS selected participants for the following career development courses:
• Women’s Executive Leadership Program: four participants. Out of that total, three were over the age of 40;
• Team Leadership Program: six participants. Out of that total, four were over the age of 40; and
• Federal Executive Institute: 20 participants. Out of that total, 18 were over the age of 40 and one over the age of 60.

There was a two-part Elder Care Workshop that was sponsored by the USGS Employee Assistance Program (EAP) covering the options to be considered when creating a plan to serve aging family members in the best way possible. Information was provided about Medicare and other health maintenance organization plans and the legal issues related to health care needs of elderly individuals.

As a follow-up to the workshop, an Elder Care Support Group was established which has continued to the present. There were
also workshops during Fiscal Year 1999 and Fiscal Year 2000 providing information on health issues related to aging including Alzheimer's disease, heart health, osteoporosis, and stroke. Health screening for health issues related to aging have been offered through the National Center Health Unit including stroke, heart disease, and osteoporosis screening.

There were eight complaints filed based on age during this time. The following chart illustrates the numbers of individuals who retired from USGS, some of whom have continued to provide outstanding services to USGS and the public nationwide in a variety of capacities.

<table>
<thead>
<tr>
<th>Categories</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirees</td>
<td>278</td>
<td>403</td>
</tr>
<tr>
<td>Docents</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Scientists Emeritus</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

The USGS Scientist Emeriti are welcomed back to the USGS after retirement to continue important scientific research. The USGS benefits immeasurably from the accumulated knowledge, experience, and dedication from the Scientists Emeriti.

MINERALS MANAGEMENT SERVICE

The Minerals Management Service (MMS) continues to work to support programs for older Americans. MMS's workforce statistics are as follows:

- Eighty-two percent of MMS's workforce is comprised of employees age 40 and over (1,450 of 1,767);
- Older employees are well represented in a variety of occupations within MMS, including accountants, auditors, computer specialists, engineers, and physical scientists;
- The MMS has implemented and continues to implement effective personnel management policies to ensure that equal opportunity is provided to all employees and applicants, including the aged;
- Employees are given flexibility to accommodate family needs through Family and Medical Leave Act initiatives;
- Eligible MMS employees attend retirement planning workshops; and
- Managers and supervisors continue to receive equal employment opportunity training, which includes age discrimination and how to avoid it.

The MMS continues to perform its mission related functions with diligence and with appreciation of the importance of MMS's mission. A major mission responsibility affecting large numbers of citizens is the approval of mineral royalty payments to various landholders, including numerous older Americans who often greatly depend on these payments to meet their basic human needs and rely on the ability of the MMS to effectively discharge its finance responsibilities.

The MMS offshore mission has the ultimate objective of increasing domestic minerals (oil and gas) production through offshore re-
sources, thereby decreasing our nation's dependence on foreign imports. Such activities have a significant effect on the economic well being of all Americans, especially older Americans.

In summary, the MMS has a strong commitment to all of its employees, including older workers. Older workers are a source of valuable knowledge and experience and a significant factor in the success of the MMS mission.

U. S. FISH AND WILDLIFE SERVICE

The U. S. Fish and Wildlife Service (FWS) provides opportunities for all employees regardless of their age and ensures that older individuals are utilized through special programs, volunteer programs, and employment opportunities. The following are the FWS reports on aging for 1999 and 2000.

1999

The FWS currently employs a total of 7,666 individuals. There are 5,433 (71%) of FWS employees over the age of 40, which is an increase of 319 employees from the previous year. Of the FWS employees over the age of 40, there are 306 (4%) over the age of 60, an increase of 4 employees from the previous year.

The majority of the FWS's mission related occupations, which include biologists, are in professional positions. Demographic information regarding FWS employees over the age of 40 is as follows:

- 2,407 (31%) were in Professional position; 80 (1%) were over the age of 60;
- 1,073 (14%) were in Administrative positions; 47 (0.6%) were over the age of 60;
- 841 (11%) were in Technical positions; 63 (.6%) were over the age of 60;
- 381 (%5) were in Clerical positions; 36 (0.5%) were over the age of 60;
- 30 (0.4%) were in Other positions; one was over the age of 60;
- 690 (9%) were in Wage Grade position; 79 (1.0%) were over the age of 60.

In 1999, there were 30 employment related discrimination complaints filed alleging discrimination on the basis of age (40 and above). Among the federally assisted program related complaints filed during this period, none contained an allegation of discrimination on the basis of age (40 and above).

A total of 6,686 Golden Age Passports were issued throughout the FWS in 1999. The Golden Age Passport Program provides free or lower entrance fees to most national parks, monuments, historic sites, recreation areas and national wildlife refuges for any individual over the age of 62.

The FWS recognizes the numerous contributions of older individuals through various awards programs. There were 4,947 FWS employees over the age of 40 who were recognized for their exceptional contributions through the FWS's Special Act or Service Awards. Additionally, six FWS employees over the age of 40 received Senior Executive Service performance awards.
The FWS employed a total of 7,922 individuals. There were 5,629 (71%) of FWS employees over the age of 40, which was an increase of 207 employees from the previous year. Of the FWS employees over the age of 40, 324 (4%) were over the age of 60; a increase of 18 employees from the previous year.

- 2,527 (32%) were in Professional position; 80 (1%) were over the age of 60;
- 1,109 (14%) were in Administrative positions; 53 (0.6%) were over the age of 60;
- 902 (11%) were in Technical positions; 76 (1%) were over the age of 60;
- 362 (4%) were in Clerical positions; 35 (0.4%) were over the age of 60;
- 27 (0.3%) were in Other positions; none were over the age of 60;
- 702 (9%) were in Wage Grade position; 80 (1%) were over the age of 60.

The following chart illustrates the total number of FWS employees over the age of 40 who were employed in mission related occupations in calendar years 1999 and 2000.

FWS Employees Over the Age of 40 Employed in Mission Related Occupations in Calendar Years 1999 and 2000

<table>
<thead>
<tr>
<th>Position</th>
<th>CY 1999</th>
<th>CY 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Over 40</td>
<td>Over 60</td>
</tr>
<tr>
<td></td>
<td>Over 40</td>
<td>Over 60</td>
</tr>
<tr>
<td>Professional</td>
<td>2,407</td>
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<tr>
<td>Administrative</td>
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</tr>
<tr>
<td>Technical</td>
<td>841</td>
<td>63</td>
</tr>
<tr>
<td>Clerical</td>
<td>381</td>
<td>36</td>
</tr>
<tr>
<td>Other</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td>Blue Collar (Wage Grade)</td>
<td>690</td>
<td>79</td>
</tr>
<tr>
<td>Total</td>
<td>5,422</td>
<td>306</td>
</tr>
</tbody>
</table>

In 2000, there was one employment discrimination complaint filed alleging discrimination on the basis of age (940 and above). Additionally, the FWS has two federally assisted program related complaints filed during the year alleging discrimination on the basis of age.

In 2000, a total of 7,513 Golden Age Passports were issued throughout the FWS. The Golden Age Passport Program provides free entrance or lower entrance fees to most national parks, monuments, historic sites, recreation areas and national wildlife refuges for any individual over the age of 62. The FWS recognizes the numerous contributions of older individuals through various awards programs. There 1,437 cash and other incentive awards given to employees over the age of 40 to recognize their exceptional contributions to the FWS. Additionally, three FWS employees over the age of 40 received Senior Executive Service performance awards.
ITEM 9—DEPARTMENT OF JUSTICE

INITIATIVES RELATED TO OLDER AMERICANS 1999–2000

INTRODUCTION

As the largest law firm in the Nation, the Department of Justice (DOJ) serves as counsel for its citizens. It represents them in enforcing the law in the public interest. Through its thousands of lawyers, investigators, and agents, the Department plays the key role in protection against criminals and subversion, in ensuring healthy competition of business in our free enterprise system, in safeguarding the consumer and government programs, and in enforcing drug, immigration, and naturalization laws. The Department also plays a significant role in protecting citizens through its efforts for effective law enforcement, crime prevention, crime detection, and prosecution and rehabilitation of offenders.

In addition, the Department conducts all suits in the Supreme Court in which the United States is concerned. It represents the Government in legal matters generally, rendering legal advice and opinions, upon request, to the President and to the heads of the executive departments. The Attorney General supervises and directs these activities, as well as those of the U.S. Attorneys and U.S. Marshals in the various judicial districts around the country.

The evolving role of the Department of Justice in protecting older Americans began with efforts to fight street crime, health care fraud that depletes programs intended to benefit older people, consumer fraud targeting elders, and civil rights violations. More recently, through its Nursing Home Initiative and Elder Justice efforts, the Department also increasingly has focused on elder abuse and neglect prevention and prosecution, spanning the continuum of care from home, to community-based, to nursing home settings.

Historically, elder abuse and neglect cases have been the province of Federal regulatory and state and local law enforcement efforts. At the same time, the Department increasingly has recognized the role for stepped up Federal leadership and law enforcement, and works closely with the Department of Health and Human Services and with its state and local colleagues on these matters.

In 1999–2000, the Department sponsored the following initiatives relating to older Americans:

PROTECTING OLDER AMERICANS FROM CONSUMER FRAUD

During the past decade, older Americans have increasingly become the targets of a wide range of fraudulent schemes. Telemarketing “boiler room” operations, for example, have often tar-
geted seniors with fraudulent offerings ranging from "guaranteed" foreign lotteries to prize-promotion schemes to fraudulent charities that purport to help persons in need, such as anti-drug programs and relief for victims of natural disasters. In some cases, fraudulent telemarketers even operate "recovery rooms," pretending to be law enforcement agents, lawyers, or court personnel who can help victims recover a portion of their past losses. The effects of these schemes have often been magnified by the fact that telemarketing operations buy so-called "mooch lists" (i.e., lists of people victimized by previous schemes) and then recontact those victims to offer new fraudulent opportunities. As a result, telemarketing fraud victims have often suffered substantial financial losses in some instances, even their life savings and their homes as well as tremendous personal humiliation and embarrassment. Other fraudulent schemes, such as home-repair and advance-fee schemes, have also targeted seniors for substantial losses.

To combat the criminals who conduct such ruthless schemes, the Department developed a three-part approach that incorporates a number of new and innovative measures.

**Undercover Investigations and Prosecutions.**—In cooperation with other Federal law enforcement agencies, the Federal Bureau of Investigation conducts undercover operations directed at telemarketing fraud. For example, Federal agents and investigators take over the telephone numbers of people who have been repeatedly victimized by telemarketing schemes or established undercover identities as victims. Agents tape record fraudulent and deceptive solicitations to provide evidence for search warrants, criminal indictments, and information relating to Federal criminal violations. To date, these efforts have resulted in the indictment of thousands of fraudulent telemarketers and have crippled fraudulent telemarketing operations. In some cities where telemarketing "boiler rooms" had been widespread, such as Las Vegas, Chattanooga, and San Diego, telemarketing fraud was virtually eliminated as a result of targeted Federal and state law enforcement efforts.

**International Cooperation and Coordination.**—Even as law enforcement has made major inroads against U.S.-based telemarketing operations, more and more major telemarketing schemes directed at seniors have been operating internationally, typically calling from venues in Canada to U.S. residents. To combat this problem of cross-border telemarketing fraud, in 1997 the United States and Canada established a binational working group on telemarketing fraud that produced a major report and recommendations for the two nations on measures needed to combat cross-border telemarketing fraud more effectively. These recommendations included identifying telemarketing fraud as a serious crime, establishing regional task forces to provide cross-border cooperation on telemarketing fraud, and coordination of national strategies against telemarketing fraud. During the past several years, both countries have implemented substantially all of these recommendations; the United States, for example, has adopted enhancements to the U.S. Sentencing Guidelines that authorize higher sentences in all telemarketing cases, and in cases where a substantial part of the scheme is conducted from outside the United States. In addi-
tion, U.S. law enforcement authorities have been working closely with Canadian law enforcement in Montreal, Toronto, and Vancouver on telemarketing fraud investigations and prosecutions.

**Public Education and Prevention.**—The Department has taken several significant steps to improve its outreach and prevention efforts to combat fraud directed at seniors. One initiative involves “Elder Fraud Prevention Teams” (EFPT), in which United States Attorneys’ Offices and other law enforcement agencies partner with the AARP to educate older Americans about consumer fraud scams that target them. In Arizona, for example, the EFPT collaborated with the AARP and the Arizona Cardinals football team to produce a series of public service advertisements on telemarketing fraud, and to conduct a “reverse boiler room” an event in which law enforcement, AARP, and Cardinals’ representatives telephoned people on fraudulent telemarketers’ call lists to warn them about telemarketing fraud that reached thousands of people in Arizona and other states. The pilot project is currently operating in 5 cities, and the Department is now exploring the expansion of the EFPT concept to additional jurisdictions.

The Department also has created a series of English- and Spanish-language Webpages on telemarketing fraud to inform the public about the problem and to assist in reporting possible telemarketing fraud. In addition, the Department provided significant advice and assistance to the AARP in the AARP’s development of a massive public-service advertisement campaign to inform older Americans about the dangers of telemarketing fraud and how to protect themselves from it.

**Telemarketing Fraud Prevention and Public Awareness Program.**—The Department’s Office of Justice Programs (OJP) also continued activities under its Telemarketing Fraud Prevention and Public Awareness Program in 1999 and 2000. The program, which began in 1997, is supported by a Congressional earmark for “programs to assist law enforcement in preventing and stopping marketing scams against senior citizens.” The goal of the program is to support Federal, state, and local efforts among law enforcement, crime prevention, victim assistance, consumer protection, adult protective services, and programs that serve older people in implementing public education and training efforts.

Under this program, OJP’s Bureau of Justice Assistance created a Telemarketing Fraud Training Task Force to develop and provide training for state and local investigators and prosecutors and to develop public awareness materials. The task force is a consortium comprised of the National Association of Attorneys General (NAAG), the American Prosecutors Research Institute (APRI), the National White Collar Crime Center (NWCCC), and AARP. As part of the program, BJA also provided grants to five demonstration sites to undertake a collaborative multijurisdictional approach to prosecuting and preventing telemarketing fraud and other scams targeting the elderly.

Additionally, under the Telemarketing Program, OJP’s Office for Victims of Crime continued funding for three projects that are addressing these crimes:

- The Oregon Senior and Disabled Services Division developed a training curriculum and provides training on fraud
against older people for bank personnel throughout Oregon. The training curriculum has been used by jurisdictions throughout the country. The project also created services for senior fraud victims.

- The National Sheriffs' Association (NSA) established "Operation Fraudstop," a national, coordinated public education and awareness and training effort among NSA and a range of agencies and corporations, including AARP, NDAA, NAAG, Triad, state sheriffs' associations, and Radio Shack.
- The National Hispanic Council on Aging funded a public education campaign to combat telemarketing fraud in the Latino community.

PROTECTING GOVERNMENT PROGRAMS THAT BENEFIT OLDER AMERICANS

In addition to combating consumer fraud directed at individual older Americans, the Department pursues health care fraud that depletes government programs designed to benefit older Americans. As a result of these efforts, the Department has collected billions in funds defrauded from Federal health care programs, recouping more than $1.7 billion between October 1998 and December 31, 2000 alone. In 1999 the Department, together with AARP and the Department of Health and Human Services (HHS), launched a public awareness campaign called "Who Pays? You Pay," which encouraged older people to join in the fight against health care fraud by asking questions and checking their bills. The Department also made a grant to the National Association of Attorneys General to strengthen health care fraud efforts at the state level.

In fiscal year 2000, DOJ brought to successful conclusion the investigation and prosecution of numerous costly health care fraud schemes. Among them are the following:

- The Department recently announced an $840 million criminal and civil settlement with HCA-The Hospital Company, the largest for-profit hospital chain in the United States. The settlement, for $95 million in criminal fines and $745 million in civil recovery, is the largest health care fraud settlement ever reached by the Federal Government and reflects the coordination of resources and collaboration DOJ has brought to bear in investigating health care fraud. This was the largest investigation of a health care provider ever undertaken. It involved a multi-agency investigation by attorneys, investigators, auditors, and other agency personnel over the course of several years. The Department is continuing to follow up on a number of issues unresolved by the civil settlement implicating HCA's cost report practices (i.e. the method by which the company charges Medicare, Medicaid, and other programs for the costs of operating its hospitals), as well as its alleged unlawful practices in paying remuneration to physicians in exchange for referrals of patients to HCA facilities.
- In fiscal year 2000, before the HCA settlement, the Federal Government won or negotiated more than $1.2 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and ad-
ministrative impositions, the Federal Government in 2000 collected $716 million. More than $539 million of the funds collected and disbursed in 2000 was returned to the Medicare Trust Fund. An additional $27 million was recovered as the Federal share of Medicaid restitution.

- Fresenius, Inc., the world’s largest provider of kidney dialysis products and services, agreed to pay the United States government $486 million to resolve a sweeping investigation of health care fraud. This investigation revealed that Fresenius submitted false claims seeking payment for nutritional therapy provided to patients during their dialysis treatments, for services that were provided to patients as part of clinical trials, for hundreds of thousands of fraudulent blood testing claims, for kickbacks, and for improper reporting of credit balances. The criminal fine and the civil settlement were, at the time, the largest ever recovered by the United States in a health care fraud investigation.

- The government entered a global settlement agreement with Beverly, Inc., the Nation’s largest operator of nursing homes, to resolve allegations that it fabricated records to make it appear that nurses were devoting more time to Medicare patients than they actually were. Although the company received an estimated $400 million in overpayments from Medicare, the settlement required the company to pay $170 million in civil settlement, a figure negotiated based on the chain’s limited ability to pay.

- Anthem Blue Cross and Blue Shield of Connecticut, a former Medicare fiscal intermediary (a contractor that processes Medicare claims for the government), agreed to pay $74 million to resolve claims that it falsified interim payments on settled hospital cost reports in order to meet HCFA’s Contractor Performance Evaluation standards. In so doing, the contractor caused improper Medicare payments or reduced offsets to a number of hospitals, overpayments that exceeded $30 million.

- A $53 million settlement with GAMBRO Healthcare resolved allegations of false billings for laboratory services primarily provided to dialysis clinics treating patients with end-stage renal disease (ESRD). The government’s investigation revealed that the laboratories billed Medicare, Medicaid, and TRICARE for medically unnecessary lab tests; double billed for lab tests included in ESRD composite rate payments; and violated the 50 percent rule, which specifies that if 50 percent or more of the laboratory tests performed as a profile of tests are included in the composite rate, then the entire profile is considered to be included in the composite rate.

- Community Health Systems (CHS) paid $31 million to resolve allegations it improperly assigned diagnostic codes for the purpose of increasing reimbursement amounts. Seven states received a portion of the settlement for losses to their Medicaid programs.

- More than 70 entities that provided or assisted in providing radiation oncology services to cancer patients, as well as their billing companies, agreed to pay almost $10 million to
settle allegations of false claims to federally funded health care programs. These radiation oncology service providers often billed Medicare for services that were not provided, billed twice for the same service, or sought a higher rate of reimbursement than that to which they were entitled. The settlement also resolved claims that the defendants fraudulently transferred assets to avoid repaying the United States.

- In the first settlement with a Medicare managed-care company, Humana, Inc. paid $14.5 million to settle allegations that the company provided inaccurate payment information from 1990 through 1998. Humana incorrectly listed beneficiaries as eligible for both Medicare and Medicaid, thus securing the higher reimbursement afforded such dually eligible beneficiaries.

- During fiscal year 2000, the United States recovered $2.6 million from clients of the Oklahoma-based Emergency Physician Billing Services (EPBS) to settle claims of overpayments based on false claims submitted by EPBS. These settlements follow on the heels of a September 1999 settlement with EPBS and its physician founder for $15 million for fraudulent billing to Medicare, Medicaid, TRICARE, and the Federal Employees Health Benefits Program (FEHBP). The government's investigation revealed that EPBS submitted false Medicare, Medicaid, TRICARE, and FEHBP claims on behalf of their physician-clients for patients seen by the physicians. EPBS then typically "upcoded" claims and billed for services more extensive than those actually provided. Including settlements in prior years, recoveries from EPBS clients top $13 million. The Department continues to pursue other clients of the company.

- The Department uncovered a sophisticated scheme by a prominent Texas doctor, his attorney brother, their mutual certified public accountant, a physician's assistant, a physical therapist, office managers, and staff, as well as clients. The scheme defrauded local, state, and Federal Government health programs, as well as private insurers, of over $46 million from 1986 to 1998. The conspiracy involved a large cross-referral scheme of auto-accident, personal injury, and workers compensation patients/clients between the brothers.

PREVENTING ELDER ABUSE AND NEGLECT: ELDER JUSTICE AND NURSING HOME INITIATIVE EFFORTS

In October 1998, the Department launched an initiative to crack down on abuse, neglect, and fraud in nursing homes and other residential care facilities. The Nursing Home Initiative focuses on issues cutting across many of the Department's components. In 2000, the Initiative expanded to address Elder Justice issues generally, not limited to nursing home matters. The primary objective of these efforts was to enhance enforcement, training, coordination, and awareness; create the infrastructure for broad-based collaboration at the national policy level, as well as at the state and grass roots levels; and to bridge the historical gap between those on the front lines, who see the problems first hand, and those charged with enforcing the law. These efforts have focused on the following areas:
1. Stepped Up Enforcement.—The Department has worked to step up investigations and prosecutions at the Federal, state, and local levels through the training and coordination efforts described below. Federal cases to redress elder abuse and neglect primarily involve nursing homes and other Medicare and Medicaid recipients. In those cases, the Department works closely with the Department of Health and Human Services to balance the law enforcement and public health goals and seek remedies that protect residents, punish wrongdoers, recoup Federal funds, and improve care. Examples of cases in this area include:

- The Department is bringing more civil False Claims Act and false statement prosecutions for failure of basic care leading to profound malnutrition, pressure ulcers, and other harm. The Civil Division is pursuing such cases against national nursing home chains. To date, the United States Attorney for the Eastern District of Pennsylvania has resolved six such cases, and several other jurisdictions have resolved or are pursuing these cases. In addition, nursing home officials in Arkansas recently were convicted and sentenced for making false statements regarding the cause of death of a resident.
- In a public corruption matter in Oklahoma, the deputy commissioner for health and a nursing home owner were convicted in October 2000 of soliciting and offering to pay a bribe, respectively. The investigation is ongoing.
- Five of the country's seven largest nursing home chains Vencor, Sun, Mariner, Integrated Health Services (IHS), and Genesis (cumulatively owning about 2000 facilities) as well as several mid-sized chains, are attempting to reorganize under the Federal bankruptcy code. The Department's Civil Division is handling these massive cases to find resolutions that protect residents and the Federal programs designed to benefit them. To that end, Vencor recently entered into a far-reaching Corporate Integrity Agreement (CIA) with the Department of Health and Human Services, Office of Inspector General (HHS/OIG) that is similar to the consent orders in the Eastern District of Pennsylvania nursing home cases.
- Because these cases often raise difficult legal, investigative, and medical issues, the Department prepared a proposal for a Resource Group that would be available to assist Department attorneys with such matters. The group would consist of a small number of Department attorneys and medical experts with relevant expertise. Decision-making and litigation responsibility for the cases would remain with the respective U.S. Attorneys Offices handling the cases.

2. Training, Publications, and Information Sharing.—The Department of Justice also has sponsored conferences and symposia and publishes and disseminates reports and other documents to promote knowledge about the problem of elder victimization and what works and needs to be done in preventing, investigating, and prosecuting abuse and neglect of older Americans. These include the following:

- Nursing Home Fraud, Abuse and Neglect Prevention Conferences and State Working Group Meeting.—Between July 1999 and June 2000, the Department held four regional con-
ferences and one State Working Group meeting to provide training and promote multidisciplinary coordination among the many players with responsibility for nursing homes and their residents. During the regional conferences, State Working Groups were formed to continue the work at the state and local levels. In all, more than 1,000 Federal, state, and local law enforcement, regulatory, survey, health care, advocacy, and social service professionals were trained in how to identify, respond to, coordinate, and prosecute cases of abuse, neglect, and fraud.

- **National Symposium on Elder Victimization.**—In October 2000, DOJ sponsored a national symposium entitled “Our Aging Population: Promoting Empowerment, Preventing Victimization, and Implementing Coordinated Interventions” in partnership with the Department of Health and Human Services. The symposium focused on promising approaches to preventing and responding to the victimization of our aging population. It showcased Federal, state, and local multidisciplinary programs designed to: promote empowerment of older people to live safe and healthy lives; prevent them from becoming victims of abuse, fraud, exploitation, and neglect; and improve the response of law enforcement and social service agencies to victimization. The programs highlighted collaborations among health, human service, and social service agencies, advocates, medical professionals, law enforcement, and other public safety professionals to prevent and respond to victimization. Multidisciplinary teams from each state and several Indian tribes, representing public safety, social service, and health care professionals, were invited to participate in the symposium. A report of the proceedings was released in January 2001 and is available online at [http://www.ojp.usdoj.gov/docs/ncj-186256.pdf](http://www.ojp.usdoj.gov/docs/ncj-186256.pdf).

- **Medical Forensic Issues in Elder Abuse and Neglect.**—There is widespread consensus that detection, diagnosis, research, training, availability of experts, and multidisciplinary cooperation are significantly less advanced in the area of elder abuse and neglect than in other areas, such as child abuse and domestic violence. This has an impact, among other things, on the ability to pursue such cases because elder abuse and neglect often go undetected and the medical community is rarely trained to diagnose or report it. Even when it is identified, there are very few experts who can investigate or prepare or provide medical forensic testimony in these cases. To address these and other issues, the Department hosted a medical forensic roundtable discussion in October 2000. Health care, law enforcement, and social service experts addressed impediments to fighting elder abuse and neglect in institutional, community, and home settings. Those impediments include the dearth of expertise among first responders and health care providers in detecting and diagnosing elder abuse and neglect, the paucity of research and training in the area, the infrequency with which medical forensic evidence is available to law enforcement, and the need for improved collaboration among all disciplines with a role in this area. The experts also presented their conclusions and recommendations to the Attorney Gen-
eral, who joined their discussion. A report of the event is available online at http://www.ojp.usdoj.gov/niij/elderjust/index.html. Also available at that Web site are brief papers authored by the experts and a transcript of the proceedings.

- **Focus Group on Abuse and Neglect in Nursing Homes.**—In 1999 the Office for Victims of Crime (OVC) sponsored a focus group entitled “Preventing Abuse, Neglect and Fraud in Nursing Homes” to explore the needs of victims in residential settings. The focus group included representatives of aging organizations, elder advocacy organizations, offices of state attorneys general, ombudsman programs, victim advocacy organizations, the National District Attorneys Association, the National Association of Medicaid Fraud Control Units, the National Association of Adult Protective Services, the Centers for Disease Control, the American Bar Association Commission on Legal Problems of the Elderly, and DOJ. The discussion highlighted several general categories of need: (1) more effective measures by providers to assure quality of care; (2) improved law enforcement and administrative/regulatory enforcement; (3) programs to increase family and community involvement in nursing homes; (4) improved laws and regulations; and (5) improved detection of abuse and neglect by those with contact with residents. The recommendations have been incorporated into the Department’s Nursing Home Initiative and a focus group report is expected to be issued in early 2001.

- **Promising Practices Monograph.**—OVC is in the final stages of producing a publication that profiles several innovative approaches to reaching older individuals who are abused, neglected, and financially exploited. The monograph is designed for use by victim service providers, allied professionals, and agencies and organizations that serve older people.

- **Clearinghouse on Domestic Violence.**—Under the Violence Against Women Act Technical Assistance Program, OJP’s Violence Against Women Office funded the Wisconsin Coalition Against Domestic Violence in 1999 and 2000 to establish a national clearinghouse on domestic violence in later life. The purpose of the clearinghouse is to provide technical assistance and training to service providers and criminal justice personnel and to enhance services to older battered women.

- **Statistical Data/Publications.**—In January 2000, OJP’s Bureau of Justice Statistics released “Crimes against Persons Age 65 or Older, 1992–97” using data from its National Crime Victimization Survey (NCVS). The statistics include: comparisons of victimization of senior citizens with that of other age groups; patterns of victimization that are different among the elderly than other groups in the population; and some statistics on violence committed against senior citizens by relatives and other people who are well-known to the victim.

3. **Coordination, Outreach, and Public Awareness.**—As part of the Nursing Home Initiative, the Department established multidisciplinary, interagency State Working Groups (SWGs) at the state and local levels to bolster enforcement, prevention, training and coordination on an ongoing basis. These SWGs provide a forum for
key players to share information and skills and to identify problem facilities, best practices, and ways to improve the quality of care given the unique situations in the various states. In June 2000, the Department held a meeting of SWG representatives and relevant national organizations to address the challenges and successes of those groups. A report of that meeting will be released in 2001.

- Federal coordination also has been enhanced by productive monthly Nursing Home Steering Committee meetings attended by DOJ and HHS representatives. In addition, nursing home issues are frequent topics at DOJ/HHS Health Care Fraud Senior Staff and Executive Level Health Care Fraud Policy Group meetings, as well as before the Health Care Fraud and Abuse Task Force, which brought together Federal state and local law enforcement entities.

- To promote public awareness, Attorney General Janet Reno presented three keynote speeches in 2000 addressing elder issues at the Department’s State Working Group meeting on June, the AARP Foundation’s Aging and the Law conference in October, and the National Citizens’ Coalition for Nursing Home Reform (NCCNHR) Annual Meeting in October. The Attorney General was presented with awards for the Department’s efforts at the two latter events. The Attorney General also presented remarks to and participated in the Department’s symposium on promising practices to address elder victimization and roundtable on medical forensic issues in elder abuse and neglect discussed below. In addition, other Department personnel have spoken publicly on a regular basis to promote efforts to reduce elder abuse and neglect of all types.

- In an attempt to raise the profile of elder abuse and neglect issues in the medical and public health communities, Attorney General Reno and Secretary Shalala together sent letters to deans of medical, public health, and 100 nursing schools asking them to consider devoting research monies and teaching time to the issues of elder abuse and neglect. In addition, other Department personnel have spoken publicly on a regular basis to promote efforts to reduce elder abuse and neglect of all types.

4. Legislation.—There are gaps in Federal law that limit the ability of Federal law enforcement to pursue cases of abuse and neglect, whether in nursing homes or other settings. For example, the Department has no primary jurisdiction to bring a case for inadequate care, per se, against a privately owned nursing home. Failure of care cases currently are pursued under financial fraud and/or falsification of records theories. In addition, HHS may impose sanctions only against individual facilities; its authority does not extend to chains or management companies. Therefore, the Department drafted and the Administration sent to Congress a bill that would address gaps in current law by creating criminal, civil, and injunctive remedies for patterns of abuse or other illegal conduct causing harm to residents.

5. Data.—Through the Nursing Home Steering Committee, the Departments of Justice and Health and Human Services are working to analyze the myriad nursing home data sources to determine how they might be used most effectively and to assist SWGs to
identify problem facilities. The Department of Justice worked with HHS to draft a certification for the Minimum Data Set (MDS) forms, which include key information used to determine reimbursement rates and resident care.

6. **Criminal Background Checks.**—The Department has renewed efforts to work with industry to boost compliance efforts, among other things, by encouraging increased use of Federal criminal background checks. In October 1998, Congress enacted Public Law 105-277, which provides that “[a] nursing facility or home health care agency may submit a request to the Attorney General to conduct a search and exchange of [Federal Bureau of Investigation (FBI) criminal history] records . . . regarding an applicant for employment if the employment position is involved in direct patient care.” By early 2000, that statute had been used only a handful of times. The Department has been working with the FBI to educate providers and the relevant state entities about the existence of and procedures for obtaining background information under this statute. A report to Congress on the use of this statute will be filed in early 2001.

**PROTECTING THE CIVIL RIGHTS OF OLDER PEOPLE**

Through its Civil Rights Division, DOJ enforces Federal statutes prohibiting discrimination on the basis of race, sex, disability, religion, and national origin. In the civil rights arena, the Department pursues several types of cases. Where predatory lenders target older persons usually elderly minority women for loans with higher prices and more onerous conditions than for other borrowers, DOJ has brought cases under the Equal Credit Opportunity Act, which prohibits discrimination on the basis of age. The Department also pursues cases under other civil rights statutes, such as the Americans with Disabilities Act for seniors with disabilities, under the Fair Housing Act, where nursing homes or other facilities employ discriminatory admission practices, and under the Civil Rights of Institutionalized Persons Act (CRIPA), where public nursing homes or other facilities provide substandard care.

**PROTECTING OLDER PEOPLE AGAINST STREET CRIME**

During this period OJP’s Bureau of Justice Assistance funded Triad, a national program to reduce victimization of older citizens, which is cosponsored by the National Sheriffs’ Association, the International Association of Chiefs of Police, and AARP. Triad combines the efforts and resources of law enforcement, older individuals and organizations that represent them, and victim assistance providers. Activities include educating communities about elder abuse; strengthening the criminal justice system’s process of prevention, detection, and assistance for elderly crime victims; implementing reassurance programs for homebound and isolated elders; and providing technical assistance for new and existing Triads. There are now more than 730 Triad programs in 46 states, Canada, and England.

*For More Information* about OJP programs or activities on behalf of older Americans, contact OJP’s Office of Congressional and Public Affairs at 202/307-0703 or access the OJP homepage at
www.ojp.usdoj.gov. Funding information is available from the Department of Justice Response Center at 1–800/421–6770. OJP and other criminal and juvenile justice-related publications are available from the National Criminal Justice Reference Service by calling toll-free, 1–800/851–3420, or online at www.ncjrs.org. For information about other Department initiatives, see the main Web site at www.usdoj.gov. In particular, the “Elder Justice” Web page at www.usdoj.gov/elderjustice.htm contains information about the Department’s activity on these issues. For information about the activities of the Civil, Criminal or Civil Rights Divisions or the United States Attorneys Offices, see the Web sites for those components.
ITEM 10—DEPARTMENT OF LABOR

Our Nation is experiencing a dramatic growth in the population of Americans aged 55 and older, and our citizens can look forward to living longer, healthier, and more productive lives. Unfortunately, it is often the case that individuals aged 55 and older encounter serious difficulty finding new employment when they lose a job or seek to change careers. In the global economy of the 21st century, job growth will make it imperative for us to fully utilize our experienced older workers. They have much to offer American business, and, at a time of notable skills shortages, older workers are a crucial resource that America cannot afford to squander.

The welfare and security of our Nation’s older citizens is a matter of substantial concern to the Department of Labor. We are pleased to provide this summary of the programs the Department administers which can provide helpful assistance to older Americans. These include—job training and related services, dislocated worker services, and other employment services, 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; the Bureau of Labor Statistics’ statistical programs providing employment and unemployment data for older persons; protection for certain employees to take unpaid, job-protected leave to provide care for sick, elderly parents under the Family and Medical Leave Act, administered by the Employment Standards Administration; and various initiatives and collaborations relating to older persons, work and family, and retirement income sponsored or administered by the Women’s Bureau, including the National Resource and Information Center, a Clearinghouse which provides information and resources to workers and employers interested in developing or implementing family-friendly policies such as elder care. These programs and services are addressed more fully in the following discussion.

EMPLOYMENT AND TRAINING ADMINISTRATION

INTRODUCTION

The Department of Labor’s (DOL’s) Employment and Training Administration (ETA) provided a variety of training, employment and related services for the Nation’s older individuals during Program Years 1998 (July 1, 1998-June 30, 1999) and 1999 (July 1, 1999-June 30, 2000) through the following programs and activities: the Senior Community Service Employment Program (SCSEP);
grams authorized under the Job Training Partnership Act (JTPA); and the Federal-State Employment Service system.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

Through grants from the Department of Labor to states and National organizations, SCSEP, which is 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, child care, and in beautification; 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, non-profit facilities. Participants also receive personal and job-related counseling, are offered annual physical examinations, job training, and in many cases, referral to private sector jobs.

About 80 percent of the participants are age 60 or older, and about 60 percent are age 65 or older. Almost three-fourths are female; about 40 percent have not completed high school. All participants are economically disadvantaged.

On November 13, 2000, President Clinton signed into law the Older Americans Act Amendments of 2000, Public Law 106–501. This legislation reauthorizes and enhances the SCSEP by increasing emphasis on assisting participants in obtaining unsubsidized employment; establishing an enhanced performance accountability system to assess the performance of grantees; reinforcing connections between the SCSEP and the workforce investment system established under the Workforce Investment Act; and providing for broad participation in the development of a plan in each State to ensure an equitable distribution of projects and the coordination of services to seniors.

Table 1 below shows SCSEP enrollment and participant characteristics for the program year July 1, 1998, to June 30, 1999, in Column 1 and July 1, 1999, to June 30, 2000, in Column 2.


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<th>Program Years</th>
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<td>24.2</td>
<td>24.2</td>
</tr>
<tr>
<td>75 and over</td>
<td>20.2</td>
<td>20.2</td>
</tr>
<tr>
<td>75 and over</td>
<td>17.2</td>
<td>18.2</td>
</tr>
</tbody>
</table>

1 Figures may not add to 100 percent due to rounding. Source: U.S. Department of Labor, Employment and Training Administration.

JOBT TRAINING PARTNERSHIP ACT PROGRAMS

The Job Training Partnership Act (JTPA), in effect through June 30, 2000, provided job training and related assistance to economically disadvantaged individuals, dislocated workers, and others who face significant employment barriers. The ultimate goal of JTPA was to move program participants into permanent, self-sustaining employment. Under JTPA, Governors had the approval authority over locally developed plans and were responsible for monitoring local program compliance with the Act. JTPA functioned through a public/private partnership which planned, designed and delivered training and other services. Private Industry Councils (PICs), in partnership with local governments in each Service Delivery Area (SDA), were responsible for providing guidance for, and oversight of, job training activities in the area.

JTPA amendments affecting older workers became effective July 1, 1993. These amendments targeted program services to those with serious skill deficiencies; and individualized and intensified the quality of services provided. Five percent of the funds appropriated for the adult program (Title II—A) had to be used by States in partnership with SDAs for older workers. The amendments also required Governors to ensure that services under the adult program were provided to older workers on an equitable basis.

In the fall of 1998, President Clinton signed into law the Workforce Investment Act (WIA), Public Law 105—220, which replaced JTPA. This bipartisan legislation streamlined the job training system for the 21st century. The WIA empowered individuals by giving adults and dislocated workers more control and choice over their training or retraining and providing universal access to core labor market services; streamlined job training services by mandating the consolidation of a dispersed network of individual programs into a simple system through a nationwide network of One-Step Career Centers; enhanced accountability through tough performance standards for States, localities, and training providers; and increased flexibility so that States could innovate and experiment with new ways to better train America's workers.
While there are fewer federal set aside provisions than had previously existed under JTPA, the WIA does provide states with discretionary funds that can be used for statewide workforce investment strategies, representing an opportunity for developing and expanding services to older workers. States may reserve up to 15 percent of each of their separate adult, youth and dislocated worker WIA allotments to “carry out statewide employment and training activities.” The state set aside funds may provide an opportunity for developing and funding special services for older workers.

**BASIC JTPA GRANTS**

Title II–A of JTPA authorized a wide range of training activities to prepare economically disadvantaged adults for employment. Training and training-related services available to eligible older individuals through the basic Title II–A grant program included vocational counseling, jobs skills training (either in a 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 left the Title II–A program during the period July 1, 1998, through June 30, 1999, and during the period July 1, 1999, through June 30, 2000. (The data do not include the 5 percent set-aside for older individuals, which is discussed separately.)

**TABLE 2.—JTPA DATA JULY 1, 1998—JUNE 30, 1999 [Title II–A]**

<table>
<thead>
<tr>
<th>Item</th>
<th>Number served</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PY98</td>
<td>PY99</td>
</tr>
<tr>
<td>Total Adult Terminees</td>
<td>151,580</td>
<td>138,862*</td>
</tr>
<tr>
<td>55 years and over</td>
<td>3,032</td>
<td>3,034*</td>
</tr>
</tbody>
</table>

*Preliminary data from six early WIA implementation states remain to be reported and are omitted from the Program Year 1999 figures. Comparisons with Program Year 1998 are inappropriate.

Source: U.S. Department of Labor, Employment and Training Administration.

**SECTION 204 SET-ASIDE**

The JTPA amendments which took effect in 1993 required 5 percent of the Title II–A allotment of each State to be made available for the training and placement of older individuals in private sector jobs. Generally, only economically disadvantaged individuals who are 55 years of age or older are eligible for services under this State set-aside.

Governors had wide discretion regarding use of the JTPA 5 percent set-aside. Two basic patterns evolved. One was adding set-aside resources to Title II–A to ensure that a specific portion of older persons participated in the basic Title II–A program. The other was using the resources to establish specific projects targeted to older individuals which operated independently of the basic job training program for disadvantaged adults. Likewise, States were required to provide “equitable services to older individuals throughout the State, taking into consideration the incidence of such workers in the population.” Some States distributed all or part of the 5 percent set-aside by formula to local SDAs; other States retained the resources for State administration or model programs.
Governors were expected to coordinate services as much as possible with those provided under Title V of the Older Americans Act—the Senior Community Service Employment Program. There were two separate provisions for older individual programs as they relate to Title V of the Older Americans Act. First, under the Title II–A program, up to ten percent of the participants may have been individuals who were not economically disadvantaged, but who had a serious barrier to employment. Under such title, older Americans were taken into consideration for assistance. Second, when a JTPA grantee and Title V sponsor established joint projects, individuals eligible under Title V of the Older Americans Act “were deemed to satisfy the requirements” of JTPA.

These joint (JTPA–SCSEP) projects may have included co-enrollment of Title V participants in Title II–A activities. Joint programs had to have a written agreement, which must have been financial or nonfinancial in nature, and may have included a broad range of activities. A recent joint WIA–SCSEP provision allows SCSEP participants to be deemed by workforce investment boards established under title I of WIA, as eligible for receiving services that are available to adults.

For Program Year 1998 (July 1, 1998, through June 30, 1999), 11,643 participants were enrolled in the State set-aside program for economically disadvantaged individuals 55 years of age and older. For Program Year 1999 (July 1, 1999, through June 30, 2000), it is estimated that 11,600 estimated participants were enrolled in the State set-aside program for economically disadvantaged individuals 55 years of age and older.

PROGRAMS FOR DISLOCATED WORKERS

Title III of JTPA authorized a State and locally-administered dislocated worker program that provided retraining and readjustment assistance to workers who had been, or had received notice that they were about to be, laid off due to a permanent closing of a plant or facility; laid off workers who were unlikely to be able to return to their previous industry or occupation; and the long-term unemployed with little prospect for local employment or re-employment. Those older dislocated workers eligible for the program were allowed to receive such services as job search assistance, retraining, pre-layoff assistance and relocation assistance. During the period July 1, 1998, through June 30, 1999, approximately 24,722 individuals 55 years of age and over exited the program (10 percent of the program terminations). During the period July 1, 1999, through June 30, 2000, approximately 20,252 individuals 55 years of age and over left the program (8 percent of the program terminations).

THE FEDERAL-STATE EMPLOYMENT SERVICE SYSTEM

Employment services funded under the Wagner-Peyser Act and related statutes and provided through locally-designed One-Stop systems offer employment assistance to all job seekers, including special populations such as older workers, veterans, recipients of

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1 At the time of the drafting of this summary, preliminary data from eight early WIA implementation States remained to be reported; thu, the figures do not reflect complete totals.
public assistance and disabled individuals. 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 were revised effective July 1, 1992, to capture additional information on applicant characteristics, including data on the age of all Employment Service (ES) applicants and those placed in employment. During the period July 1, 1998 through June 30, 1999 over 1,230,000 ES applicants were age 55 and older. Over 85,000 of them were placed in jobs during this period. Preliminary data for the period July 1, 1999 through June 30, 2000 show nearly 1,200,000 ES applicants age 55 and older, approximately 86,000 of whom were placed in jobs (reports from several employment service agencies had not been received at the time this summary was prepared).

In addition to those ES applicants who were placed, the Department also collects data on the numbers of persons who obtained employment within 90 days of receiving a reportable employment service. This total is not broken down by age cohort. However, many of the 1.55 million and 1.86 million (preliminary data) who were reported in the “obtained employment” category during the last two program years were age 55 and older.

INTERNET INFORMATION PRODUCTS AND AMERICA'S CAREER KIT

The Employment and Training Administration and a number of other government and academic partners have collaborated to provide a number of Internet web-based information products and services for older workers. From specially-targeted material on the Department’s website to the various tools in America’s Career Kit, the agency ensures that this expanding segment of the population can take advantage of opportunities to re-enter the workforce, acquire new skills for a short-term job pursuit, or engage in learning enrichment activities in the retirement years. The partners in America’s Job Bank (www.ajb.org), America’s Career InfoNet (www.acinet.org) and America’s Learning Exchange (www.alx.org) are continually focused on the requirement to create easily-accessible and beneficial content for our seniors. ETA also closely participates with other governmental agencies in ensuring that other public sector web-sites (such as Access America for Seniors and the First.gov special portal site for seniors) provide useful links to our various employment, training, and learning databases and services.

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 and the Internal Revenue Code, designed to ensure that employees actually
receive promised benefits. Employee benefit plans generally exempt from ERISA include church and Government plans.

The requirements of ERISA differ depending on whether the benefit plan is a pension 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 to the government and disclosure to participants (Title I, Part 1) and fiduciary responsibility (Title I, Part 4). Pension plans must comply with additional ERISA and Internal Revenue Code standards (contained in both Title I, Parts 2 and 3, and Title II), which govern membership in a plan (participation); nonforfeitalibility of a participant's right to a benefit (vesting); and financing of benefits offered under the plan (funding). Welfare plans providing medical care, also called "group health plans," must comply with ERISA continuation of coverage requirements and medical child support orders (Title I, Part 6). These plans must also comply with several consumer rights provisions (Title I, Part 7), which include protections for individuals who lose their health insurance coverage or have it terminated, women who have just given birth, individuals with mental illness, and women who have certain types of cancer.

The Departments of Labor and 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 PBGC on matters concerning pension issues.

PWBA has also been assigned additional regulatory, interpretative, enforcement, and disclosure responsibilities under the recently enacted provisions of Part 7 of ERISA. These provisions include requirements added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996, the Mental Health Parity Act of 1996, and the Women's Health and Cancer Rights Act of 1998. These laws set Federal requirements concerning health care coverage provided through health plans and added similar provisions to the Public Health Services Act and the Internal Revenue Code. As a result, the Departments of Labor, Health and Human Services, and the Treasury have shared jurisdiction with regard to these health care provisions.

Under the Savings Are Vital to Everyone's Retirement Act (SAVER), which was passed in November 1997, PWBA is responsible for establishing a program to educate the public about the importance of retirement savings—to initiate a broad-based public education program and to coordinate periodic national retirement savings summits in conjunction with the White House and Congress.

LEGISLATIVE & REGULATORY INITIATIVES

During fiscal years 1999 and 2000, PWBA examined issues that arise in connection with conversions of traditional pension plans to
cash balance plans. PWBA worked with other Agencies to formulate legislation that would require more extensive disclosure when plans are converted. The Administration also supported legislation that would ban periods during which some workers (typically older workers) would not earn benefits as a result of conversions.

PWBA also worked to protect retirement assets in bankruptcy. In this regard, PWBA drafted provisions for proposed legislation that would clarify that retirement assets are not included in a bankruptcy estate. The Assistant Secretary for PWBA testified in hearings before Congress and opposed legislation that would enable creditors to seize funds that have been set aside for retirement in tax-qualified plans.

PWBA also pushed for legislation to improve patient protections, create external review mechanisms and provide meaningful remedies for patients who have been harmed when their managed care plans wrongfully delay or deny needed care. The Assistant Secretary for PWBA testified in hearings before Congress in this regard, and also participated in roundtables, forums, and discussed the issue with the news media.

The Agency completed work on its health benefits claims regulation and released it in November, 2000. This regulation was in development for more than two years, and makes significant changes to the health benefit claims procedures that have been on the books since 1977. The new regulation will speed up the time ERISA-governed health benefit plans may take to render decisions regarding whether a specific treatment is covered, requiring 72 hour turnaround times for "urgent" care decisions and 15 days for pre-service claims (i.e., services that have not yet been delivered). For claims filed after services have been delivered, the regulation requires a plan to make a decision within 30 days. It will also speed up the appeals process for denied claims and require plans to use medical experts in appeals requiring medical judgement. PWBA has also recently released new regulations that require both pension and group health plans to clarify the information they provide to participants, and to ensure that Multiple Employer Welfare Arrangements (MEWAs) are in compliance with HIPAA.

RESEARCH

In fiscal years 1999 & 2000, PWBA continued its program of funding studies directed toward improving the understanding of the employment-based pension and health benefit systems. These studies took advantage of the newly available data on households of older workers who will be approaching retirement over the next few years. For example, two studies focused on cashing out pension benefits at job changes or retirement, one analyzing the decision to cash out benefits and the other evaluating the effects of tax legislation over the last 15 years. Additional studies examined women's retiree health and pension benefits and the implications for older women's work patterns. PWBA also published its annual compendium of private pension statistics, the most recent titled "Private Pension Plan Bulletin: Abstract of 1996 Form 5500 Annual Reports."
OUTREACH, EDUCATION & PARTICIPANT ASSISTANCE

Since 1995, PWBA has conducted a national campaign to educate workers and their families about retirement issues. With the passage of the SAVER Act in FY1998, PWBA is now mandated to continue and expand its retirement savings education activities as well as to coordinate periodic national summits on the issues. The next national summit will take place in the fall of FY2001.

During FY1999 and FY2000, PWBA developed and distributed a new series of print public service ads about retirement savings that reached millions of readers. An updated slogan was adopted for the Campaign “Saving Matters!” In collaboration with the Certified Financial Planner Board of Standards, a new publication was developed and released, “Saving Fitness: A Guide to Your Money and Your Financial Future”. The publication was featured in Parade Magazine and Dear Abby. Also in partnership with the Federal Consumer Information Center and the IRS, two million randomly selected taxpayers received an ad promoting retirement savings enclosed with their tax refund check. As a follow-up to the successful 1998 brochure for employees, a guide for employers was published to assist them in assessing 401(k) fees. Simultaneously, the American Bankers Association, the Investment Company Institute and the American Council of Life Insurance released a plan disclosure form to help employers evaluate 401(k) fees. A news segment on women and retirement savings issues was produced for CNBC’s Today’s Health, which reached 55 million households. Also a news segment was produced for Parenting in the 90s and Beyond to encourage parents to teach their kids to save. This program aired in syndication for the complete year.

In July 2000 at the Department of Labor, the Secretary hosted an event to celebrate the 5th Anniversary of the Retirement Savings Education Campaign. Several new initiatives were announced to include: a new partnership with the Consumer Federation of America to reach low-income workers through the America Saves program; a new Website developed in partnership with the Small Business Administration and the U.S. Chamber of Commerce, designed to educate small employers about pension plan options; an educational video also geared for small business owners; a new educational seminar for women, entitled the “Every woman’s Money Conference” sponsored in part by the Department of Labor; and the award of the first annual Oseola McCarty Super Saver Award.

During FY1999, the Secretary of Labor launched a companion educational campaign designed to educate individuals about their health benefits and related issues. The mission of the new Campaign is for the Department, in conjunction with over 70 public and private partner organizations, to lead an effort to educate consumers about their rights and issues of quality under their employer provided health plans, and to inform employers, particularly small employers, of the value of providing quality health benefits to employees. Several new brochures have been developed and are being distributed by the Department through its toll free hotline as well as by the partner organizations. Those brochures include, “The Top Ten Ways to Make Your Health Benefits Work for You”, “Life
PWBA publishes other 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. Further, PWBA has established an 800 number to facilitate distribution of materials and publications, has developed a comprehensive Website with access to all its publications and educational materials, and has implemented an intense outreach program to disseminate information utilizing various media.

PWBA maintains an ongoing participant assistance program throughout the 15 field and national offices to respond to pension and health plan participants, including older workers and retirees seeking assistance in collecting benefits and obtaining information about ERISA. This assistance is provided by PWBA's Benefits Advisors, who also are responsible for conducting grassroots outreach on the local and regional level to inform participants about the Agency's services and to disseminate educational materials to various targeted populations. By FY2000, 105 positions within PWBA were dedicated as Benefits Advisors. These Benefits Advisors respond to inquiries from the public regarding their pension or health benefits by mail, email, telephone or in person. In FY2000, PWBA's Benefits Advisors handled over 158,000 inquiries and obtained over $67 million in benefit recoveries on behalf of participants whose claims for benefits had been previously denied.

In addition, for the first time in FY2000, each of the field offices developed an annual strategic plan for conducting outreach in their geographic area. As a result, the Benefits Advisors, using materials developed through the educational campaigns, conducted numerous regional outreach seminars and workshops for dislocated workers to assist them in understanding their rights to transitional health benefits and their ability to roll over pension benefits to another plan. They participated in workshops geared to educate women about retirement savings issues and conducted workshops for small business owners about various pension plan options.

EMPLOYMENT STANDARDS ADMINISTRATION

The Family and Medical Leave Act of 1993 became effective on August 5, 1993, for many 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.
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 are now 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 series that reweighted the official Consumer Price Index using expenditure data for older Americans. This report updated a portion of a study originally performed by BLS in response to the Older Americans Act Amendments of 1987. BLS continues to compute the reweighted index each month.

THE WOMEN'S BUREAU

During Calendar Years 1999 and 2000 the Women's Bureau took a variety of actions that affected older Americans. They included serving as a member of an interagency planning committee and co-sponsoring conferences that dealt with issues of interest to older Americans, their caregivers, or younger workers planning for their lifelong economic security. The following are examples of these actions:

INTERNATIONAL YEAR OF OLDER PERSONS

The Women's Bureau was a member of the Federal Committee for the International Year of Older Persons, chaired by the U.S. Administration on Aging (AoA), which planned an invitational symposium for Federal leaders, held on June 2, 1999, in Bethesda, Maryland. In 2000, the Committee was renamed the Federal Ad Hoc Committee on Aging Issues. The Committee held a meeting on December 6, 2000, to discuss possible recommendations for revisions to the International Plan of Action on Aging developed at the first World Assembly on Aging held in Vienna, Austria, in 1982. (The Second World Assembly on Aging, convened by the United Nations, will be held in Madrid, Spain, April 8–12, 2002.) A representative of the Women's Bureau, as well as representatives from the Employment and Training Administration and the Pension and Welfare Benefits Administration attended the meeting.

WORK AND FAMILY

The Women's Bureau has been holding monthly virtual conference calls to educate employers on the range of work-life programs available to them to improve the recruitment, retention, and productivity of their employees, and to assist their employees in balancing work and family responsibilities. This program started as a Northwest regional program but now involves all Women's Bu-
reau regional offices. Employers, unions, work-family advocates, and interested individuals are invited to participate, and are encouraged to share their own information and resources with other employers across the Nation. The Women's Bureau "Work and Family Exchange" utilizes a combination of conference call and electronic mail discussion.

In Fiscal Years 1999 and 2000, the Women's Bureau worked to promote programs to help workers balance work and family. In FY1999, among other activities, the Women's Bureau collaborated with the San Diego Work-Life Coalition, the San Diego City and County Commissions on the Status of Women, and the Redlands Childcare professionals to create a work-life partnership in Southern California. Also in Fiscal Year 1999, the Women's Bureau had an exhibit table at the Southern University Women's Symposium "Balanced Lives: Constructing a Vision" in Dallas, Texas. The symposium was attended by approximately 400 people, and the Women's Bureau distributed over 1,200 publications on many topics, including the Family and Medical Leave Act and elder care.

Efforts in Fiscal Year 2000 included the Business-to-Business Work Life Exchange Forum in Chicago, Illinois, cosponsored by the Women's Bureau and the Governor's Commission on the Status of Women in Illinois. The forum fostered information-sharing among 150 Illinois employers who have or who are considering work/life options. Many employers indicated in their evaluations of the forum that they would utilize the information received to implement or explore options for work life programs for their employees.

Also in Fiscal Year 2000, the Women's Bureau, along with the New Jersey Chamber of Commerce, whose members include Johnson & Johnson, Merrill Lynch, and the Public Service Energy Group, the Middlesex Chamber of Commerce, and many other New Jersey businesses, co-sponsored the first ever Work Family Fair in the Convention Center in Edison, New Jersey. The purpose of the Fair was to provide small and mid-sized employers with work-life options and resources available to them. Approximately 1500 individuals passed through the Work Family Fair and obtained self-selected tailored information and resources from a variety of work-life exhibitors. Forty percent of the participants stated that they would do more research on work/family options and 10 percent indicated that they would implement a work/family program at the workplace.

RETIREMENT INCOME

In Fiscal Years 1999 and 2000, the Women's Bureau planned or participated in a number of conferences and seminars concerning retirement security for women. For instance, in FY1999 the Women's Bureau took part in planning for the Atlanta meeting "Americans Discuss Social Security," a video broadcast which featured First Lady Hillary Rodham Clinton and drew 236 persons. The broadcast, which was interactive, allowed the participants to express their concerns and to explore issues relating to Social Security reform.

The Women's Bureau also cosponsored the Milwaukee meeting of "Americans Discuss Social Security." The 200 Milwaukee participants, most of whom were women, learned about the importance of
Social Security as a safety net, especially for older women, and about various proposals on Social Security reform. They were able to voice their individual opinions through electronic polling devices and share their views on Social Security reform with each other.

On April 17, 1999, in Chicago, the Women's Bureau, the International Foundation of Employee Benefit Plans, and the University of Illinois at Chicago co-sponsored a "Summit on Financial Security: A Blueprint for Today's Woman." The summit provided education to women, employers, unions, and the general public on the unique financial challenges facing women that can lead to poverty in their later years. Seventy-five participants, mostly women, learned to evaluate their needs and take positive steps toward a financially secure retirement, to establish a budget with savings and investment goals, to better understand the laws and government programs that affect their security, to assess the investment options available, and to evaluate their current and future pension and health care protection.

The Women's Bureau joined the White House Office for Women's Initiatives, the Office of Federal Contract Compliance Programs, the Pension and Welfare Benefits Administration, and key women's organizations to develop a model conference called "Your Future Paycheck: What Smart Women Don't Know about Pay Equity, Social Security, Health Care, Pensions, Saving, and Investing." The conference, which was held on September 16, 1999, in Purchase, New York, was designed as a "train the trainer" retreat for some 200 leaders of major New York City and Westchester County women's organizations. Co-sponsors included the U.S. Treasury, the Women's Institute for a Secure Retirement, American Women in Economic Development, the New York Women's Agenda, and the Westchester County Office for Women.

In Fiscal Year 2000, the Women's Bureau, along with the Westchester County Office for Women, the New York Women's Agenda, American Women in Economic Development, the Women's Institute for a Secure Retirement, and the Heinz Foundation, co-sponsored the second part of the conference "Your Future Paycheck," at Bell Atlantic Headquarters. Approximately 80 local leaders of women's organizations in the New York Metropolitan Area were given intensive training on pensions, savings, debt, and investing by key experts in the field. They, in turn, took the information and materials back to approximately 5000 of their members regionally.

On April 7, 2000, in San Juan, Puerto Rico, the Women's Bureau co-sponsored an all day conference on "Financial Self-sufficiency for Women." Topics covered included women's equality in wages, Social Security, Pensions, and Savings. The other co-sponsors were the Puerto Rican Department of Labor, the Women's Committee of the Puerto Rican Senate, the Puerto Rican Commission on the Status of Women, the University of Sacred Heart, the Puerto Rican Development Bank, the Office of Federal Contract Compliance Programs, and the Pension and Welfare Benefits Administration. Two hundred and fifty women participated and received training, expert opinions, and materials in Spanish on the importance of knowing about their financial future.

Other Women's Bureau events in FY2000 included: (1) organizing a presentation on Social Security, pensions, and savings that
was delivered by a panel of experts on August 3, 2000, in Washington, DC; (2) participating in the Louisiana "Women and Social Security" statewide video conference and 65th Anniversary Celebration on August 9, 2000, in Baton Rouge, Louisiana; and (3) co-sponsoring a three-hour seminar for women business owners entitled "Pension Options for You and Your Employees" in Hartford, CT on September 25, 2000.

NATIONAL RESOURCE AND INFORMATION CENTER

The National Resource and Information Center (NRIC), was established in 1999 to provide the nation's working women with the most direct means of access to information on issues of concern to them, their families, and their employers. Among other things, the NRIC offers a Work and Family Clearinghouse, Fair Pay Clearinghouse, "Don't Work in the Dark!" Public Education materials, an array of other publications, and conference and convention information. NRIC is accessible through two toll-free phone numbers (1-800-827-5335 and 1-800-347-3741) as well as via the Internet, and offers updated information on Women's Bureau programs and publications as well as contacts for additional and supporting resources. Each year, NRIC serves approximately 25,000 nationwide.

Work and Family Clearinghouse

The Work and Family Clearinghouse is a computerized database and resource center responsive to women's employment issues that impact work and family, such as child care and elder care. Among its popular resources are the Working Women Count Honor Roll Report and the Working Women Count Executive Summary, which provide information on companies with policies and programs that make work better for working women; a business mentoring initiative on child care, which matches companies with successful programs that assist employees with balancing the demands of work and family with those looking to implement similar programs; and numerous supporting publications and resources.

"Don't Work in the Dark!" Public Education Campaign

The "Don't Work in the Dark!" public education campaign began in January 1994 as a means of alerting America's working women about their rights in the workplace. With a widely-identified base of brochures, women can access reader-friendly information on laws regarding issues such as sexual harassment, the Family and Medical Leave Act, age discrimination, wage discrimination, and disability discrimination. Supporting information includes publications from the Women's Bureau and related agencies on the aforementioned topics. Available employment rights brochures include:

- Don't Work in the Dark-Disability Discrimination
- Don't Work in the Dark-Sexual Harassment
- Don't Work in the Dark-Family and Medical Leave Act
- Don't Work in the Dark-Age Discrimination
- Don't Work in the Dark-Wage Discrimination
"FACTS FOR CAREGIVERS AND THEIR EMPLOYERS" FACT SHEET

Published in May 1998, and utilized in 1999–2000, this fact sheet gives an introduction which discusses statistics on the aging population, women workers, and elder care.

The second section discusses the types of elder care assistance available: geriatric care managers; homemakers and home health aides; companions/friendly visitors; telephone reassurance systems; respite care; daily money managers; home-delivered meals; chore and repair; legal assistance or resources; family and medical leave; and assistance with financing care.

The third section discusses ways employers/labor organizations can help employees with elder care: needs surveys; elder care resource and referral; seminars; support groups; employee assistance programs; caregiver fairs; counseling; long-term care insurance; visiting nurse services; adult day care, including intergenerational day care; emergency care; elder care pager programs; flexible spending or dependent care accounts; flexible schedules and leaves of absence; case management; and transportation.
ITEM 11—DEPARTMENT OF STATE

The Department is pleased to report that we continued to expand services for aging Americans and their caregivers during 1999 and 2000. Not only are employees working longer (the mandatory retirement age for Foreign Service is 65, and there is no mandatory retirement age for Civil Service), but employee responsibilities for caring for aging family members have continued to grow.

In 1999 the Department of State established an Eldercare Coordinator position in the Office of Employee Relations to develop and promote a series of initiatives to significantly improve the level of support the Department offers to employees with caregiving responsibilities for parents and other elderly relatives. The Coordinator formed a working group to conduct a policy review that considered caregiving issues identified by the Foreign Service union, by the Associates of the American Foreign Service, Worldwide (AAFSW) at an AAFSW-organized Eldercare Forum held at the Department, and by the Director General of the Foreign Service and Director of Personnel of the Department.

The Eldercare Working Group studied the unique needs of both Civil Service and Foreign Service employees as well as current rules, regulations and practices with a major impact on caregivers. It devised an Eldercare Mission Statement to guide the development of Department eldercare support policy and recommended the establishment of a dependent care resource and referral service, a reinvigorated information program at Washington headquarters, and several major regulatory changes that could help caregiving employees who serve at overseas posts.

The Eldercare Mission Statement, which was accepted by unions that represent Department Civil Service and Foreign Service employees, serves as a guide to developing a coordinated eldercare support program. The Statement says, "The Department recognizes that growing numbers of employees will have caregiving responsibilities for parents and other elderly relatives. To enable employees to make better decisions for the well being of their families, the Department will endeavor to provide information on available supports and services that affect the elderly. For employees serving abroad, it will also seek ways consistent with budget constraints to make available certain allowances and other benefits that assist in defraying additional eldercare costs due to service overseas. In Washington, the Department will provide a professionally-led eldercare support group, current and useful information on resources, and referral to community support services in the metropolitan area."

In 2000 the Office of Employee Relations launched LifeCare, a dependent care resource and referral service; created a new travel
benefit for Foreign Service employees when a parent faces a health crisis that may threaten continuing independence; and continued as a coordinating and advisory body for the eldercare support programs and services offered by other offices in the Department.

The Employee Consultation Service, the Department’s employee assistance program, continued to offer counseling and referral and facilitated an ongoing Eldercare Support Group with weekly meetings for employees in the Washington area. The Family Liaison Office surveyed employees overseas to determine the number of elderly parents accompanying Foreign Service members on assignment abroad and publishes information papers on caring for an aging parent. It also advocated within the Department on behalf of Foreign Service employees and family members with caregiving issues arising out of high international mobility. The Office of Allowances expanded rules governing the Separate Maintenance Allowance to permit an employee to obtain additional financial support from the Department if a parent who has lived in the employee’s household for a year prior to overseas assignment cannot accompany the family to the next post abroad.

The Office of Employee Relations organized a bimonthly lunchtime seminar series called “Caring for Your Aging Parents” which provided information on legal issues of aging, long-distance caregiving, housing options for the elderly, coping with Alzheimer’s Disease, respite care, and more, as well as promoted the use of LifeCare, the dependent care referral service. This office presented an annual Eldercare Fair at headquarters of the Department which brought organizations and local businesses offering support to seniors ranging from Medicare to AARP to private geriatric care managers into direct contact with employees. The Office of Medical Services hosted an annual Health Fair in Washington and additional lunchtime seminars that focussed on active, healthy aging.

During this period, the Office of Employee Relations’ Employee Programs Division took steps to enhance flexible work schedules and arrangements which can help caregiving employees. The Department’s first telecommuting policy was published in 1999. A “Leave and Alternative Work Schedules” handbook which explains family-friendly changes in sick leave policy as well as alternative work schedules available to Department employees was published in 1999. Home leave policy was revised in 2000 to allow Foreign Service employees to use 5 weeks (vice 3) of home leave in the U.S. following a tour overseas, thus permitting employees to spend more time with parents and other family members left behind during assignment abroad.

Finally, staff from the Office of Employee Relations have been active participants in OPM’s Interagency Family-Friendly Workplace Working Group which aims to share information about best practices in this area throughout the federal government.
ITEM 12—DEPARTMENT OF TRANSPORTATION

SUMMARY OF ACTIVITIES TO IMPROVE TRANSPORTATION SERVICES FOR THE ELDERLY

INTRODUCTION

The following is a summary of significant actions taken by the U.S. Department of Transportation during calendar years 1999 and 2000 to improve transportation for elderly persons.\(^1\)

DIRECT ASSISTANCE

FEDERAL TRANSIT ADMINISTRATION (FTA)

Under 49 USC 5310, the FTA provides assistance to private non-profit organizations and certain public bodies for the provision of transportation services for the elderly and persons with disabilities. In FY1999, $67 million was used to help 1,332 local providers purchase 1,755 vehicles and for contracted services. In FY2000, $140 million was used to help approximately 1,400 local providers purchase more than 1,800 vehicles and for contracted service for the provision of transportation services for the elderly and individuals with disabilities. The large increase in funds obligated between FY1999 and FY2000 is due mostly to two transfers of flexible funds (a category of funds that may be used for highway or transit projects), totaling $62.6 million, into the Section 5310 program by Los Angeles County Metropolitan Transit Authority for the provision of paratransit services required by the Americans with Disabilities Act for operators of fixed-route service. Most of the agencies funded under the elderly and persons with disabilities program are either disability service organizations or elderly service organizations, and service provided under the program is nearly equally divided between the two. Those agencies servicing the elderly are, however, more dependent on funding from the elderly and persons with disabilities program as 53 percent of their vehicles are purchased with Section 5310 funds compared to 42 percent of vehicles purchased by agencies serving persons with disabilities. Vehicles purchased with these funds may also be used for meal delivery to the homebound as long as such use does not interfere with the primary purpose of the vehicles.

Under 49 USC 5311 (Formula Grants for Other Than Urban Areas), the FTA obligated $208 million in FY1999 and $229 million in FY2000. These funds were used for capital, operating, and ad-

\(^1\) Many of the activities highlighted in this report are directed toward the needs of persons with disabilities. However, one-third of the elderly are persons with disabilities and thus will be major beneficiaries of these activities.

(347)
ministrative expenditures by state and local agencies, nonprofit organizations, and operators of transportation systems to provide public transportation services in rural and small urban areas (under 50,000 population). The nonurbanized are program funds are also used for intercity bus service to link these areas to larger urban areas and other modes of transportation. An estimated 36 percent of the ridership in nonurbanized systems is elderly, which represents nearly three times their proportion of the rural population.

Under 49 USC 5307 (Urbanized Area Formula Grants), the FTA obligated $2 billion in FY1999 and $4 billion in FY2000. 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.

Section 3038 of the Transportation Equity Act for the 21st Century authorized a program to fund the incremental capital and training costs of complying with DOT's over-the-road bus accessibility final rule. In FY1999, the first year of the program, $2 million was obligated to 11 providers of intercity fixed-route service. These funds were used to make 87 vehicles wheelchair accessible and for training. In FY2000, $3.7 million was provided to 47 providers of intercity fixed-route service and others, including charter and tour operators. These funds were used to make 168 vehicles wheelchair accessible and for training. Approximately 25 percent of the over-the-road bus industry's ridership is elderly, and a large proportion of persons who use wheelchairs are elderly. Providers of over-the-road bus services are encouraged to use accessibility training resources developed by the National Easter Seal Society’s Project Action, an FTA-funded program to promote cooperation between the disability community and transportation industry.

FEDERAL RAILROAD ADMINISTRATION (FRA)

The National Railroad Passenger Corporation (Amtrak) continued throughout calendar years 1999 and 2000 to provide discounted fares, accessible accommodations, and special services, including assistance in arranging travel for older citizens and passengers with disabilities. These passengers continue to represent a substantial part of Amtrak’s ridership—in 2000 alone ridership among seniors age 62 or older increased by almost 8 percent to approximately 1.8 million travelers.

Discounted Fares.—Amtrak has a systemwide policy of providing elderly persons and persons with disabilities a 15 percent discount on ticket purchases. During this period, Amtrak also offered a 15 percent discount to adult companions traveling with a passenger with a mobility impairment. This 15 percent discount cannot be combined with any other discount. Amtrak also offered passengers with mobility impairments a 30 percent discount on the standard fare for accessible bedrooms.

Accessible Accommodations.—Amtrak provides accommodations that are accessible to elderly persons and passengers with disabilities, including those using wheelchairs, on all of its trains. Long-distance trains include accessible sleeping rooms as well as accessible coach seating and bathrooms. Short-distance trains, including
Northeast Corridor trains, have accessible seating and bathrooms. Many existing cars are being modified to provide more accessible accommodations and all new cars, including the recently unveiled Acela Express high-speed rail cars, provide enhanced accessibility for passengers, with mobility and other types of disabilities. Amtrak allows only passengers with mobility impairments to reserve an accessible bedroom up until 14 days prior to the date of a train's departure from the city of origin.

Mechanical lifts operated by train or station staff provide passengers with access to single-level trains from stations with low platforms and short plate ramps provide access to bi-level equipment. An increasing number of Amtrak stations are fully accessible, particularly key intermodal stations that provide access to commuter trains and other forms of transportation.

Special On-Board Services.—Amtrak continues to provide special on-board services to elderly persons and passengers with disabilities, including aid in boarding and deboarding, special food service, written menus, special equipment handling, and provisions for wheelchairs. Amtrak has also improved training of its employees to enable them to respond better to passengers with special needs.

Assistance in Making Travel Arrangements.—Amtrak has available publications describing its services and facilities for the benefit of passengers with disabilities. A pamphlet entitled “Access Amtrak: A Guide to Amtrak Services for Travelers with Disabilities” is available upon request. Persons may request special services by contacting the reservations office at 1–800–USA–Rail. This office is equipped with text telephone (TTY) service for customers who are deaf or hard of hearing. To ensure that passengers receive the assistance they need, Amtrak maintains a Special Services Desk, which supports its reservations agents seven days a week. This desk has successful responded to nearly 100,000 requests for special services. Passengers may also inform their travel agent or the station ticket agent of their assistance requirements when making travel reservations.

Research

Department-Wide Aging Initiative

National Agenda for the Transportation Needs of an Aging Society.—As a follow-up to its January 1997 study, and to prepare the nation’s transportation system for the near doubling of older Americans expected between now and 2030, the Department has initiated development of a National Agenda, laying out the actions needed to manage safe transportation for older adults in the first decades of the new century. The U.S. Department of Transportation Office of the Secretary, National Highway Traffic Safety Administration (NHTSA), Federal Highway Administration (FHWA), and Federal Transit Administration are participating in this effort. The agenda is based on a national dialog on the transportation needs of an aging population, begun by the Department in 1999. This dialog has included regional forums, workshops, professional society meetings, international conferences, and the work of a companion study done by the Transportation Research Board (see below). Its purpose has been to get the broadest possible viewpoint...
from those practicing in the field—transportation professions, medical and social service providers, public officials, and the agencies and interest groups who deal with the elderly on a day-to-day basis. Concurrent with the regional forums a series of focus group discussions were held with other people and their lay care givers (usually adult children) to obtain their perspectives on elderly driving, the difficulties associated with driving cessation and the use of other transportation options. Several telephone surveys of older adults were also conducted.

The result of this effort is a report entitled **Safe Mobility for a Maturing Society: A National Agenda**. It points out that there is no simple solution, nor is responsibility vested in one single organization. It lays out what needs to be done to manage safe transportation for our older adults, with a comprehensive set of recommendations and the potential roles that different authorities, agencies, the private sector, and the public can have in implementing them. It includes an array of possible innovations and measures for maintaining transportation safety and quality of life for older adults: improved roads, safer cars, better driver screening and retraining, more access to non-driving alternatives, and dissemination of better information to the public. It will be a source of guidance on the actions that hold the most promise by transportation planning, law enforcement, social service, and medical agencies at all levels, as well as the private sector, and by older adults themselves and their advocates. The report should be available in early 2002.

**Transportation Research Board (TRN) Report.**—The TRB, with the support of the Department, is working to update a 1988 report on needed research covering transportation for older adults. The update examines what has been done since 1988, what the requirements are for new work, and what the new research priorities should be for meeting the needs of an increasing elderly populace over the next 25 years. This report, *Transportation for an Aging Society—a Decade of Experience* will be published by TRB in 2001.

**FEDERAL AVIATION ADMINISTRATION (FAA)**

The Office of Aviation Medicine's Civil Aeromedical Institute (CAMI) has contributed to the following research related to the needs and concerns of the aging population in aviation transportation.

**Cognitive Function Test.**—The CogScreen test was developed to measure the underlying perceptual, cognitive, and information processing abilities associated with flying. It is being validated against a group of older military aviators, including repatriated military aviators and a control group. This validation extends the age groups of the original CogScreen validation by including more aviators in older age groups. Analyses are completed; results have been presented at a scientific meeting, and an Office of Aerospace Medicine (OAM) technical report is being written. Overall, results indicate a pattern of lowered CogScreen scores with advancing age.

**Flight Deck-Related Human Factors Research.**—Previous observations in simulator studies suggest that older segments of the General Aviation pilot population are having difficulty hearing specific auditory warnings in the cockpit. A study to assess age-related
changes in pilots' auditory thresholds was completed using stratified age sampling. Comparisons of threshold for pilots and non-pilots revealed the expected high-frequency decrements attributable to aging and general environmental exposure. Significant differences were found between non-pilots and pilots, with greater threshold shifts, between 2 and 6 kHz, among pilots. Results were presented at a scientific meeting and a draft report is currently under review.

Age-60 Rule.—A series of four studies on the Age 60 rule were completed by CAMI in response to a Congressional request. The first study provided an overview and update of the relevant scientific literature. The second study re-analyzed accident and incident data published by the Chicago Tribune in July 1999. That re-analysis found, as did the Tribune, no significant differences in accident/incident rates for pilots age 40–49 and 50–59. The third study analyzed the accident rate for professional pilots holding an air transport pilot (ATP) and Class I medical certificate by age, for accidents occurring under Part 121. While there was an overall statistically significant "U"-shaped relationship between pilot age and accident rate, the difference between accident rates between pilots aged 55–59 and 60–63 was not statistically significant. The fourth study analyzed the accident rate for professional pilots holding an ATP or Commercial Pilot and Class I or Class II medical certificate by age, for accidents occurring under Part 121 and Part 135. There was an overall statistically significant "U"-shaped relationship between pilot age and accident rate. In addition, the accident rate for pilots aged 60–63 was statistically greater than the rate for pilots age 55–59. However, the difference may be attributable to the fact that all accidents involving pilots age 60 to 63 occurred under Part 135, which are generally acknowledged as having a higher base rate. The reports were provided by the FAA to the Department of Transportation in September 2000, and a formal OAM technical report is in preparation. Additional analyses are planned in FY2002, based on suggestions and recommendations from the researchers in this area.

On August 14, 2001, the U.S. Court of Appeals for the 7th Circuit, in Yetman vs. Garvey, affirmed an FAA decision to deny exemptions to its age 60 rule sought by a total of 69 pilots. The court upheld the exemption denials in light of FAA’s paramount safety concerns.

Air Traffic Control.—The model developed in a previous report that focused on a systematic projection of the aging of the current air traffic control workforce and retirement eligibility was revised. The revised model was developed to reflect more closely the actual retirement trends and expanded to airways facilities.

As part of the validation of a new computerized selection instrument for air traffic controllers, a study was conducted to determine the relationship between age and performance on both the selection tests and on the criterion measures of controller performance. The two criterion measures used in the study were ratings (peer and supervisor) and the score on a newly developed computer-based performance measure. Results revealed a curvilinear relationship between age and both test scores and criterion measures, with performance declining for controllers over the age of 42. Results were
presented at scientific meetings and published as two OAM technical reports in 1999.

FEDERAL HIGHWAY ADMINISTRATION (FHWA)

Beginning in 1989, a High Priority Area for research was established to develop a clear understanding of older driver needs and capabilities with respect to the roadway environment. Research under this program started as problem identification, and quickly moved to focus on the specific areas, which cause the greatest problems for older drivers and pedestrians.

Research findings from this program were incorporated into an Older Driver Highway Design Handbook (FHWA–RD–97–135) that became available in January 1998. The handbook serves as an important resource for traffic engineers in assuring that highways meet the needs and capabilities of older drivers and pedestrians. The handbook has been widely distributed and extremely well received. A condensed version, titled Older Driver Highway Design Handbook: Recommendations and Guidelines (FHWA–RD–99–045), became available in December of 1998.

Currently, an update to the Handbook is in the final stages of development. Besides including the most recent research findings, this document will address a broader range of highway design areas and will contain format and content changes to improve its usefulness. The new editions: Highway Design Handbook for Older Drivers and Pedestrians (FHWA–RD–01–103) and Guidelines and Recommendations to Accommodate Older Driver Highway Design Handbook: Recommendations and Guidelines (FHWA–RD–99–045), became available in December of 1998.

Currently, an update to the Handbook is in the final stages of development. Besides including the most recent research findings, this document will address a broader range of highway design areas and will contain format and content changes to improve its usefulness. The new editions: Highway Design Handbook for Older Drivers and Pedestrians (FHWA–RD–01–051) are due to be printed and delivered this fall. Both documents will be produced in electronic as well as traditional paper media.

It should be noted that all human centered research, including Intelligent Transportation Systems initiatives, conducted by FHWA includes an older driver component to ensure the system’s utility for all potential users.

The FHWA is continuing work to fulfill a mandate issued by Congress that requires public agencies to maintain signs and pavement markings to minimum levels of retroreflectivity (i.e., brightness). In the process of establishing these minimum guidelines, research has been conducted to determine the brightness of signs and pavement markings necessary for older drivers to drive safely and comfortably at night. A recent study using older drivers as subjects, has determined an optimum brightness for overhead guide signs. FHWA is also investigating the effectiveness of new automobile headlight systems, which have the potential to drastically improve the visibility of signs, pavement markings, and pedestrians at night. Older drivers have been included in the field experiments of the ultraviolet infrared, and other new headlamp technologies, and results indicate that there are several options that can enhance
night visibility for older drivers. Efforts are continuing on this project to evaluate driver visibility with these headlight systems under adverse weather conditions at the Virginia Smart Road (a high priority project in Blacksburg, Virginia, funded by the Transportation Equity Act for the 21st Century). The FHWA is also using the sophisticated fixed lighting test system at the Virginia Smart Road to test varying light types, levels, and placement to identify optimum lighting design for older drivers. Ninety older drivers have participated in field experiments, which measured their ability to see objects on the road under varying levels of street lighting and glare from on-coming vehicles. This effort is expected to validate new lighting design standards.

The results of these studies and other research will be incorporated into the Manual on Uniform Traffic Control Devices, the Highway Lighting Handbook, and other documents used in highway design.

FEDERAL TRANSIT ADMINISTRATION (FTA)

The National Easter Seal Society's Project Action (funded by FTA) hosted three consumer education workshops in 2000 for seniors with disabilities. Participants had an opportunity to learn about the transportation provisions of the Americans with Disabilities Act (ADA) and to gain first hand experience in using fixed route services in their communities. Over the past few years Project Action has worked with a number of aging organizations in addressing accessible public transportation. Among the more than 100 products available free of change from its clearinghouse are three publications that specifically focus on seniors and public transportation.

Through the Transit Cooperative Research Program, FTA is sponsoring the research project begun in FY1999, "Improving Public Transit Options for Older Persons." This project will examine the population of interest in detail and will: identify barriers to mobility and methods to overcome them; detail best practices from transportation programs designed to improve transportation opportunities for older persons; and identify further innovations. An interim report was issued on December 8, 2000.

The Independent Transportation Network (ITN) in Portland, Maine, provides convenient and affordable transportation for seniors who have chosen to reduce or totally eliminate driving their own cars. Service is provided by a fleet of standard size sedans driven by paid drivers and a large number of volunteer drivers using their own cars. Innovative payment plans eliminate the need for cash transactions and member accounts make it easy for other family members to help pay for a senior's transportation needs. This project is primarily funded by FTA with additional funding assistance from the Transportation Research Board (TRB), AARP, NHTSA, as well as foundation awards and corporate and community support.

NATIONAL HIGHWAY TRAFFIC ADMINISTRATION (NHTSA)

Vehicle Design for Crash Avoidance.—NHTSA's crash avoidance research program addresses the relationship between vehicle design and driver performance and behavior. Emerging vehicle tech-
nologies could help reduce older driver crashes and enhance their mobility. For example, voice turn-by-turn in-vehicle navigation systems may allow drivers to concentrate on watching for dangerous traffic conflicts instead of being distracted while searching for road signs. Similarly, collision-warning systems would alert drivers to potential crash situations. In this area, NHTSA continues development of crash warning systems for rear-end crashes, lane changes crashes, road departure crashes, and intersection crashes. Other developments in driver interfaces could provide technology-based innovations that would help older, functionally less able people continue to drive by offering all drivers much wider adaptability to unique personal needs, say through programmable "glass dash" options where older drivers could improve contrast and font size programming rather than settling for current fixed-configuration designs, and could even control the nature of the information that is passed to them from the vehicle. NHTSA's research focus is thus to determine how the design and function of vehicle systems could/should be adapted to better meet the needs of older drivers, including the unique capabilities and needs of older drivers.

Pedestrian Safety Issues.—Older pedestrians, 65 and over, account for a smaller proportion (7.7 percent) of all pedestrian crashes than would be expected by their numbers in the population (12.8 percent). However, they account for more than one in five (22.4 percent) pedestrian fatalities. In response to this problem, NHTSA and FHWA are continuing work aimed at preventing crashes involving pedestrians. One example is a pilot project that was initiated by NHTSA in Miami/Dade County, Florida. That project involves a demonstration program of targeted behavioral safety information combined with enforcement activities and traffic engineering applications in selected zones of the county that have been shown to have a high incidence of pedestrian crashes. In 2000, awareness for senior citizens; the medical community that serves them; community organizations that provide outreach to them; and transportation providers that service them. Another project begun in 2000, with the State of Texas, will evaluate the conversion of their safety materials for more than 25 percent of the population is of Hispanic origin, and it is important to address the safety needs of this growing group. This will also help NHTSA in refining materials for older pedestrians—Spanish-speaking or otherwise.

Older Driver Safety.—The majority of older drivers do not constitute a major safety problem. Research has indicated that most older drivers adjust their driving practices to compensate for declining capabilities. They reduce or stop driving after dark or in bad weather and avoid rush hours, and unfamiliar routes. There are, however, individuals who are at increased risk for crashes. NHTSA is hard at work trying to identify those drivers through its research program. The research study Intersection Negotiation Problems of Older Drivers revealed that cognitively impaired drivers referred to the DMV for further testing are more likely than other older drivers to exercise poor judgment in making left turns. Evaluating Drivers Licensed with Medical Conditions in Utah, 1992–1996 used NHTSA's Crash Outcome Data Evaluation System (CODES) to link crash data with licensing information. Drivers who had certain reportable conditions, such as memory problems
and musculoskeletal abnormalities had an increased risk for crash involvement.

In addition to conducting research in this area, NHTSA participated in the November 1999 Transportation Research Board (TRB) conference on Transportation in an Aging Society: A Decade of Experience. Participants at this conference identified research gaps in the knowledge base regarding older road users. In July 2000, NHTSA initiated a contract to develop research problem statements for studies from that conference that fall under NHTSA's mission.

Driver Assessment Activities.—Those older drivers who remain a problem are not easily detected with standard licensing procedures. Further, there is some doubt as to whether most licensing staff have the skills necessary to detect these problems drivers, even with training and state-of-the-art testing techniques. Diagnostic tests currently in use have not been shown to be effective in identifying those older drivers who are at increased crash risk, but some tests of "speed of attention" and "visual perception" may have such potential, particularly at detecting the cognitively impaired. An ongoing study in the State of Maryland promises to reveal which of these tests is most predictive of crash involvement. Similar research is being conducted at Ohio State University, looking specifically at their medical assessments of older drivers and how the assessments relate to driving performance. In addition, a project with the State of Florida aims to better identify and counsel cognitively impaired drivers. NHTSA is also investigating the degree to which rehabilitation is an option in drivers with certain medical conditions. The goal is to keep people driving for as long as it is safe for them to do so.

Mobility Issues.—One factor that must be considered with regard to interventions is the fact that elderly people who give up driving often lose mobility. For many, the automobile is their primary mode of transportation and acceptable alternatives are simply not available. Because older women are more likely to stop driving than older men, a Literature Review on the Status of Research on the Transportation and Mobility Needs of Older Women was conducted. Because mobility is so closely tied to economics, living arrangements, and health and life expectancy, this review revealed that older women are at a disadvantage with regard to mobility.

RESEARCH AND SPECIAL PROGRAMS ADMINISTRATION (RSPA)

RSPA manages the Department's University Transportation Centers Program as revised and expanded in the Transportation Equity Act for the Twenty-First Century (TEA-21).

Each center focuses its research on a specific theme or interest area. Several of these themes are linked in whole or in part with improving mobility for elderly citizens:

- University of Arkansas: Rural Transportation
- University of California—Berkeley: Improving Accessibility for All
- Marshall University: Economic Growth and Productivity in Rural Appalachia Through Transportation
- Montana State University: (Western Transportation institute): Rural Travel and Transportation
Morgan State University: Transportation—A Key to Human and Economic Development
University of Nebraska—Lincoln: Improved Design and Operation of Transportation Facilities and Services in Mid-America
North Carolina A&T State University: Urban Transit
University of Southern California and California State/Long Beach: Solutions to Transportation Issues in Major Metropolitan Areas
University of South Florida: Urban Transit
North Dakota State University: Rural and Non-Metropolitan Transportation

In addition, the Director of the University Transportation Center at the Massachusetts Institute of Technology presented a paper at the October 2000 White House Forum on Technologies for Successful Aging. The Department of Veterans Affairs hosted the Forum, with support from the Department of Health and Human Services, the Department of Education, the National Institutes of Health, and the Office of Science and Technology Policy.

INFORMATION DISSEMINATION

FEDERAL HIGHWAY ADMINISTRATION (FHWA)

A one-day workshop was developed to familiarize traffic engineers and highway designers with the Older Driver Highway Design Handbook. The workshop covers the needs and capabilities of older road users, reviews the recommendations of the Handbook in detail, and presents case studies as learning exercises. It was designed for federal, state, and local highway designers, traffic engineers, and transportation professional. To date, over 50 workshops have been held in over 30 states, training approximately 1500 traffic engineers. FHWA personnel from across the country have attended “train the trainer” sessions, thereby allowing FHWA to better meet the numerous requests for workshops. The workshop is being revised to reflect the new edition of the Handbook that will be available in Fall 2001.

In 1999, the FHWA established the Pedestrian and Bicycle Information Center (PBIC) to provide technical assistance to localities on accommodating pedestrians, including older pedestrians. The PBIC is operated by the Highway Safety Research Center of the University of North Carolina, and offers a website (www.walkinginfo.org), an 800 number (877-925-5245), fact sheets and expert assistance. The PBIC enhances the effectiveness of the USDOT by providing additional technical expertise to individuals with questions about pedestrian and bicycle facilities and programs.

As an implementing agency for the Americans for Disabilities Act (ADA), FHWA published a guideline Designing Sidewalks and Trails for Access—A Review of Existing Guidelines and Practices—Part 1. A Best Practices Guidebook will be released in September 2001. This document explains the needs of pedestrians with disabilities, including the needs of older pedestrians, and provides guidance on how to design universally accessible pedestrian facilities. FHWA also initiated a project in 2000 focusing on Intelligent
Transportation Systems-based pedestrian countermeasures, including some technologies (infra-red detection that will benefit older pedestrians. Older pedestrian issues are included in all ongoing FHWA outreach activities, including the Intersection Hazard Index for Pedestrians and Bicyclists, and the University Pedestrian/Bicyclists Graduate Course, as well as other active work with State DOT's and other transportation agencies.

**FEDERAL RAILROAD ADMINISTRATION (FRA)**

Information about Amtrak accessibility is available to senior citizens and passengers with disabilities in a brochure entitled “Access Amtrak” which can be obtained by calling 1–800–USA-RAIL or ordering from the Amtrak website at www.amtrak.com. Amtrak also works directly with a number of organizations each year on moving groups of passengers needing assistance and traveling together.

**NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION (NHTSA)**

A broad array of public information materials and resources were first introduced in 1999 and 2000. Through partnerships with outside organizations and within DOT, NHTSA has been able to expand its outreach efforts and reach new audiences. Adapting Motor Vehicles for People with Disabilities is a step-by-step guide for making vehicle adaptations to enhance the mobility of the disabled passenger and driver. It is estimated that half of the disabled population is over age 50, and that each individual will experience at least one form of disability in their lifetime.

NHTSA has contributed to FHWA’s Pedestrian and Bicycle Information Center (PBIC), most notably to the segment on pedestrians over 50 on www.walkinginfo.org. In particular, there was a partnership with FHWA to develop the Pedestrian and Bicycle Crash Analysis Tool, which became available in 2000, and is distributed through PBIC. The tool helps users analyze crash data to select appropriate countermeasures to prevent such crashes from recurring. Countermeasures might include traffic calming or targeted education.

*Driving Safely While Aging Gracefully* contains information on common age-related changes as they relate to driving, paired with actions an older person can take to minimize the effects of those changes. This booklet is the result of a partnership with AARP and USAA Educational Foundation.

**RESEARCH AND SPECIAL PROGRAMS ADMINISTRATION (RSPA)**

RSPA continues to disseminate technical reports describing the mobility needs of senior citizens, and alternative ways to meet them. Documents are available in hard copy from the Department at no charge, and may be ordered on the INTERNET at the Technology Sharing Program home page: http://www.tsp.dot.gov.

RSPA provided staff support to the National Science and Technology Council’s (NSTC’s) Committee on Technology, including its subcommittee on Transportation R&D. In April 1999 the NSTC National Transportation Science and Technology Strategy was released, which included recommendations for several government/academic/private sector strategic partnership initiatives to promote
technology application and implementation. One of these initiatives deals specifically with "Accessibility for Aging and Transportation Disadvantaged Populations." A goal of this initiative is to create model alternative transportation systems that serve the needs of the elderly and transportation-disadvantaged people while taking full advantage of existing services, resources, and development patterns. More detailed implementation activities were defined in the NSTC Transportation Technology Plan, which was being released in May 2000. The DOT Transportation Research, Development and Technology Plan also emphasizes this topic as an area for implementation partnerships.

To facilitate communication and information-sharing on technology issues and support the NSTC, RSPA has brought a science and technology INTERNET home page on line. The element deal with the accessibility partnership is located at http://scitech.dot.gov/partech/accage/accessaging.html. It includes background information on the need, links to selected on-line manuals and technical reports, and announcements of upcoming conferences and events.

The University Transportation Centers Program integrates its products in a directory of University Research Results on its INTERNET Home Page at http://utc.dot.gov. The directory includes the title of each report and a contact who can provide further information on the research and the availability of documentation from it. In addition, program staff is exploring making key UTC products available on-line as volumes in the National Transportation Library at (http://www.bts.gov/NTL).
ITEM 13—DEPARTMENT OF TREASURY

U.S. TREASURY ACTIVITIES IN 1999–2000 AFFECTING OLDER AMERICANS

The Treasury Department recognizes the importance and the special concerns of older Americans.

SOCIAL SECURITY TRUST FUNDS

The Secretary of the Treasury is the Managing Trustee of the two Social Security Trust Funds (Old-Age and Survivors Insurance and Disability Insurance). The Trustees issue an annual report on the short- and long-run financial status of these Trust Funds. In the March 2000 report, covering calendar year 1999, the Trustees project that full benefits can be paid for about the next 37 years, three years longer than in the 1999 report. The 75-year actuarial deficit of the Social Security program in the 2000 report is estimated to be 1.89 percent of taxable payroll, an improvement from 2.07 percent in the 1999 report. The improvement in the status of the trust funds in 2000 comes from strong recent economic growth, a higher long-run wage growth assumption, and changes in assumptions and methods. The OASDI Trustees' Report is available at www.ssa.gov/OACT/TR/index.html.

There was an automatic 2.4 percent benefit increase in December 1999, and an additional 3.5 percent in December 2000. The taxable wage base was increased to $72,600 in 1999 and $76,200 in 2000, and is $80,400 in 2001.


MEDICARE TRUST FUNDS

The Secretary of the Treasury is the Managing Trustee of the Federal Hospital Insurance (HI) and Federal Supplementary Medical Insurance (SMI) Trust Funds. In their (corrected) March 2000 report, covering calendar year 1999, the Trustees project that the HI trust fund will be exhausted in 2025, compared to 2015 in the 1999 report. In the 2000 report the 75-year HI actuarial deficit is projected to be 1.21 percent of taxable payroll, compared to 1.46 percent in the 1999 report. This improvement is due to lower benefit expenditures and higher economic growth than projected. The SMI trust fund is projected to remain adequately funded into the indefinite future because its funding, by law, comes almost entirely from general revenues and premium payments. The Medicare Trustees' Reports are available at www.hcfa.gov/pubforms/tr.
Each year, the width of the income tax brackets and the personal exemption and standard deduction amounts are increased to reflect the effects of inflation during the preceding year. The personal exemption allowed for each taxpayer and dependent increased from $2,700 in 1998 to $2,750 in 1999 and to $2,800 in 2000.

Taxpayers age 65 or over (and taxpayers who are blind) are entitled to larger standard deductions than other taxpayers. Each single taxpayer who is at least 65 years old was entitled to an extra standard deduction of $1,050 in 1998 and 1999, and $1,100 in 2000. Each married taxpayer age 65 or over was entitled to an extra standard deduction of $850 in each of the three years. Thus, in all three years, married couples where both members were at least age 65 were entitled to an extra standard deduction of $1,700. Including the extra standard deduction amounts and the basic standard deduction amounts, taxpayers age 65 and over were entitled to the following standard deductions for tax years 1998 through 2000:

<table>
<thead>
<tr>
<th>Filing Status</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$5,300</td>
<td>$5,350</td>
<td>$5,500</td>
</tr>
<tr>
<td>Unmarried Head of Household</td>
<td>7,300</td>
<td>7,400</td>
<td>7,550</td>
</tr>
<tr>
<td>Married Filing Jointly:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One spouse age 65 or older</td>
<td>7,950</td>
<td>8,050</td>
<td>8,200</td>
</tr>
<tr>
<td>Both spouses age 65 or older</td>
<td>8,800</td>
<td>8,900</td>
<td>9,050</td>
</tr>
</tbody>
</table>

The tax credit for the elderly (and permanently disabled) was retained throughout the period.

Two provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are particularly relevant to the aged. HIPAA provides that accelerated death benefits received under a life insurance contract or from a viatical settlement provider are generally excluded from income subject to tax. Also, qualified long-term care insurance premiums and the unreimbursed expenses for the care of a chronically ill individual may be deductible, but only as part of the itemized deduction for medical expenses. Employer-paid long-term care premiums are excludable from the employee's income subject to taxation. Long-term care premiums paid by self-employed workers are partially deductible in the calculation of adjusted gross income, to the same extent as other health insurance premiums. (The Taxpayer Relief Act of 1998 accelerated the increases, and ultimately raised to 100 percent, the deductibility of health insurance premiums for a self-employed individual and the individual's spouse and dependents if neither the individual nor spouse are eligible for health insurance coverage as employees. The changes are phased in beginning in tax year 2000.)

**Medical Savings Account**

The Balanced Budget Act if 1997 permits Medicare-eligible individuals to choose either the traditional Medicare program or Medicare Plus Choice, which may include a medical savings account (MSA). The option became available in 2000. Under the Medicare Plus Choice MSA, limited contributions will be made to the individual's MSA, and those contributions and the earnings on balances
in the MSA account will not be subject to tax. Withdrawals which are used to pay for qualified medical expenses will not be subject to tax. Withdrawals which are used to pay for qualified medical expenses will not be subject to tax. Withdrawals used for other purposes will be included in income subject to tax and, subject to certain rules, will also be subject to additional tax.

GIFT AND ESTATE TAX

A gift tax is imposed on lifetime transfers by gift, and an estate tax is imposed on transfers at death. A unified credit applying to both the gift and estate taxes permits a certain amount to be transferred before gift or estate taxes are imposed. The Tax Reform Act of 1997 increased the unified credit, providing an effective exemption of $625,000 for 1998, $650,000 for 1999, and $675,000 for 2000 and 2001. Further increases are scheduled until the effective exemption reaches $1 million in 2006. (The unlimited exemption for transfers to spouses was retained.) Estates may elect special estate tax treatment for certain qualified family-owned business interests; the elected deduction for family-owned business interests together with the general effective exemption may not exceed $1.3 million.

INTERNAL REVENUE SERVICE

Publications

The IRS recognizes the importance and special concerns of older Americans, a group that will comprise an increasing proportion of the population in the years ahead. The following publications, revised on an annual basis, are directed to older Americans. Each year, IRS reviews the publication to ensure that they are updated to reflect changes in tax law as well as to simplify the explanation in them.

Publication 524, "Credit for the Elderly or 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 age 65 who retire with a permanent and total disability and receive taxable disability income from a public or private employer because of that disability may be eligible for the credit.

Publication 554, "Older Americans' Tax Guide," explains the income conditions under which single taxpayers aged 65 or older, and married taxpayers filing jointly if at least one of the spouses is 65 or older, are generally not required to file a Federal income tax return. The publication also advises older taxpayers about possible eligibility for the earned income credit. The taxpayer may be eligible for a credit based on the number of qualifying children in the home or a smaller credit if the taxpayer has no qualifying children. The Guide serves as a primary source of tax information for older Americans.


Publication 907, "Tax Highlights for Persons with Disabilities" is a guide to issues of particular interest to persons with handicaps or disabilities and to taxpayers with disabled dependents.
Publication 915, "Social Security and Equivalent Railroad Retirement Benefits," assists taxpayers in determining the taxability, if any, of benefits received from Social Security and Tier I Railroad Retirement.

Publication 590, "Individual Retirement Arrangements (IRAs)," includes information about deductions and tax treatment of distributions for various retirement accounts.

All publications are available free of charge. They can be obtained by using the order forms found in the tax forms packages or by calling 1-800-TAX-FORM (1-800-829-3676.) Many libraries and post offices stock the most frequently requested forms, schedules, instructions, and publications for taxpayers to pickup. Also, many libraries stock a reference set of IRS publications and a set of reproducible tax forms and also may have access to the Internet to download tax materials.

Most forms and some publications are on CD-ROM and are on sale to the general public through the National Technical Information Service on the Internet at www.irs.gov/orders, or by calling toll free 1-877-CDFORMS (1-877-233-6767). Forms, instructions, and tax information are available by fax by calling (703) 368-9694 using a telephone connected to a fax machine.

Taxpayers may obtain most forms, instructions, publications, and other products via the IRS Internet web site 24 hours a day, 7 days a week, at www.irs.gov.

The IRS has continued the availability of large-print versions of the Form 1040 and print versions of the Form 1040 and Form 1040A packages earmarked for older Americans. These packages (designated as Publication 1614 and 1615, respectively) are newspaper-size and contain both the instructions and the forms (for use only as worksheets, with the amounts to be transferred to regular-size forms for filing).

Volunteer and Outreach Programs

Volunteer Income Tax Assistance Program

The Volunteer Income Tax Assistance (VITA) program offers FREE tax help to people who cannot afford paid professional assistance. Volunteers answer questions and help prepare basic tax returns for taxpayers with special needs, including persons with disabilities, non-English speaking persons, those with low income, and elderly taxpayers. Assistance is provided at community and neighborhood centers, libraries, schools, shopping malls, and other convenient locations across the nation. Many sites provide free electronic filing of tax returns. Volunteers generally include college students, law students, members of professional organizations; members of retirement, religious, military, and community groups; and IRS employees.

During 2000, over 48,200 volunteers donated more than 945,600 hours assisting over 2 million individuals. There were over 1.1 million returns prepared at over 8,200 VITA sites across the nation.

Tax Counseling for the Elderly (TCE) Program

Congress first authorized the TCE Program in 1978 as part of the Revenue Act of 1978. The Revenue Act authorizes an appro-
priation of special funds, in the form of grants, to provide free income tax assistance to individuals 60 years of age or older. The IRS, in partnership with the AARP, supports the TCE program by providing training for volunteers, as well as the use of computers and printers for electronic filing. In 2000, there were over 9,100 TCE sites in retirement homes, neighborhood and senior citizens centers, and shopping malls. Volunteers also traveled to the private residences of the homebound. There were over 29,700 TCE volunteers providing more than 1.6 million hours of income tax assistance to over 1.6 million taxpayers in 2000. The TCE volunteers prepared over 458,000 federal income tax returns.

Community Outreach Tax Education Program

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 tax-related topics. Conducted at various community locations, the seminars are tailored for groups and individuals with common tax interests, such as groups of older Americans.

In 2000, over 2,900 volunteers provided tax information to over 1.4 million taxpayers in over 7,000 sessions through this program.

Small Business Tax Education Program (STEP)

The STEP provides information about business taxes and the tax-related responsibilities of operating a small business. During 2000, small business owners and other self-employed persons had an opportunity to learn about business taxes through a partnership between IRS and approximately 2,000 community colleges, universities and business associations. Assistance was offered at convenient community locations and times. Many retired individuals participate in this program.

Banks, Post Offices and Library (BPOL) Program

During 2000, the BPOL program provided approximately 36,900 locations with free tax preparation materials such as tax forms and publications to assist in preparing 1999 Federal Income Tax Returns. In some areas, the IRS recruited volunteers who worked at libraries answering tax questions and directing taxpayers to the appropriate tax forms.

FINANCIAL MANAGEMENT SERVICE

In Fiscal Year 2000, the Financial Management Service (FMS) issues more than 892 million payments, including Social Security, Supplemental Security Income, and Veterans benefits. Working under the mandate of the Debt Collection Improvement Act, signed by President Clinton on April 26, 1996, Federal Departments and agencies are on the fast track to convert Federal payments to electronic funds transfer (EFT). The law required most payments to be made electronically by January 2, 1999, but also gave the Secretary of the Treasury broad authority to grant waivers. EFT significantly improves the certainty of payments reaching the intended recipients on a timely basis, and improves the ability of recipients to use
those payments safely and conveniently. Payment inquiries and claims are significantly reduced under EFT.

Payment by EFT has substantial benefits in terms of reliability, safety, and security that are especially important for the elderly. Recipients are thirty times more likely to have a problem with a paper check than with an EFT transaction, and in FY2000 Treasury received more than 1.4 million inquiries from recipients regarding checks not received. Waiting days for a replacement check is an inconvenience and a burden on recipients, especially elderly persons living on low incomes. EFT payments are much more convenient and secure—misrouted EFT payments are never lost, and, if misrouted, the payments are typically routed to the correct bank account within 24 hours.

During the past four years, Treasury has overseen government-wide implementation of the Debt Collection Improvement Act of 1996, working with Federal agencies to identify and resolve the major issues confronting stakeholders. Federal agencies have made significant progress to convert payments made electronically, has increased from 53 percent in Fiscal Year 1996 to 70 percent in Fiscal Year 2000. More than 77 percent of Social Security payments were made electronically, an increase or more than 16 percentage points since Fiscal Year 1996. Other Federal benefit agencies show similar increases in EFT payments. Approximately 14.6 million benefit checks are still issued on a monthly basis.

Federal payment recipients who elect to receive their payments via Direct Deposit enjoy the benefits of this simple, safe, and secure payment mechanism. Recipients who have not signed up for Direct Deposit do have choices, as described in 31 CFR 208. Federal check recipients receiving salary, wage, benefit, or retirement payments can choose to: (1) receive payment via Direct Deposit through a financial institution, (2) open a low-cost Electronic Transfer Account (ETA SM) at a participating Federally insured financial institution, or, (3) continue to receive a paper check, if receiving payment by Direct Deposit would cause the recipient a hardship.

In 1999 Treasury developed ETA SM, a basic, low-cost account which is available to individuals who receive Federal benefit, wage, salary, or retirement payments. Over 600 Federally insured financial institutions at over 9500 branch locations nationwide, offer the ETA SM on a voluntary basis, subject to published standards and terms set forth in an agreement between Treasury and the financial institution. These low-cost accounts are designed to meet the statutory mandate that recipients have access to an account at a reasonable cost and with consumer protections, comparable to other accounts at the same financial institution. Anyone who receives a Federal benefit, wage, salary, or retirement payment is eligible to open an ETA SM, even if they have been unable to qualify for a checking or savings account in the past. The ETA SM cost $3.00 a month or less, and requires no minimum balance to open or maintain the account, except as required by law.

FMS and Treasury have been conducting a massive public education campaign on both a national and regional basis. Seeking the involvement of national, regional, and local consumer and community-based organizations, financial trade associations, and Federal
regulatory agencies to distribute materials and conduct “in touch” programs with Federal recipients to educate them about their choices under the law. The campaign has produced Public Service Announcements for television and radio; print ads; and posters, brochures, and other educational materials.

FMS continues to support the implementation of a nationwide program to make Electronic Benefits Transfer (EBT) a viable electronic payment option. EBT is an electronic benefit delivery mechanism that enables recipients to use plastic cards to access their benefits at automated teller machines and point-of-sale terminals. Forty-one states have some type of EBT program which provides electronic access to their benefits; thirty-six of these states and the District of Columbia are full-fledged, statewide programs, and others are either in the pilot phases, expanding statewide, or in the process of being awarded to providers. In 1996, FMS partnered with the Southern Alliance of States SAS, to deliver Federal and State benefits through EBT to recipients in an eight-state area. In the SAS, recipients of Federal and State benefits can access their benefits using the same EBT card. All 50 States are required by statute to operate statewide EBT systems for food stamps by October 2002.

Information on EFT '99 is available on the FMS Web site (www.treas.gov/eft), describing FMS products and services. Information available includes recent FMS activities related to EFT '99, publication, statistics, and contact information. The EFT web site includes topics on General Information, Regulations and Policy, Agency Assistance, News and Media, Education and Marketing, Vendor Information, and the ETA SM.

The Check Forgery Insurance Fund

The Check Forgery Insurance Fund (CFIF) legislation was enacted into law on April 26, 1996 as part of the Debt Collection Improvement Act of 1996. The CFIC is a revolving fund established to settle payee claims of non-receipt where the original Treasury check has been fraudulently negotiated. FMS uses the Fund to promptly issue replacement checks to innocent payees.

Check forgery is a concern of FMS and individuals who receive paper check payments, and FMS continues to address this concern. On March 26, 1998, FMS enhanced various Treasury Systems, utilizing the CFIC, to comply with the legislation and modify both internal and external operational and system procedures required to process check forgery claims in a more timely manner. Reinstitution of the CFIF relieves the burden for recipients of forged checks, especially the elderly.

Although EFT payment has substantial benefits, some recipients of Federal payments prefer paper checks. Many elderly continue to receive payments by check; however, this increases the probability of forgery. Many of those harmed by forgery are elderly, low-income, unbanked, and dependent on the monthly payment for their basic subsistence. The CFIF allows for immediate relief to the elderly and other payees after FMS has substantiated the claim of forgery.

CFIF relieves Federal Program Agencies (FPAs) of the responsibility for issuing replacement checks out of their appropriations
on forgery claims. Typically, the FPAs would not issue a replace-
ment check on a forgery claim until after FMS had recovered the
forged amount from the financial institution (FI) and credited the
agency with the check amount. The FI has 60 days to respond to
FMS’ request for refund. The CFIF provides for expeditious proc-
cessing of these cases and does not make issuance of the replace-
ment check contingent on recovery of the forged amount.

**Debt Collection Improvement Act**

The Debt Collection Improvement Act of 1996 and the Taxpayer
Relief Act of 1997 authorize the collection of delinquent debt
through administrative offset and levy of Federal payments, includ-
ing Social Security benefits. Over the last several years, FMS has
coordinated with the Internal Revenue Service and the Social Secu-
rity Administration to collect $372 million annually in delinquent
debt potentially available through levy and offset of benefit pay-
ments. FMS and SSA recently have agreed to begin phased-in im-
plementation of benefit payment offset in March 2001 and contin-
uous tax levy in October 2001. Implementation will begin with the
offset of Cycle EFT payments. The offset of Cycle Check payments
and Third of the Month EFT and Check payments will be phased
in following the Cycle EFT payments implementation. Supple-
mental Security Income payments are exempt from offset, as re-
quired by law. Old-Age Survivors and Disability Insurance benefit
payments are offset internally by SSA.

In a preliminary FMS test in February 1998, a comparison of
SSA benefits payees and the FMS Debtor Database found 35,670
matches, implying more than 400,000 annual benefit offset pay-
ments. Annual government collections from these offsets are esti-
mated at $36 million to $61 million. The amount of the offset of
the Social Security benefit payment will be the lesser of (1) the
amount of the debt, or (2) an amount equal to 15 percent of the
monthly benefit payment, or (3) the amount, if any, by which the
monthly benefit payment exceeds $750. Fifteen percent is the maxi-
mum amount that will be offset from an individual’s benefit pay-
ment.

FMS will provide the debtor with a notice of the intent to offset
and an opportunity to review the basis for the debt twice in writ-
ing, at both 60 days and 30 days prior to the anticipated offset. The
warning letters will include the name of the agency that originated
the debt and the name of a contact within that agency to answer
questions regarding the delinquent debt. FMS will also send the
debtor an offset notice that includes the amount and date of the off-
set, as well as the information in the previous notices, to coincide
with the timing of the pre-scheduled payment. The offset remains
legal even if the debtor does not receive the notices.

In the case of payment levies to collect delinquent tax debt, IRS
will send each tax debtor a notice that includes the tax bill, a state-
ment of the intent to levy, an explanation of an individual’s appeal
rights, and an IRS telephone number for inquiries and assistance.
The notice, which will be sent by certified mail to the taxpayer’s
last know address, will also inform the debtor that if repayment ar-
rangements are made within 30 days, the levy will not occur. Also,
IRS will send tax debtors who receive Social Security benefit pay-
ments an additional notice of intent to levy. At the time of the levy, FMS will send a notice to the debtor explaining the reason for the reduced payment and giving a contact at IRS who will answer questions regarding the tax debt. At any time during this process, either prior to or after the levy process begins, a debtor may make repayment arrangements with IRS, which will then release the levy.

**BUREAU OF THE PUBLIC DEBT**

Public Debt continues to improve its programs to better serve all investors, including older Americans. The Bureau is particularly committed to providing its retail marketable securities and savings bonds customers and expanding number of services over the Internet or through automated telephone services. These services, in many cases, allow Public Debt customers to conduct investment activities from their homes, a benefit for many older investors.

** Marketable securities**

Treasury securities are popular with older Americans; they are safe, secure investments and provide interest income. Through **TreasuryDirect**, an electronic securities system provided by Public Debt, investors can purchase Treasury bills, notes and bonds and hold them in an account directly with the U.S. Treasury. Sixty-seven percent of **TreasuryDirect** investors are 65 or older.

**Toll-Free Access to Account Services**

In 2000, Public Debt completed the consolidation of 37 **TreasuryDirect** offices into three. The three consolidated offices include modern customer contact centers offering a full-range of services to customers. By using one toll-free telephone number (1–800–722–2678), **TreasuryDirect** investors can access electronic account services, order forms, listen to auction information, or reach a customer service representative. The offices also process a wide variety of transaction requests received through the mail. Voice menus were recorded with older investors in mind and contact center employees received special training on how to meet the needs of older investors.

**Electronic Services Expanded**

Public Debt continues to expand **TreasuryDirect** electronic services so investors can conduct their business from home. Today more than half of **TreasuryDirect** customers use either our Internet or automated telephone services. Pay Direct allows existing customers to pay for their securities by authorizing Treasury to debit their bank account on the day the security is issued. Reinvest Direct allows customers to reinvest maturing securities by phone or Internet 24 hours a day, 365 days a year.

Sell Direct allows customers to authorize Public Debt to sell their securities rather than first having to transfer them to a bank or brokerage firm. Buy Direct gives current **TreasuryDirect** customers an easy way to purchase securities through the Internet or automatically by telephone. Recently investors were given new options of checking or changing addresses and phone numbers via the
Internet. And now forms can be completed online, making it con-
venient for investors to complete a transaction.

**SmartExchange from Definitive to Book-Entry**

Public Debt continues to encourage investors holding registered and bearer security certificates to convert them to book-entry. Book-entry provides safer and more reliable electronic payments and eliminates the need for investors to safeguard physical certifi-
cates.

**New Survey to be Conducted**

As part of an ongoing effort to stay in touch with our customers. Public Debt will conduct a new TreasuryDirect survey in 2001 to gather consumer information. This will help Public Debt identify ways to better serve customers by understanding their needs and preferences. It will also provide a profile update of investors, now predominantly 65 or older.

**Savings Securities**

U.S. Savings Bonds have been sold since 1935 and today 55 million investors hold them. Many older Americans purchase bonds for themselves, as well as for gifts. Through its web site (www.publicdebt.treas.gov), Public Debt continues to make it easier for investors to buy bonds; calculate their value; download forms to complete for lost, stolen or destroyed bonds; and access a wide vari-
ety of bond information.

**Savings Bonds Direct**

Savings Bonds Direct, introduced in November 1999, allows in-
vestors to buy savings bonds over the Internet directly from Treas-
ury. Bonds can be purchased by credit card 24 hours a day, 7 days a week from the convenience of an investor's home. Based on cus-
tomer feedback, a large number of bonds sold online are gifts pur-
chased by older Americans for their grandchildren.

**Home Banking**

Today more than 460 banks and credit unions sell savings bonds from their home banking web sites 350 more financial institutions than in 1999. Now more older investors can purchase savings bonds from home using the same "electronic connection" that they use for other banking business. This benefits customers who have trouble getting out of the house. Public Debt continues to work with banks, credit unions, and software companies to expand the availability of this convenient electronic service.

**Online Savings Bond Calculator**

Public Debt's web site has added a calculator allowing customers to price their bonds online. The calculator prices bonds and pro-
vides additional information such as current interest rate, next ac-
crual date, and final maturity date. The calculator also reminds in-
vestors to cash in their matured bonds. Customers can also cal-
culate year-to-date interest earned on their bonds for tax purposed. Past redemption values, back to 1996, are also accessible to assist in tax and estate valuations. The online calculator accommodates
most operating systems and a variety of web browsers, including WEB TV. Customers can price their bonds and save the page to reload at a later date to update their bond values.

**Inflation-Indexed Savings Bonds**

In September 1998, Public Debt introduced the Series I, inflation-indexed savings bond. I Bonds offer small investors a vehicle that preserves the purchasing power of their savings with a fixed real rate of return over and above inflation. This purchasing power protection is attractive for many investors, including those on fixed incomes.

**EasySaver**

Public Debt has conducted a concentrated marketing effort over the past year to let investors, especially retirees, know about the EasySaver Plan for purchasing savings bonds. Now investors, particularly the retired and those without access to payroll savings plans, can buy bonds automatically for themselves and their families. All the customer needs to do is complete an order form authorizing Treasury to charge their bank account for the price of the bond and choose the date(s) to charge their account for savings bond purchases. Bonds are then delivered by mail.

**Matured Unredeemed Banks**

Public Debt has been working to increase investor awareness of savings bonds that are no longer earning interest. Up-to-date information about these bonds is on the Public Debt web site and millions of inserts have been sent out with tax refunds and bond mailings. In addition to a public service advertising campaign released in May 2000, numerous articles have appeared in newsletters, newspapers, magazines, and on web sites. The Savings Bond Wizard and Savings Bond Calculator, available on the Public Debt web site, identify matured bonds. Public Debt tries to locate owners of matured bonds to let them know their bonds are no longer earning interest. Since most of these bonds are at least 30–40 years old, many owners are senior citizens.

**Forms Available Online**

Savings bond customers can order most forms directly from Public Debt's web site, eliminating the need to call or write to request them. Additional downloadable forms were added in 2000 to bypass the request process. Customers can download some of our more popular forms, print them, and then complete and mail them. Several forms can now be filled-in online, eliminating the need to manually write in the necessary information.

**Cross-Cutting Initiatives**

The following initiatives cut across programs and affect the way Public Debt does business.

**New Retail Customer Service System**

In 2000 Public Debt launched a long-term effort to develop a single system to support retail customers. This system will allow holders of Treasury securities, from savings bonds to direct-access
marketables, to more conveniently access a wide range of information and services through a single consolidated Internet interface. It will be a collection of processes composed of new components and legacy applications that will be knit together with a variety of information technologies and through a series of progressive releases. Over time, back-end systems will be reengineered to support new Treasury securities offerings. The single retail system will greatly extend the Bureau's commitment to high-quality customer service to all investors, including older Americans, who will be able to do all their investment business with the Bureau from one web site.

Outreach

Through direct participation in a variety of public events, including Securities and Exchange Commission Investor Town Meetings, AARP conventions, and other investor education forums, Public Debt provides information, answers questions, and solicits feedback from current and potential investors.

Web Site Meets Accessibility Standards

In April 1999, Public Debt certified that all of the pages on its web site met accessibility standards established by the Center for Applied Special Technology (CAST). The purpose of these accessibility standards—called "Bobby" standards—is to ensure that persons with disabilities, such as blindness and deafness, can use the worldwide web. For instance, because Public Debt complies with Bobby, a blind person can come to the Bureau's web site and listen to a word-for-word reading of the site's pages; this reading includes a verbal description of all graphics. These features, in addition to assisting those with disabilities, also benefit many older Americans who, for example, may have hearing loss.

Public Debt Web Sites to Visit

www.publicdebt.treas.gov to learn about Treasury securities, Treasury auctions, what the current public debt is and much more. www.treasurydirect.gov to read about TreasuryDirect, which allows investors to buy, hold, reinvest, and sell marketable Treasury securities. www.savingsbonds.gov to find out the various ways to buy savings bonds and their attractive investment features. www.easysaver.gov to learn about EasySaver, an easy way to buy savings bonds on a recurring schedule.

SECRET SERVICE

Advanced Fee Fraud Schemes

Advanced fee fraud schemes are very creative and innovative cons in which victims are enticed into believing that they have been "singled out" to share in a multi-million dollar windfall profit. The most prevalent type involves an unsolicited letter, fax, or e-mail to a business or individual from a Nigerian criminal claiming to be a senior official from the Nigerian government. These communications request the recipient's assistance in transferring tens of millions of dollars out of Nigeria, in exchange for a commission of ten to thirty percent.
Such fraudulent schemes result in reported financial losses of tens of millions of dollars annually. The true losses are much higher because many victims fail to report their losses due to embarrassment or fear. The elderly population is especially susceptible. The Secret Service has received numerous reports from elderly individuals who have lost their life savings to such fraudulent schemes. In conjunction with the Departments of State and Commerce, the Secret Service has contacted organizations that are associated with the principal targets of this scam, namely small businesses and the elderly. The Better Business Bureau, the American Bankers Association, and AARP have assisted the Secret Service in publishing materials designed to educate the public about these schemes, with the goal of preventing further victimization.

The Secret Service public education effort also includes a public awareness advisory that is posted on the Secret Service homepage (www.ustreas.gov/usss). This advisory provides detailed explanations of the more common advance fee fraud schemes, gives advice to those who have received solicitations, and lists contact information for the Secret Service Financial Crimes Division. The site also allows users to send an e-mail directly to the Secret Service Nigerian Crime Coordinator.

Although the Internet is a very effective tool for disseminating information, the Secret Service recognizes it does not yet reach all segments of the population. Therefore, the Secret Service also uses the more traditional mediums of print and television journalism. From July 1, 1999 through June 30, 2000, a number of media reports features Secret Service Financial Crimes Division representatives in an effort to encourage the general public to protect themselves from financial crimes, including advance fee fraud. These media reports included thirteen articles in ten major newspapers and newsmagazines, and ten television interviews which aired on national news for ABC, CBS, NBC, CNN, as well as local affiliates. The Secret Service is committed to the fight against advance fee fraud, and will continue with these public education initiatives.

Identity Theft

In today's economy, Social Security numbers, in conjunction with other personal identifiers, are used to grant credit and open bank and investment accounts. Government agencies request Social Security numbers on applications for licenses, permits, and benefits, and most health care providers require them for the maintenance of medical records. Because of this increased availability of personal information, even relatively unsophisticated criminals can perpetrate the crime of identity theft with minimal effort.

As a result, identify theft affects more people each year. It is the responsibility of government regulators, law enforcement agencies, financial institutions, and other private sector entities to work together and reduce the risk that this information falls into the wrong hands. These groups must also work together to identify, investigate, and prosecute individuals who perpetrate identity theft schemes. The Secret Service has taken a lead role in this area, working with Congress to modify existing laws applicable to identity theft to increase the rights of victims and strengthen sentencing provisions. The Secret Service has also coordinated two na-
tional conferences addressing issues related to the investigation, prosecution, and prevention of identity theft.

The Secret Service also actively participates in public education and awareness campaigns to instruct consumers on avoiding identity theft. The Secret Service has also worked closely with the Federal Trade Commission and the Department of Justice to develop educational materials designed to reach all consumers, including the elderly, and give them the information needed to protect them from being victimized.

**U.S. CUSTOMS**

The Customs Service offers special treatment for the elderly, the handicapped, the ill, and those who are unable to wait in line when arriving from abroad. Such travelers can speak with a Customs supervisor upon arrival in the Customs processing area of the airport or another Customs port of entry. The supervisor can facilitate the traveler's Customs clearance.

Customs strives to treat all travelers entering and leaving the United States with professionalism and courtesy. In addition, Customs works to ensure that Federal inspection facilities, such as restrooms, facilitate the movement of the elderly and handicapped.

The Customs Service also has a number of programs supporting Customs employees. For example, the Employee Assistance Program encourages elderly employees to seek additional assistance if needed. The Customs Health Enhancement Program offers activities and classes to Customs employees, including the elderly, in areas such as fitness, CPR/first aid, stress management, conflict resolution, defense tactics, allergy and asthma inoculations, nutrition, and health screening. In addition, special seminars and video broadcasts are offered throughout Customs on elder care. Topics include long-term health care, legal issues, caregiver issues, and nursing homes, and are available for the elderly as well as younger employees who may have older relatives and friends. The Customs Service also offers retirement seminars several times each year to all employees who are eligible to retire within the next 5 years. These seminars cover retirement benefits, legal matters and financial planning.

**UNITED STATES MINT**

The United States Mint continues to consider the needs and concerns of older Americans in its programs, activities, and operations.

*Golden Sacagawea Dollar*

Launched as the first coin of the new millennium, the Golden Sacagawea Dollar coin features a smooth, raised edge that is distinctive to the touch for the visually impaired.

*Mint Tours and Exhibits*

The staff of the public tours and exhibits areas of both the Philadelphia and Denver Mints recognize the special needs of older persons and persons with disabilities. The Mints provide special service such as wheelchairs, benches placed strategically along the tour route, and additional individual assistance as requested.
Employee Training

Mint staff participate in various workshops that provide knowledge and skills needed to assist, effectively interact with, and be sensitive and responsive to the diverse needs of the aged and persons with disabilities.

Employee Assistance

The Mint offers its employees a number of on-going services that address issues related to aging. The Mint provides employees with direct counseling, information, and referral services related to aging issues and caregiving for the elderly.

BUREAU OF ENGRAVING AND PRINTING

Currency

The National Academy of Sciences conducted a study on ways to assist the blind and visually impaired with currency transactions. Based upon the recommendations of that study, the Bureau of Engraving and Printing (BEP) redesigned the $10 and $5 Federal Reserve notes with several features to assist the elderly and visually impaired. The Federal Reserve introduced these notes into circulation on May 24, 2000.

In addition to several counterfeit deterrent features, the notes contain a large high-contrast numeral on the back, lower right corner. The large high-contrast numeral is designed to assist the more than 23 million Americans, mostly elderly, with varying degrees of vision impairment.

Based upon discussions with the American Council for the Blind, the BEP has also incorporated a machine-readable feature into the new $10 and $5 bills. This feature is intended to facilitate the development of convenient scanners for the blind and people with low vision. With the exception of the $1 bill, which has not been redesigned, the BEP has incorporated the machine-readable feature into all denominations of U.S currency ($100, $50, $20, $10 and $5).

OFFICE OF THE COMPTROLLER OF THE CURRENCY

During 1999 and 2000 the Office of the Comptroller of the Currency (OCC) continued to enforce fair lending laws relating to age discrimination. OCC has also continued to emphasize evaluating the performance of national banks with respect to the Community Reinvestment Act (CRA). Created in 1998, a new OCC division has specifically focused on consumer compliance, the CRA, and fair lending. This division became fully operational in 1999, and now provides a direct link between policy makers and compliance examiners in the field, supporting the OCC's consistent enforcement of compliance laws.

OCC examiners are alert to the potential for discrimination on the basis of age (as well as the other bases covered by ECOA and Reg. B) when conducting fair lending examinations. In 1999, the OCC found evidence of age discrimination during one fair lending exam and referred the case to the Department of Justice (DOJ) for action. DOJ ultimately returned the case to the OCC for administrative action. The OCC made no referrals based on age discrimina-
tion to DOJ in 2000. The addition of the case identified in 199 brings the total number of OCC cases involving age discrimination to ten since 1993.

During 1999 and 2000, Comptroller John D. Hawke, Jr. met twenty times with representatives from national and community organizations, including representatives of organizations focused on issues affecting senior citizens. These outreach sessions were to share information about OCC policy and national bank examination practices with bank customer organizations, and to learn first-hand about the concerns these organizations had with the activities of national banks, as well as the OCC's supervision of the national banking system. Topics typically discussed included fair lending, community development, EFT '99, predatory loans, payday lending, and access to financial services for the "unbanked," including elderly individuals, who do not have a relationship with a depository financial institution.

The OCC's Customer Assistance Group (CAG) is responsible for reviewing and processing complaints made about national banks, including those complaints submitted by older Americans. During 1999, the CAG received 123,000 telephone contacts resulting in 79,00 new cases. In its continuing efforts to improve accessibility and quality, the CAG has developed an Internet site (www.occ.treas.gov/customer/htm) that can provide consumers information about the OCC and how to file a complaint about a national bank. The CAG maintains a toll-free national consumer hotline (800–613–6743) that is staffed with trained professionals to assist consumers with questions about banking laws and issues related to complaints.

OFFICE OF THRIFT SUPERVISION

Community Affairs Program

During 1999 and 2000, OTS continued its Community Affairs Program. The primary mission of this program is to provide outreach and support to the thrift industry's efforts to meet its CRA obligations and to provide safe and sound loans, investments, and financial services for low- and moderate-income individuals and communities, and other areas of greatest need. As such, OTS Community Affairs staff serve as a liaison between the thrift industry, consumer and community groups, government agencies and others on housing and community development issues and opportunities; and identify opportunities for thrifts to partner with others in helping to meet financial services needs in their communities. OTS Community Affairs staff interact with many groups representing low- and moderate-income individuals, including older persons.

Community Affairs staff, along with senior management, participated in various forums with thrifts, community organizations and others across the country, including groups with particular emphasis on older persons. At these forums Community Affairs shared information on affordable housing, including affordable housing for seniors, financial services; and economic development needs, including the needs of aging population. Community Affairs also shared information on thrifts' authorities and abilities, and on opportunities for collaborative partnerships, to help meet these needs.
Community Affairs staff serve on an Interagency Predatory Lending Task Force and Consumer Education/Outreach subcommittee. Many low- and moderate-income elderly homeowners are vulnerable to and victims of predatory lending practices. The subcommittee is developing an informational brochure for consumers on how to avoid becoming victims of predatory loans. This brochure will be available on-line for consumer and community groups to download for local distribution.

Other Community Affairs Initiative

Community Affairs staff have been involved with a number of initiatives aimed at educating regulated financial institutions and their community partners about predatory lending, and ways that these entities can help consumers, including elderly homeowners, avoid predatory lenders.

OTS's Community Liaison newsletter spotlights achievements in affordable housing and community development, many of which have benefited older Americans. The newsletter is distributed to all thrifts and to several hundred community and consumer organizations. In 1999 and 2000, the newsletter included articles on the attributes of Electronic Transfer Accounts (ETAs), affecting many older Americans who receive federal benefit or retirement payments, and an article on financial exploitation of elderly adults and ways that financial institutions can help prevent financial abuse of the elderly.

OTS West Region staff has been involved in a number of forums to help educate financial institutions about financial abuse of the elderly and ways to help prevent such abuse.

In 2001, OTS Community Affairs Program will partner with the Federal Reserve Bank of San Francisco and a community-based organization to create an educational video addressing the problem of financial abuse of elderly and dependent adults. Rollout of the video will be coupled with at least one local training session. This video should be available nationwide.

OTS will host a thrift industry leadership conference for thrift CEOs and directors in April 2001. The conference will focus on strategic planning for the future and developing new market opportunities. One of the sessions will focus on maturing baby boomers, and ways that banks can better serve the housing credit and financial services needs of this group.

Other Initiatives

In July and August 1999, OTS Midwest Region senior management participated in seven forums in Houston, TX, sponsored by Representative Ken Bentsen, to educate the elderly about financial schemes and how to avoid fraud and abuse. Other participants included in the SEC, OCC, and representatives of state and local governments.

OTS's Office of the Ombudsman has taken an active role in directing seniors to other resources that can provide assistance with a variety of consumer concerns. Some of the issues the Ombudsman deals with frequently are problems with Social Security benefits, income tax preparation and assistance, information about cashing Treasury obligations, Thrift Savings Plan Accounts, and
accounts held at financial institutions. OTS also works with the state government Ombudsmen to refer consumers with concerns about assisted living and long-term care programs. The telephone number for the OTS Ombudsman is (202) 906-5685; more information is available at www.ots.treas.gov/ombudsman.html.

For many years, OTS has maintained an active program for addressing complaints that consumers may have against the thrifts that OTS regulates. OTS provides a free nationwide consumer hotline (1-800-842-6929), a TDD line (1-800-917-2849), and an e-mail address (consumer.complaint@ots.treas.gov). Professional staff is available to help people evaluate whether OTS regulations address their concerns. If the complaint falls outside of OTS's regulatory jurisdiction, OTS refers the consumer to other resources. Senior citizens are frequent users of this service.

OTS also maintains a Customer Service Plan for consumer complaints and urges the institutions it regulates to give high priority to consumer relations. Of approximately 10,530 complaints filed with OTS in 1999 and 2000, 17 complaints alleged credit discrimination based on age. OTS investigates each complaint in accordance with its expanded procedures for discrimination complaints, interviewing the complainant and reviewing the complainant's loan file. Thirteen of the complaints were reviewed and concluded without a finding of discrimination; four complaints are pending.

OFFICE OF PERSONNEL POLICY

As part of its comprehensive family-friendly Employee Assistance Program, the Treasury Office of Personnel Policy supports and promotes an eldercare program. Eldercare programs provide information on resources available to Treasury employees who care for elderly parents, spouses, or other family members. To help relieve what can be a burden for employees, the program helps Treasury employees identify needed eldercare services (ranging from 'daycare' for older persons to specialized medical attention). This support demonstrates Treasury's commitment as a progressive and family-friendly employer. The Employee Assistance Program also reduces absenteeism and anxiety which employees may experience from caring for an elderly family member, thus enhancing their productivity and benefiting the Treasury Department.
ITEM 14—COMMISSION ON CIVIL RIGHTS

During calendar years 1999 and 2000 the Commission continued to process complaints received from individuals alleging denials of their civil rights. Specifically, in 1999, 15 complaints alleging discrimination on the basis of age were received by the Commission and referred to the appropriate agency for resolution. In 2000, the Commission referred 22 complaints alleging age discrimination.
Chart 4.2: Complaints by Basis

- FY1998
- FY1999
- FY2000

- Other
- Basis not stated
- Unknown
- Reprisal
- Sexual harassment
- Inmates
- Age
- Disability
- Gender
- Religion
- Other race, national, or ethnic origin
- Asian American
- American Indian/Alaskan Native
- Hispanic
- Black
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 one million people age 65 and older are treated in U.S. hospital emergency rooms for injuries associated with products they live with and use every day. The death rate for older people is almost seven times that of the younger population for unintentional injuries involving consumer products. Consumer products used in and around the home are associated with almost 40 deaths per 100,000 persons 65 and older, and over six deaths per 100,000 persons under 65.

Fires and burns in the home

Burns from fires in the home are a significant source of injury to older Americans. In fact, adults age 65 and over are twice as likely to die in fires as all ages combined. CPSC has taken many actions to reduce the potential for fire-related injury and has set the reduction of deaths from fire-related causes as one of its five strategic goals for the period 1995–2005.

CPSC is coordinating a research project to assess current fire alarm technologies and identify potential improvements for future alarms. CPSC recommends that consumers install and maintain smoke alarms on every level of multi-story homes outside sleeping areas and inside bedrooms.

Kitchen fires also cause injury and death to older consumers. To prevent cooking fires, CPSC is evaluating the feasibility of technologies to detect a pre-fire condition and shut the burner off before a fire occurs. CPSC urges consumers to protect themselves by keeping pot handles turned inward, and keeping cooking surfaces and surrounding areas free from clutter and grease build-up. Also, CPSC advises consumers to avoid wearing loose clothing with flowing sleeves while cooking.

Older consumers are at greater risk of dying from fires involving upholstered furniture, mattresses, and bedding than the general population. CPSC is currently acting to address upholstered furniture and mattress and bedding flammability. CPSC has begun a rulemaking proceeding to establish flammability requirements for upholstered furniture. These requirements would address small open-flame ignition from sources such as lighters, matches, and candles.

CPSC is also considering a petition to develop mandatory requirements to address open-flame ignition of mattresses and bedding. A CPSC safety standard addressing cigarette ignition of mattresses has led to a decline in deaths from this ignition source. Open-flame ignition is not addressed by the standard, and deaths
from open-flame ignition remain high. Therefore, CPSC is considering taking additional steps to address open-flame ignition.

CPSC provides safety advice to consumers on steps they can take to prevent fire-related injury. First, CPSC cautions consumers who smoke never to smoke in bed, while drowsy, or while under the influence of medication or alcohol. Further, it advises consumers to use large, deep ashtrays for smoking debris and to let the contents cool before disposing of them. To help prevent burns while wearing nightwear, CPSC advises older consumers to look for nightwear that will resist flames, such as a heavy-weight fabric or tightly-woven fabrics like polyester, modacrylics, or woolen fabrics.

Burns from hot tap water are another cause of injury to many older Americans. CPSC recommends that consumers turn down the temperature of their water heater to 120 degrees Fahrenheit to help prevent scalds.

CPSC provides safety information on its web site and distributes safety publications containing information on these and other hazards. The following are two of CPSC’s popular publications for older consumers:


**Fire Safety Checklist for Older Consumers**, a booklet developed in partnership with AARP (at that time the American Association for Retired Persons) and the National Association of State Fire Marshals. In 1999–2000, CPSC distributed over 60,000 copies in English and Spanish.

**Electrical wiring in older homes**

In 1994–95, CPSC conducted a study of electrical wiring fires in older homes, a subject of particular importance to senior citizens. They frequently live in older homes, which are especially vulnerable to electrical wiring fires. Based on this study, CPSC produced a video entitled *Wired for Safety*, emphasizing hazards with old electrical wiring and safety measures to prevent fire and electric shock. CPSC has distributed about 5,000 copies of the video to electrical safety inspectors, code officials, and others nationwide.

CPSC launched the wiring safety campaign to help prevent the estimated 40,000 home electrical wiring fires each year. These fires claim 250 lives annually. CPSC is working with fire departments, electrical safety experts, and building code officials to encourage electrical reinspections and upgrades to home electrical wiring.

The publication, *CPSC Guide to Home Wiring Hazards*, is available on CPSC’s web site [www.cpsc.gov](http://www.cpsc.gov) and in hard copy. In 1999–2000, CPSC distributed approximately 20,000 copies.

**Adult-friendly poison prevention packaging**

Older consumers are involved in the childhood poisoning issue because many young children are poisoned when they swallow grandparents’ medicine. In fact, about 20 percent of prescription medicines ingested by children under age five belong to grandparents or other relatives. Child-resistant (CR) packaging has saved children’s lives. CPSC has data estimating that the wide-
spread use of child-resistant closures on aspirin and oral prescriptive medicines saved the lives of at least 900 children under age five since 1974 (about 40 or more children saved annually). Net societal savings from this action are estimated at more than $160 million annually, due to prevented deaths. These savings are more than three times CPSC’s 2000 budget of $49 million.

CPSC adopted a new regulation in 1995 to ensure that child-resistant packaging is more “adult-friendly.” Many older consumers found it difficult to open CR packaging and did not replace the caps or use the packaging at all. To make it easier for all adults, especially older ones, to use child-resistant packaging, CPSC changed its rules for testing packaging under the Poison Prevention Packaging Act. The new regulation requires that packaging be tested by panels of adults 50 to 70 years of age rather than 18 to 45 years old, as was previously the case. This change was effective for packaging marketed after January 1998. The change has encouraged the industry to develop innovative closures that rely on older people’s “cognitive skills” instead of their physical strength. CPSC expects the new packaging to help prevent more child poisonings. In addition, CPSC reminds all adults to keep medicines locked up and out of reach of children.

CPSC Chairman Ann Brown awarded commendations to two companies for safety innovations in child-resistant packaging that were especially useful for older consumers. Procter & Gamble received an award for taking the lead in marketing a major product in adult-friendly child-resistant packaging, and Sunbeam Plastics was recognized for developing an entire line of adult-friendly child-resistant packaging.

Recalls of unsafe products

One of CPSC’s most important responsibilities is to recall unsafe products from the marketplace to prevent injuries and deaths. Each year CPSC recalls millions of unsafe products, many of them products that older consumers use in their daily lives. In 1999 and 2000, CPSC conducted recalls of several products commonly used by older consumers, including candles, ceiling light fixtures, in-wall heaters, tool battery packs, vacuum cleaners, power blowers, gas grills, and furnaces. Consumers should check to be sure they do not have these recalled products in their homes. Grandparents should also check to be sure they do not have recalled toys, children’s products, or hazardous used cribs in their homes.

CPSC is able to remove potentially hazardous products from store shelves quickly, but it is much more difficult to get them out of people’s homes. Each spring CPSC conducts a “recall round-up” to remind consumers to check their attics, basements, and storage areas for previously recalled products. Before making any purchases on web auction sites, at yard sales, or in thrift stores, consumers should check to be sure the products have not been recalled. Information on all products recalled by CPSC is available on its web site www.cpsc.gov.

Sports Safety for Seniors

A recent CPSC study shows a 54 percent increase in the number of sports-related injuries suffered by persons 65 years of age and
older between 1990 and 1996—from 34,400 to 53,000. The report shows that most of these increases in injuries to older persons are in connection with more active sports, such as bicycling, weight training, and skiing. In 1998, the CPSC and the American Academy of Orthopaedic (AAOS) Surgeons teamed up to help reverse this trend.

In *Keep Active and Safe at Any Age*, a brochure developed jointly, CPSC and AAOS give older Americans important tips for remaining safe while enjoying the many benefits of exercise. Exercise is beneficial for most people of all ages, and Americans are remaining more physically active into their 70s, 80s, and 90s. Studies cited by the AAOS show that exercise can result in a longer, healthier life, while building stronger bones and reducing joint and muscle pain. Exercise improves mobility and balance, and reduces the risk of falls and serious injuries like hip fractures. However, many injuries can occur while people exercise.

The CPSC/AAOS brochure strongly recommends the use of proper safety gear when exercising or participating in sports. Safety gear is the best way to reduce or eliminate injuries while exercising. For example, bicycling injuries to older Americans increased 75 percent from 1990 to 1996. Most bicycling injuries result from falls. Head injuries accounted for 21 percent of the injuries. Virtually none of the fall victims was wearing a bike helmet. The brochure recommends that bikers always wear a helmet. Injuries associated with exercise activity (aerobics, weight training, etc.) increased 173 percent between 1990 and 1996. The most common types of injuries were falls and strains. The brochure recommends that persons using exercise equipment should read instructions carefully and, if needed, ask someone qualified to help.

In April 2000, CPSC and AAOS turned their spotlight on sports-related injuries to “baby boomers”—those ages 35–54, an age group that includes younger seniors. CPSC released a report showing that sports-related injuries to this age group increased about 33 percent from 1991 to 1998. Seven sports showed significant increasing trends in the number of emergency room-treated injuries to persons in this age group in 1998: bicycling, golf, soccer, basketball, exercise and running, weightlifting, and in-line skating. CPSC estimated there were a total of more than one million injuries to baby boomers in 1998. CPSC and AAOS released a brochure entitled *Boomeritis*, which encouraged persons in this age group to exercise for health, but to use safety gear to prevent sports-related injuries.

In 1999 and 2000, CPSC distributed almost 25,000 copies of *Keep Active and Safe at Any Age*. Copies of the brochure and both CPSC reports can be accessed at the CPSC web site at www.cpsc.gov. *Boomeritis* may be obtained from the American Academy of Orthopaedic Surgeons by calling 1–800–824–BONES (2663).

**Grandchild Safety**

The role of grandparents ranges from occasional babysitting to primary caregiving. A recent U.S. Census Bureau study states that 1.3 million children are being raised by their grandparents, and 3.9 million children under 18 live in grandparent-headed households.
In the years since grandparents were raising their own children, many safety issues have arisen or drastically changed.

As more and more grandparents became caregivers for American children, it became clear there was a need to reach them with critical child development and safety information. In 1997, CPSC Chairman Ann Brown and noted pediatrician T. Berry Brazelton, M.D., head of Pampers Parenting Institute, unveiled the booklet, *A Grandparents' Guide for Family Nurturing & Safety*. This easy-to-read booklet contains important child care and nurturing information for grandparents. It also features a safety checklist with potentially life-saving tips for childproofing homes and protecting grandchildren, from newborns to five-year-olds. This booklet is available on the CPSC web site at www.cpsc.gov in the publications section.

**International Year of Older Persons 1999**

The United Nations (UN) General Assembly recognized “humanity’s demographic coming of age” by adopting 1999 as the International Year of Older Persons (IYOP). The UN encouraged countries, organizations and governments at all levels to observe the IYOP. In 1998, CPSC joined the federal committee to prepare for the International Year of Older Persons, which consisted of 12 cabinet agencies and 15 other federal agencies, commissions, and councils, working to support government preparations for the aging of society.

The CPSC participated in both the media and conference subcommittees. CPSC developed a media sheet that summarized agency programs and activities supporting IYOP. At the official launch event on October 19, 1998, this media sheet was included in the federal committee’s IYOP press kit. The media sheet, CPSC publications and technical reports were used in a number of CPSC exhibits/displays and other CPSC-supported programs around the country during the IYOP to help increase public awareness of the CPSC safety programs CPSC for older consumers. The CPSC also contributed to planning the federal committee’s conference on June 1 and 2, 1999 and participated in panels on grandparent and home safety.

**Safety Information of Interest to Older Consumers**

The following materials have been developed by CPSC and are available to the public on CPSC’s web site www.cpsc.gov or by contacting CPSC as described below.

**Home Safety:**

*Safety for Older Consumers—Home Safety Checklist*—This CPSC booklet gives tips on home safety in a room-by-room checklist format. Although geared for older consumers, it contains important information for people of all ages.

*Fire Safety Checklist for Older Consumers*—Adults age 65 and over are twice as likely to die in fires as all ages combined. CPSC, in partnership with AARP and the National Association of State Fire Marshals, offers this booklet of tips to help protect older Americans and their families from fires.

*CPSC Guide to Home Wiring Hazards*—CPSC estimates that annually there are over 40,000 fires (with about 250 deaths) involving
home electrical wiring systems. Many of these fires occur in homes of older consumers. CPSC offers this guide to help consumers find and correct electrical dangers in their homes before fires or electrical shock occurs.

Grandchild Safety:

A Grandparents’ Guide for Family Nurturing & Safety—The role of grandparents may range from occasional babysitting to primary caregiving. In this helpful booklet, CPSC Chairman Ann Brown and noted pediatrician T. Berry Brazelton, M.D., head of the Pampers Parenting Institute, offer advice to grandparents and a grandchild safety checklist (available on CPSC web site only).

Poison Prevention:

Grandparents! Prevent Your Grandchildren from Being Poisoned safety alert. This one-page safety alert reminds grandparents to keep medicines away from grandchildren to prevent poisonings (available on CPSC web site only).

Sports Safety for Seniors:

Sports-Related Injuries to Persons 65 Years of Age and Older and Keep Active and Safe at Any Age—A recent CPSC study shows a 54 percent increase in the number of sports-related injuries suffered by older Americans between 1990 and 1996—from 34,400 to 53,000. In a companion brochure, CPSC and the American Academy of Orthopaedic Surgeons give older Americans important tips on remaining safe while enjoying the many benefits of exercise.

Baby Boomer Sports Injuries—A CPSC report released in April 2000 showed that sports-related injuries to “baby boomers” aged 35–54 increased 33 percent from 1991 to 1998.

To order materials or contact CPSC:

To order single, free copies of publications, send a postcard with the name of the desired publication to: Publication Request, OIPA, U.S. Consumer Product Safety Commission, Washington, DC 20207. Many publications are available on CPSC’s web site www.cpsc.gov (search for “Older Consumers”). These publications are in the public domain. They may be reproduced in part or in whole by an individual or organization without permission from CPSC.

To obtain safety information or report dangerous products or product-related injuries in English or Spanish, check CPSC’s web site or call CPSC’s toll-free hotline at (800) 638–2772 or CPSC’s teletypewriter at (800) 638–8270 for the hearing and speech impaired. Consumers can also report product hazards to info@cpsc.gov.
ITEM 16—CORPORATION FOR NATIONAL SERVICE

The Corporation for National Service was established in 1993 to engage Americans of all ages and backgrounds in community-based service. It supports a range of national and community service programs, providing opportunities for individuals to serve full or part-time, with or without stipends, as individuals or as part of a team. The Corporation works with Governor-appointed state commissions, nonprofits, faith-based groups, schools, and other civic organizations to provide opportunities for Americans of all ages to serve their communities.

The Corporation’s mission is to provide opportunities for Americans of all ages and backgrounds to engage in service that addresses the nation’s educational, public safety, environmental, and other human needs to achieve direct and demonstrable results and to encourage all Americans to engage in such service. In doing so, the Corporation will foster civic responsibility, strengthen the ties that bind us together as a people, and provide educational opportunity for those who make a substantial commitment to service.

The Corporation’s three major service initiatives are the National Senior Service Corps, AmeriCorps, and Service-Learning.

NATIONAL SENIOR SERVICE CORPS OVERVIEW

The National Senior Service Corps (Senior Corps) is a network of more than half a million seniors who are making a difference as Foster Grandparents, Senior Companions, and Retired and Senior Volunteer Program (RSVP) volunteers. These programs tap the experience, skills, talents, interests, and creativity of seniors age 55 and over. With more than thirty years of experience, the Senior Corps was a pioneer in developing volunteer opportunities for older adults. The Senior Corps continues to serve as a leader in testing and refining new models of senior service that will meet the needs of communities, as well as the interests and priorities of the older adults of today and tomorrow.

The Senior Corps’ three programs provide a wealth of volunteer opportunities to seniors while meeting an array of community needs.

- the Foster Grandparent Program (FGP), established in 1965, links income eligible seniors ages 60 and older to children and youth with special and exceptional needs.
- The Retired and Senior Volunteer Program (RSVP), established in 1971, places senior volunteers age 55 and older to perform a myriad of services, including organizing neighborhood block watches, identifying sources of groundwater contamination, teaching computer classes, tutoring and mentoring
children and youth, and participating in natural disaster recovery.

- The Senior Companion Program (SCP), established in 1974, creates opportunities for income eligible seniors age 60 and older to serve adults in need of extra support to continue living independently and with enhanced quality of life. Additionally, through its Senior Demonstration Programs, Senior Corps tests and pilots innovations in senior service, using the demonstration authority to try elements and program models beyond the scope of its three main programs. These demonstration activities serve as "incubators" for innovation and new ideas, with the intent of incorporating promising and successful lessons into the three existing programs.

In 1999, more than half a million Senior Corps volunteers contributed their time, skills, wisdom and experience to addressing unmet community needs, while emphasizing the impact on both the individuals and the communities served.

Table 1:—National Snapshot of the Senior Corps Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Number of Local Projects</th>
<th>Number of Volunteers</th>
<th>Volunteer Hours of Service to Communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGP</td>
<td>333</td>
<td>28,700</td>
<td>29 million</td>
</tr>
<tr>
<td>RSVP</td>
<td>764</td>
<td>485,000</td>
<td>76 million</td>
</tr>
<tr>
<td>SCP</td>
<td>207</td>
<td>14,700</td>
<td>12.5 million</td>
</tr>
<tr>
<td>Totals</td>
<td>1,304</td>
<td>528,400</td>
<td>119.5 million</td>
</tr>
</tbody>
</table>

1 Source: 1999 Annual Project Profile of Volunteer Activities (PPVA), Corporation for National Service, National Senior Service Corps.

Table 2:—Senior Corps Programs in the Community

<table>
<thead>
<tr>
<th>Program</th>
<th>Number of Local Projects</th>
<th>Number of Census Districts Served</th>
<th>Number of Local Public and Nonprofit Agencies With Senior Corps Volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGP</td>
<td>333</td>
<td>762</td>
<td>10,300</td>
</tr>
<tr>
<td>RSVP</td>
<td>764</td>
<td>1,447</td>
<td>67,500</td>
</tr>
<tr>
<td>SCP</td>
<td>207</td>
<td>567</td>
<td>3,150</td>
</tr>
</tbody>
</table>
| Totals        | 1,304                    | 2,776                            | 80,950                                                                        

FUNDING FOR THE NATIONAL SENIOR SERVICE CORPS: A COST-EFFECTIVE FEDERAL INVESTMENT IN LOCAL COMMUNITIES

The total Federal funding for National Senior Service Corps programs in fiscal year 2000 was $182,819,000, apportioned among each of the three programs as follows:

Table 3:—National Senior Service Corps fiscal year 2000 Federal Funding

<table>
<thead>
<tr>
<th>Senior Corps Program</th>
<th>fiscal year 2000 Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Grandparent Program</td>
<td>$95.8 million</td>
</tr>
<tr>
<td>Retired and Senior Volunteer Program (RSVP)</td>
<td>$46.6 million</td>
</tr>
<tr>
<td>Senior Companion Program</td>
<td>$39.7 million</td>
</tr>
<tr>
<td>Total</td>
<td>$182.1 million</td>
</tr>
</tbody>
</table>

2 Source for fiscal data: FY2000 federal appropriation, Corporation for National Service, National Senior Service Corps.
Senior Corps projects are locally sponsored and administered. Within the broad framework of its legislation, service activities grow out of agreements among the participants, funded projects, and the communities served. As a result, these activities reflect a mix of needs unique to each community.

The community-driven focus is, in large part, a reason for the local non-Federal support enjoyed by Senior Corps programs.

Table 4: Senior Corps Programs and Non-Federal Local Contributions

<table>
<thead>
<tr>
<th>Senior Corps Program</th>
<th>Federal Investment</th>
<th>Non-Federal Local Contribution</th>
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</thead>
<tbody>
<tr>
<td>Foster Grandparent Program</td>
<td>$95.8 million</td>
<td>$37 million</td>
</tr>
<tr>
<td>Retired and Senior Volunteer Program (RSVP)</td>
<td>$46.6 million</td>
<td>$46 million</td>
</tr>
<tr>
<td>Senior Companion Program</td>
<td>$39.7 million</td>
<td>$26 million</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$182.1 million</strong></td>
<td><strong>$109 million</strong></td>
</tr>
</tbody>
</table>

Senior Corps programs allow local agencies to provide greater levels of service within their relatively small operating budgets and demands placed on them as community service providers. The monetary value of the volunteer services provided by Senior Corps volunteers exceeds one billion dollars.\(^3\)

VOLUNTEER OPPORTUNITIES FOR OLDER ADULTS

Twice as many older adults live in the United States today as 30 years ago and the number of persons over age 55 will double again by 2025. Three factors make older persons the nation's best increasing natural resource:

- **Health**—More than 80 percent of Americans age 65 and over report no difficulties with activities of daily living. Less than 5 percent are institutionalized.
- **Time**—Americans are now spending a third of their lives in retirement, freeing an average of more than 20 hours a week to engage in additional activities.
- **Interest**—According to the Independent Sector, a Washington, D.C.-based organization that studies American volunteerism, when persons 55 and older are asked to volunteer, over 70 percent do.

Service by seniors is changing the definition of satisfaction and success in post-retirement, and is increasingly regarded as an essential ingredient in productive aging. For example, in a 2.5 year follow-up of the MacArthur Successful Aging study, participation in volunteer activities was predictive of improved functioning in older adults, with 32 percent lower risk of poor physical function in those so involved, independent of the effective of being physically active. There is preliminary evidence from the same study that the amount of time one is involved in formal volunteering activities is important in conferring health benefits, with greater time involvement predictive of the level of physical functioning 2 years later. Finally, there is evidence that organized and structured roles and behavior are among the best predictors of survival (Fried, Freedman, et. al, 1997). It follows, therefore, that public investment in

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\(^3\)Based on the 1999 Biannual Report, Giving and Volunteering in the United States, Independent Sector, which assigned a comparable value of $14.00 per hour to volunteer service.
volunteer service by seniors is not only prudent, but that it has multiple benefits.

FOSTER GRANDPARENT PROGRAM (FGP)

In fiscal year 1999 nearly 29,700 Foster Grandparents gave care and attention to more than 230,000 children and youth with special and exceptional needs.

PROGRAM OVERVIEW

The Foster Grandparent Program began in August 1965 as a national demonstration effort. Since its inception, the Foster Grandparent Program has provided young and old the chance to grow together. Today, nearly 30,000 older Americans serve as Foster Grandparents. They give care and attention every day to 175,000 children and youth with special and exceptional needs, and served an annual total of more than 230,000 children. In improving the lives of children they serve, Foster Grandparents also profoundly enrich their own lives.

Foster Grandparents volunteer in schools, hospitals, drug treatment centers, correctional institutions, and Head Start and day care centers. They offer emotional support to children who have been abused and neglected, mentor troubled teenagers and young mothers, care for premature infants and children with physical disabilities or severe illnesses, including AIDS. This special care helps young people grow, gain confidence, and become more productive citizens. In the process, Foster Grandparents strengthen communities by providing personalized services to special needs children that community budgets cannot afford and by building strong bridges across generations.

Foster Grandparents must be at least 60 years of age and meet certain income eligibility requirements. They serve 20 hours per week and receive pre-service orientation, training throughout their service, and a modest stipend to offset the cost of volunteering. They receive reimbursement for transportation, some meals during service, an annual physical, and accident and liability insurance while on duty.
NATIONAL PROFILE OF FOSTER GRANDPARENT VOLUNTEERS

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
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<td>Distribution by Gender:</td>
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<td>Female</td>
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<tr>
<td>60-64 years</td>
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<td>Distribution by Ethnicity:</td>
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<td>American Indian/Alaskan Native</td>
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Population Served

<table>
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<tr>
<th>Population Served</th>
<th>Percent (%)</th>
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</thead>
<tbody>
<tr>
<td>Urban</td>
<td>60 percent</td>
</tr>
<tr>
<td>Rural</td>
<td>40 percent</td>
</tr>
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</table>

FOSTER GRANDPARENT PROJECT EXAMPLES

Foster Grandparent Shirley Lewis of New Orleans, Louisiana worked for more than 25 years as a nurse's aide. As a Foster Grandparent, she serves at a group home for teenage girls in crisis. One of her first assignments was 16-year-old Cindy. Cindy was withdrawn, depressed, sullen, the child of drug-dependent parents, and her only passion was a love for animals. Cindy was also a poor student, failing academically. With the patient tutoring and encouragement of her Foster Grandparent, Cindy was able to obtain her GED. “Grandma Shirley” encouraged her through the next few years, as she found work at the zoo, caring for animals. Two years later, Cindy attends Delgado College, working toward a degree as a veterinary technician. She remembers “Grandma Shirley” with love and fondness, as the “real grandmother” who loved her, believed in her, pushed her when she needed it, and took the time to understand and listen. It made all the difference.

IOWA

FGP of Rock Valley Rotary Club, Rock Valley

A significant focus at River Valley School is preparing students to become active participants in society when they leave school. For many students, that means learning how to become a “working” member of society. The students are taught prevocational skills from how to stay on task, to how to complete a task correctly, to how to complete a task timely, etc. Foster Grandparents are assigned to assist these students with their prevocational tasks. Initially, many of River Valley's students need one-to-one supervision and training in order to complete the task assigned to them with a goal of being able to complete the vocational task independently. The 22 Foster Grandparent served a total of 61 children in 1999.

The goal of this program is to give the students real vocational experience so they will be prepared to enter the work force or be able to participate in a sheltered workshop environment.

The types of prevocational skills in which students and Foster Grandparents are involved include:
• School laundry—gathering, sorting, washing, etc.
• Juice—making, distributing, etc.
• Rug making—marking material, cutting material, sewing material, looming, etc.
• Shredding recycled paper—gathering, separating papers, folding papers, and operating the shredding and clipping machines.
• School trash—collecting and disposing
• Recycling—gathering and disposing

MAINE

PROP Foster Grandparent Program, Portland

Eight Foster Grandparents served a total of 175 children in literacy-focused placements in 1999. During the school year, PROP FGP project conducted an evaluation of teachers supervising in-school FGP volunteer tutors. The goal was to assess the impact the FGP program was having on the children with whom Foster Grandparents were working and to determine how effective the Foster Grandparents were as in-school tutors.

The findings confirmed that Foster Grandparents are an integral member of the school community providing support to children with special needs. A summary of the findings were:

• Overall, teachers reported that they observed “significant improvement” in the assigned children.
• When asked to score how much Foster Grandparents contributed to this observed improvement, teachers said that the volunteers contributed in a meaningful manner.
• Foster Grandparents received high scores in improving children’s self-esteem, increasing enjoyment from reading, and increasing self-confidence.

NEVADA

Elvirita Lewis Forum FGP, Reno/Sparks

The Elvirita Lewis Forum (ELF) teamed up with the Foster Grandparent Program to have Foster Grandparents work with the children of families going through Family Drug Court. At present there are 9 volunteers working with 40 children who are placed in foster care while their parents serve out time for drug related convictions. The volunteers work with the children to help them maintain relationships with their parents, and help keep the child actively engaged during the parent(s) absence. Volunteers organize picnics and outings for the children, and when parents are allowed supervised visits with their children, volunteers help organize activities that both the children and parents can enjoy.

In addition to working with the children, volunteers will work with the convicted parents, providing them with emotional support, advice on parenting, and at times educational training, such as helping them study and pass the GED test so they can be better educated.
OREGON

*Rogue Valley Manor FGP, Medford*

In the summer of 1999, the highest risk, economically depressed area of Medford was served by an innovative program called "Kids Unlimited". The summer day camp delivered 8 weeks of activities, grouped into weekly themes called Grandma's Corner, Earth First Club, Reading Clubs, Multicultural Camps, The Creative Corner and Weird Science Club. Foster Grandparent, Joy Burns did such an outstanding job, she was nominated for and received the coveted Jackson County Community Service Award in recognition of her service to youth. Four Foster Grandparents, including Beneva McKinley, Gayle Varang and Nerribee Warner provided vital community service and made a difference in the lives of 150 at risk youth.

PENNSYLVANIA

Many of Pennsylvania's Foster Grandparents served as tutors and mentors in schools, working with students in small groups and one-to-one on such activities as literacy and learning skills. Ninety-four volunteers gave special attention to 948 students, many of whom improved their reading levels and abilities as a direct result. Projects reporting significant impact include:

*FGP of Luzerne and Wyoming Counties, AAA of Luzerne and Wyoming Counties, Wilkes-Barre*

In the Hazleton Area School District, teachers reported that 95 percent of the students served by Foster Grandparents had received a passing grade in reading and math, while 100 percent demonstrated improvement in their self-esteem and work habits. In the Wilkes-Barre Area School District, teachers reported that 22 percent of the students assisted had improved their grade in reading by at least one letter grade, while 82 percent of the students received at least a passing grade in reading, an improvement of 20 percent. Meanwhile, 98 percent of the students demonstrated improvement in their self-esteem, and 90 percent improved their work habits.

*FGP of Montgomery County, Family Services of Montgomery County, Norristown*

Sixty-nine percent of the students served improved their reading levels, 68 percent improved their verbal communication skills, 59 percent improved their math skills, 54 percent improved their written communication skills, and 59 percent demonstrated improved self esteem.

WISCONSIN

*Statewide FGP and the Central Wisconsin Center for the Developmentally Disabled*

The Central Wisconsin Center for the Developmentally Disabled is one of three facilities operated by the Wisconsin Department of Health and Family Services for Wisconsin residents with develop-
mental disabilities. Currently 33 Foster Grandparents are working with 108 young residents to help them develop independent living skills so that they can work and/or live in a community setting. Foster Grandparents also accompany residents on community outings, take them to special functions and help staff during recreational activities. With the support of Foster Grandparents, three Central Wisconsin Center residents attained the necessary independent living skills to transition to a home in the community. After moving into the community, Foster Grandparents will often maintain their relationship with a resident through letters, phone calls and home visits.

SENIOR COMPANION PROGRAM (SCP)

In fiscal year 1999 14,700 Senior Companion volunteers served 61,900 adults in need of additional support.

PROGRAM OVERVIEW

The Senior Companion Program awarded funds to its first projects in August 1974. This program recruits low-income persons age 60 and over to provide assistance and friendship to frail adults, mostly the elderly who are homebound and living alone. The services Senior Companions provide help others to live independently in their own homes instead of moving to expensive institutional care. Senior Companions also provide respite care for short periods of time to relieve live-in caretakers.

By assisting clients with simple chores, providing transportation to medical appointments, and offering needed contact to the outside world, Senior Companions often provide the supportive services that the frail need to continue to live independently. Because Senior Companions spend significant amounts of time with their clients, they are often a critical part of the client's care team. Senior Companions alert doctors and family members of potential health problems, allowing them to provide immediate care to the client.

Senior Companions serve three to four clients in an average week, predominately in the clients' own homes. Community organizations that address health needs of the elderly such as home health care agencies, hospitals, or centers on aging serve as volunteer stations. These organizations identify individuals who need assistance and then work with Senior Companion projects to match them with available Senior Companions.

Like Foster Grandparents, Senior Companions serve 20 hours per week. They also receive pre-service orientation, training throughout their service, and a modest stipend to offset the cost of volunteering. They are provided transportation, some meals during service, an annual physical, and accident and liability insurance while on duty.

Compared with the average cost of nursing home care, which exceeds $38,000 annually, the annual cost for Senior Companion services is $3,850. This is a very cost-effective way to provide supportive services to an average of five frail adults per Senior Companion, who might otherwise be at risk for premature institutionalization.
NATIONAL PROFILE OF SENIOR COMPANION VOLUNTEERS

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Percent (%)</th>
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<tbody>
<tr>
<td>Distribution by Gender:</td>
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<tr>
<td>Female</td>
<td>85 percent</td>
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<tr>
<td>Male</td>
<td>15 percent</td>
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<tr>
<td>Distribution by Age:</td>
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<tr>
<td>60–64 years</td>
<td>16 percent</td>
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<tr>
<td>65–74 years</td>
<td>51 percent</td>
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<tr>
<td>75–84 years</td>
<td>28 percent</td>
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<td>85 and over</td>
<td>5 percent</td>
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<tr>
<td>Distribution by Ethnicity:</td>
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<tr>
<td>White</td>
<td>60 percent</td>
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<td>African American</td>
<td>33 percent</td>
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<tr>
<td>American Indian/Alaskan Native</td>
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<tr>
<td>Population Served</td>
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<tr>
<td>Urban</td>
<td>63 percent</td>
</tr>
<tr>
<td>Rural</td>
<td>37 percent</td>
</tr>
</tbody>
</table>

SENIOR COMPANION PROJECT EXAMPLES

Mr. Ware is a diabetic amputee with failing vision, no family in the area, and who was increasingly depressed and withdrawn. His life was almost entirely isolated until Senior Companion “Nate” came along. Other than going to the doctor, Mr. Ware had not left his house in 8 months. Nate suggested a ride, and the two of them ended up driving through the area, taking the first steps in what would become a strong bond between two aging men: one who needed help and one who needed to be needed.

Nate visits Mr. Ware five days a week. Mr. Ware now gets out of wheelchair, does his own shopping, and goes to the barbershop with Nate. The two men are good friends, and Nate is like family. Mr. Ware’s physical appearance and mental attitude changed vastly, much more like the proud man he once was.

—Senior Citizens Services SCP, Georgia

ARKANSAS

West Central Arkansas SCP, Hot Springs; Central Arkansas SCP, North Little Rock Garland County SCP, Rock Garland

These three Senior Companion projects mobilize 236 volunteers who provide in-home care for 472 clients, helping delay or prevent institutionalization. They provide personal care, light housekeeping, meal preparation, transportation to medical appointments, shopping and banking, and provide respite and hospice care. Respite care is especially important for primary caregivers who are in a highly stressful situation. Nineteen Senior Companions were given special training in providing personal and respite care for both the client and the caregiver. In addition, four Leaders provide 340 home visits, and each client family received 3 telephone reassurance calls each week. Pre-and post-stress tests were given the primary caregiver and virtually 100 percent showed lower stress levels thanks to the assistance of Senior Companions.
IDAHO

Panhandle Health District Senior Companion Program, Coeur d'Alene

Many elderly who require respite care are in jeopardy of institutionalization without help from the Senior Companion Program. Under this program, 80 Senior Companions provide respite care, companionship, and assistance with daily living activities such as meal preparation and light chores, to 240 clients and caregivers. Companions also help clients maintain healthy eating and exercise plans, provide transportation, and locate resources for both clients and caregivers. As a result of Senior Companion volunteers, caregivers receive relief from the 24-hour care of a loved one, helping them maintain more balance in their own lives.

KENTUCKY

Blue Grass Community Action Agency Senior Companion Program, Frankfort

Prior to the start of its 1998 grant year, the Blue Grass CAA SCP project surveyed new clients for nutritional health to gauge their risk for involuntary weight gain/loss, poor eating habitats, reduced social contact, diabetes, high blood pressure, and other possible negative factors. After 12 hours of in-service training by local nutrition and health professionals, 15 Senior Companions administered a nutrition screening tool to 25 of their in-home clients who were most at nutritional risk based on the above mentioned factors. During a 5-month period, each client received support from their Senior Companion, who taught them how to prepare and eat balanced meals, shop for healthy foods and exercise regularly. At the end of the 5 month period, the Senior Companions again administered the nutritional risk assessment tool to each client. Results included one-third of those who were at high risk for poor nutritional health moved into the moderate risk category; and 16 percent moved into the good or low risk category.

NEBRASKA

Lincoln Senior Companion Program Eastern Nebraska Senior Companion Program, Omaha

Both Senior Companion Programs in Nebraska provide respite care a time away for caregivers. During one 3-month period in 1999, the Lincoln program alone provided 24 Senior Companions to relieve 42 caregivers an average total of 147.5 hours a week. Most of the caregivers feel that without this support they would be unable to care for their family member at home. Since the cost of paid unskilled respite care is out of reach for many families, the Senior Companions literally stand between the client remaining at home and going to the nursing home.

RETIRED AND SENIOR VOLUNTEER PROGRAM (RSVP)

In fiscal year 1999, a total of 39,847 RSVP volunteers provided assistance and services to 264,495 children as follows:
• 21,354 RSVP volunteers served as literacy tutors to 119,821 children;
• 7,917 RSVP volunteers served as mentors to 55,859 children;
• 4,554 RSVP volunteers assisted 57,742 children through before and after school activities;
• 2,853 RSVP volunteers worked with 19,220 children in child care programs;
• 3,129 RSVP volunteers provided outreach to ethnic groups with limited English proficiency; and
• Reached 43,840 parents through services to their children.

PROGRAM OVERVIEW

The Retired and Senior Volunteer Program (RSVP) was launched in 1971. RSVP matches the personal interests and skills of seniors age 55 and older with opportunities to help solve the problems in their communities and meet the needs of their fellow citizens. RSVP volunteers choose how and where they want to serve—from a few to over 40 hours a week in a wide range of community organizations such as hospitals, youth recreation centers, schools, and local police stations.

RSVP volunteers provide hundreds of community services. They tutor at-risk youth, computerize information systems for community health organizations, get children immunized, teach parenting skills to teen parents, provide respite care for caregivers of Alzheimer's victims, establish neighborhood watch groups, plan community gardens, and a myriad of other community services. Through such efforts, RSVP is meeting community needs that strained local budgets cannot afford to address.

In 1999, over 485,000 RSVP volunteers served through 764 projects sponsored by local public and private nonprofit agencies. RSVP volunteers contributed approximately 85 million hours of service to their communities annually in approximately 1,400 counties nationwide.

NATIONAL PROFILE OF RSVP VOLUNTEERS

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Percent (%)</th>
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<tbody>
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<td>54 percent</td>
</tr>
<tr>
<td>Rural</td>
<td>46 percent</td>
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</tbody>
</table>
RSVP PROJECT EXAMPLES

“More than 40 RSVP volunteers spend time each week in our elementary schools helping children to improve their reading and comprehension skills. The volunteers meet with the children one-on-one. This project is credited with boosting student self-esteem, as well as improving overall reading success. It provides opportunities for positive interaction between older adults and children. The services provided by the RSVP volunteers are a valuable resource to the children in Unified School District #428.”

With a teaching and nursing career, Sandy Smith has many commitments. She is a registered nurse and an instructor at Northwest Technical College in East Grand Forks. However, last winter, she heard about child literacy efforts and became an RSVP volunteer tutor. Ms. Smith admits that she is a “non-traditional” RSVP recruit. She is not retired and significantly younger in age. According to Ms. Smith, RSVP helped to meet her volunteer goals of getting involved with a dedicated community project to help connect her to meaningful programs. “RSVP is easy to work with,” she notes. “RSVP is also a great way to match interests with volunteers, in unlimited opportunities. My interest is reading and tutoring. Someone else may have a background in law enforcement, insurance, tax planning, or home economics. RSVP is a wonderful way to pursue those interests.

INDIANA

RSVP of Daviess County, Washington

Daviess County ranks 87th of 92 Indiana counties in family income, with 54 percent of households living on less than $25,000 annually. Many families are unable to afford immunizations for their pre-school children. The local health department now offers free immunizations and asked RSVP volunteers for assistance at the immunization clinics. Six RSVP volunteers register the children, check immunization records and act as receptionists, calling the children in order of registration. Last year, 3,600 children were immunized, many of them from local Amish and Hispanic communities that previously had low rates of immunization.

LOUISIANA

Calcasieu Parish Police Jury RSVP

Louisiana’s “Shots for Tots” Program set a goal of having 90 percent of 2-year olds immunized by the year 2000. In April, five RSVP volunteers joined forces with local nurses to coordinate monthly clinics in various locations throughout the community in order to make them more accessible to the public. RSVP volunteers “meet and greet” clients and record information on client immunization histories. To date, RSVP volunteers have assisted with nine clinics, providing immunizations to 145 young children.
MONTANA

RSVP of Flathead County, Kalispell

The RSVP of Flathead County, in collaboration with the Agency on Aging, local food banks, and disabled community organizations, put together a Senior Surplus Commodity Program. This initiative was in response to discovery that only 3 percent of those using area food banks were seniors and that problems of transportation, access, and unwillingness to use the food banks even in times of need were major issues. Handicap accessibility is an issue at food banks as well. RSVP volunteers deliver commodities monthly to the homes of seniors and the disabled. The first month of operation saw 144 deliveries and by the third month the RSVP volunteers were reaching 260 people in need.

OREGON

Rogue Valley Manor FGP, Medford

In the summer of 1999, the highest risk, economically depressed area of Medford was served by an innovative program this summer called "Kids Unlimited". The summer day camp delivered 8 weeks of activities, grouped into weekly themes called Grandma's Corner, Earth First Club, Reading Clubs, Multicultural Camps, The Creative Corner and Weird Science Club. Foster Grandparent, Joy Burns did such an outstanding job, she was nominated for and received the coveted Jackson County Community Service Award in recognition of her service to youth. Four Foster Grandparents, including Beneva McKinley, Gayle Varang and Nerribee Warner provided vital community service and made a difference in the lives of 150 at risk youth.

VERMONT

Rutland/Addison, RSVP, Rutland

Rutland/Addison RSVP, sponsored by Rutland Area Community Services, Inc. Rutland READs program. A collaboration between RSVP Volunteers, Volunteer Center Volunteers, A*VISTA and FGP, the program brings volunteer readers into K-grade 2 classrooms in Rutland County to read once a week for 6 weeks. Many volunteers continue to support the classes by acting as mentors to them for the duration of the school year. Other volunteer readers will be working with after school activities and in-school enrollment programs. Volunteer readers go through specific training that provides reviews of books that are appropriate to be read to the age K–2. Rutland Reads program will bug a paperback book for each participating classroom, which have been donated by the Rutland Herald and the Rutland Rotary Club. This past year, 24 RSVP volunteers were involved with Rutland Reads and 457 students participated in group readings and thirty five students were individually tutored. A new program also began this year that brought older students to the schools to read to children during breakfast time for eligible students. One hundred and thirty students participated in this program.
Southeast Wyoming RSVP, Cheyenne

The Cheyenne Community Solar Greenhouse was created due to the arid conditions of southeast Wyoming and the need for vegetation throughout the city. The staff of the Botanic Garden, where the greenhouse is located, provides education in horticulture and landscaping techniques for Cheyenne residents, including RSVP volunteers who serve at the Botanic Garden. The 21 RSVP volunteers spent an average of 330 hours per month planting, cultivating and harvesting seedlings and vegetables. The efforts of the volunteers saved the city $9,230 in initial plant costs the city was able to use to meet other needs. The garden work saved food banks an average of $35 per person served, or a total of $3,850. This saving was then applied to meeting housing and medical needs. Three local food banks estimate they received 315 pounds of produce with community people gleaning what was left over.
ITEM 17—ENVIRONMENTAL PROTECTION AGENCY

No submission from the Environmental Protection Agency
THE UNITED STATES EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

REPORT OF ACTIVITIES

ON BEHALF OF

OLDER AMERICANS

for

Calendar Years 1999 and 2000

to the

Senate Special Committee on Aging
The U.S. Equal Employment Opportunity Commission

INTRODUCTION

The U.S. Equal Employment Opportunity Commission (EEOC) is responsible for enforcing the Age Discrimination in Employment Act of 1967, 29 U.S.C. §621 et seq. (ADEA). The following report details EEOC's activities on behalf of older Americans for calendar years 1999 and 2000. Within EEOC there are three major components through which the agency enforces the ADEA in the private sector: 1) the Office of Legal Counsel, 2) the Office of Field Programs, and 3) the Office of General Counsel. The report summarizes the regulatory and educational activities of these offices, as well as the ADEA administrative and litigation enforcement efforts undertaken by the Commission.
I. OVERVIEW OF THE OFFICE OF LEGAL COUNSEL

A. Mission

The Office of Legal Counsel is the Commission’s principal legal advisor. Its customers are the Commissioners, headquarters program offices, field offices and those affected by Commission-enforced laws, regulations, and policy statements. The Office has two basic functions: (1) To develop policy guidance and provide legal advice regarding the federal employment discrimination statutes, with the ultimate goal of eliminating unlawful employment discrimination through voluntary compliance efforts backed up by a sound and balanced enforcement program; and (2) to serve as the Commission’s in-house counsel.

Policy guidance on the Age Discrimination in Employment Act of 1967 is provided by the Coordination and Guidance Services group, as described below.

B. Policy Development Functions

Coordination and Guidance Services (C&GS), which carries out the Office’s policy development role, operates under the direction of an Associate Legal Counsel. C&GS performs the following Commission functions:

- Administers the Commission’s interagency coordination mandate under Executive Order 12067;
- Serves as central locus for developing Commission policy under all EEOC-enforced statutes, including the Age Discrimination in Employment Act (ADEA);
- Provides policy advice to the Commission, headquarters and field offices; and
- Provides advice to the public in response to written and oral requests, and through public presentations.

C&GS drafts a range of policy documents for the Commission, including:

- Regulations and Guidelines which provide substantive and interpretive guidance;
- Volume II of the Compliance Manual which explains generally how to interpret and apply the laws enforced by EEOC, to assist the public in understanding the laws and EEOC staff in investigating complaints;
- Enforcement Guidelines and Policy Statements which present a more in-depth analysis of particularly complex or novel issues.
• **Formal Opinion Letters**, provided at the discretion of the Commission, which respond to requests from the public for interpretations of the law and EEOC policies on which the requestor may be able to rely as a defense to liability in future enforcement actions.

• **Commission Decisions** which apply and interpret the law and policies in actual cases pending before the Commission.

• **Memoranda of Understanding** with other federal agencies designed to ensure consistent enforcement of the federal employment discrimination laws and to eliminate duplication of effort.

• **Informal advice** to the Commission, its staff, and members of the public through options papers, legal memoranda, responses to correspondence, training, speeches, and other forms of technical assistance and outreach.

II. PROGRAM ACTIVITIES ON BEHALF OF OLDER AMERICANS

A. **Regulations**

**Tender Back Regulation** – On December 11, 2000, the EEOC issued a final regulation that prohibits the return, or "tender back," of consideration in connection with challenges to waivers under the Age Discrimination in Employment Act (ADEA). The new rule addresses the Supreme Court's 1998 decision in *Oubre v. Entergy Operations, Inc.* (522 U.S. 422) and related issues regarding waivers.

An ADEA waiver is an agreement between an employer and employee in which the employee gives up the right to pursue an age discrimination claim against the employer in exchange for severance, early retirement benefits, or something else of value. Employees are often asked to sign waivers in connection with layoffs or RIF's. Under Title II of the Older Workers Benefits Protection Act of 1990 (OWBPA), which amended the ADEA, Congress permitted these waivers if they met a series of specific requirements.

In *Oubre*, the Supreme Court ruled that an older worker is not required to return, or "tender back," severance payments before filing suit under the ADEA and that keeping the payments does not constitute ratification of the agreement. Consistent with that ruling, the regulation provides that an employer may not require an employee to return, or "tender back," severance pay or other benefits and may not subject the employee to other financial penalties for challenging a waiver's validity in court. The rule does, however, permit an employer to recover attorney's fees if a challenge is filed in bad faith. It also sets out standards regarding when an employer may obtain restitution of funds it has paid an employee.

By providing detailed guidance on the tender back issue, this regulation will enhance the ability of both employers and employees to understand and comply with the law. The
regulation's detailed approach will also be helpful to courts deciding suits filed to challenge the validity of waivers. The regulation follows a negotiated rule issued by the Commission in June 1998, that prohibited tender back when an older worker files a charge with the Commission.

B. Compliance Manual Sections

Compliance Manual Section on Employee Benefits – On October 3, 2000, the Commission issued a new section of its Compliance Manual on Employee Benefits. The new section addresses issues related to discrimination in benefits under all of the statutes enforced by the Commission, with particular focus on issues arising under the Age Discrimination in Employment Act. The section analyzes discrimination claims in life and health insurance benefits; long-term and short-term disability benefits; severance benefits; pension and disability retirement benefits; and early retirement incentives.

The section represents the Commission’s first comprehensive treatment of many of the most significant benefits issues under the anti-discrimination laws. The section explains in detail, for example, the limited circumstances in which employers are permitted to provide lower benefits to older employees than to younger workers. It discusses, for example, the reasons for and operation of the equal cost/equal benefit rule; the circumstances in which one age-based benefit may be offset from another benefit; and the ways in which early retirement incentives may be structured lawfully. The section also addresses when employers may make disability-based distinctions in their benefit plans. The section makes clear, on the other hand, that employers may never take race, sex, national origin, or religion into account in making benefits decisions.

The section provides an accessible analytical framework for investigating charges involving employee benefits, and makes clear -- through plain language explanations and numerous examples -- the often dense and technical provisions that govern age discrimination cases in the benefits area. By providing a practical, step-by-step, sequential approach to benefits discrimination issues, the section helps to demystify these issues and further educate employees and employers about their rights and responsibilities in this important area of the law.

Compliance Manual Section on Compensation Discrimination – On December 8, 2000, the Commission issued a new chapter of its Compliance Manual to address claims of compensation discrimination under all of the statutes enforced by the Commission, including the Age Discrimination in Employment Act. The new section sets forth a comprehensive and clear approach to processing claims of discrimination in wages or other forms of compensation, and will be of significant benefit to Commission investigators, attorneys, and stakeholders.
C. **Interagency Coordination Efforts**

**Cash Balance Pension Plans** – Throughout this period, Commission staff from numerous offices have actively participated in an interagency task force established to consider and address the numerous issues related to employers' adoption of cash balance pension plans. In these plans, which have been growing in popularity in recent years, employers typically convert traditional defined benefit plans—plans that promise a specified benefit upon retirement, based on a formula derived by the employer—into defined benefit plans in which each employee has a hypothetical individual account. The amount of the benefit is based on hypothetical employer contributions to the hypothetical account, plus interest at a specified rate of return.

Numerous charges have recently been filed challenging conversions from traditional defined benefit to cash balance pension plans. Commission staff has been actively studying the issues in these charges to determine whether, or under what circumstances, cash balance pension plans are unlawful. Commission staff has been coordinating closely with the Department of Labor, the Department of the Treasury, and the Internal Revenue Service, among others, in analyzing these issues.

D. **Analysis and Advice**

**Age Discrimination Against State Government Employees** – In January 2000, the Supreme Court issued a decision in *Kimel v. Florida Board of Regents* (120 S. Ct. 631) holding that Congress lacked the power under the Fourteenth Amendment to the United States Constitution to abrogate state sovereign immunity to suits by individuals under the Age Discrimination in Employment Act. As a result of the *Kimel* decision, suits by applicants and employees of state government entities have been severely limited.

Commission staff took an active role in analyzing the *Kimel* decision and its impact on Commission enforcement activities. The Commission has made clear, for example, that nothing in *Kimel* affects the Commission's authority to sue states for age discrimination. The Commission intends to continue to vigorously enforce the age discrimination laws.
III. OVERVIEW OF THE OFFICE OF FIELD PROGRAMS

A. Mission

The Office of Field Programs (OPF) oversees the EEOC’s private sector programs of administrative enforcement for Federal statutes prohibiting discrimination in employment, including the Age Discrimination in Employment Act. The Office provides overall direction, coordination, leadership and administrative support to administrative enforcement activities in 24 District Offices, the Washington Field Office and 25 Area and Local Offices.

B. Functions

The Office is responsible for the following functions:

- Makes recommendations for Commission policy related to the implementation of the laws the Commission enforces and translates substantive policy into operational form through development of procedures and manuals for guidance to the field staff.

- Develops and provides guidance, advice, technical assistance, and education for the field, other headquarters offices and members of the public on EEOC’s administrative enforcement process and the laws EEOC enforces. Coordinates these activities with pertinent headquarters offices.

- In conjunction with field offices, develops operational plans and budgets and implements approved plans relevant to: EEO charge resolution processes for Title VII of the Civil Rights Act of 1964, as amended (Title VII), the Equal Pay Act of 1963 (EPA); the Age Discrimination in Employment Act of 1967, as amended (ADEA); and the Americans with Disabilities Act (ADA).

- Coordinates with other headquarters and field offices to ensure the development, implementation and maintenance of appropriate systems that result in effective and efficient management of the Commission’s charge resolution programs.

- Coordinates with the Office of General Counsel to assure the effective integration of the investigative and legal staff activities in all aspects of the enforcement program.

- Develops and administers substantive staff development programs for managers and employees.

- Coordinates with the Office the Chief Financial Officer and Administrative Services (OCFOAS) to assure efficient delivery of budgetary and general administrative services to field offices.
Manages and coordinates the Commission's administrative enforcement Alternative Dispute Resolution (ADR) program and provides support and technical assistance for the program.

Manages the Revolving Fund for technical assistance programs in coordination with appropriate Commission offices.

Directs and supervises all aspects of field office administrative enforcement operations.

C. Policy Framework for Enforcement Activities

During 1999 and 2000, field offices continued implementation of the agency's National Enforcement Plan (NEP), the Commission's framework for policy priorities ratified in 1996. The NEP employs a three-pronged approach for addressing the agency's mission: (1) prevention of discrimination through enhanced education, technical assistance and outreach to the employer community, advocacy groups, and other stakeholders; (2) the eradication of discrimination through investigation, conciliation, and litigation of charges with significant impact; and (3) effective caseload and inventory management, including effective use of Alternative Dispute Resolution methods, to allow the Commission to focus substantial resources on those matters having the greatest impact.

In addition, the EEOC formulated and began implementation of an agency-wide Comprehensive Enforcement Program (CEP) to improve all aspects of agency operations in both the private and federal sectors. A central aspect of the CEP is the strategically focused integration of agency resources, to increase collaboration among staff in all agency functions, from outreach through resolution of cases.
At the core of the private sector CEP is coordinating enforcement and litigation efforts, sustaining a commitment to mediation-based alternative dispute resolution, and establishing strong partnerships with state and local Fair Employment Practices Agencies (FEPAs.) An integral aspect of the CEP is the close collaboration between investigators and attorneys in providing effective outreach, education, and technical assistance; faster and more effective resolution of charges; and vigorous enforcement of the law when employers fail to voluntarily take corrective action.

The CEP builds on the success of the Priority Charge Handling Procedures (PCHP) and the NEP. Through the implementation of the CEP, the Commission further reduced the pending inventory of private sector charges and lowered the average processing time while increasing settlements between aggrieved parties and employers.

In 1999 and 2000, field offices designed new approaches to outreach and education and substantially increased their efforts in this area, including new outreach initiatives intended to reach previously under-served groups. Field offices also implemented an expanded nation-wide mediation program. In 2000, the District Offices updated their own Local Enforcement Plans (LEPs), which are tailored to local issues and situations that fall within the scope of the NEP. The revised LEPs are based on guidance jointly developed the Office of Field Programs and the Office of General Counsel.

By 2000, after five years of implementation of the agency's Priority Charge Handling Procedures (PCHP), the agency realized extraordinary gains in reducing its charge inventory. Prior to implementation of the PCHP, in June 1995, the agency had a pending inventory of
111,451 charges. At the end of the 2000 calendar year, the inventory stood at 41,021, an astonishing 63% reduction. This was accomplished by focusing on closing non-meritorious charges from the inventory as quickly as possible, referring the majority of charges to mediation, and focusing investigations on the development of category “A” charges—those with the highest likelihood of violations or significant impact on deterring or eradicating discrimination. By 2000 the workload consisted of more complex charges requiring a better trained workforce, as almost no non-meritorious charges remained.

The major trends in EEOC’s overall enforcement activity during 1999 and 2000 are reflected in enforcement of the Age Discrimination in Employment Act (ADEA). These trends include significant reduction of the agency’s pending charge inventory, reduction in charge processing time, an increase in settlements and in monetary benefits for charging parties, increased use of mediation to resolve charges, and expanded outreach and educational activity.

IV. HIGHLIGHTS OF ADEA ADMINISTRATIVE ENFORCEMENT ACTIVITY

Major achievements during these two years included:

- **Continued reduction of the pending charge inventory.** At the end of 2000, the inventory of ADEA charges pending resolution was reduced by 1,894 from the level at the end of 1998 (down from 10,627 charges at the end of 1998 to 8,733 charges at the end of 2000).

- **Reduction in the age of charges in the pending inventory.** At the end of 1998, the average ADEA charge in the inventory was 278 days old. By the end of 2000, the average age had been reduced to 198 days.

- **Reduction of the time required to resolve cases.** Average processing time for ADEA charges was reduced by 125 days—from 314 days at the end of 1998 to 189 days at the end of 2000.

- **An increase in mediated charges also dramatically reduced the time for resolving charges.** The average processing time for mediated ADEA charges in 2000 was only 137 days, compared to 189 days for ADEA charges resolved through other means.

A. Charge Receipts

In 1999, the Commission received 14,777 ADEA charges, representing 18.8% of the 78,711 charges received under all statutes that year. Approximately 50% of the ADEA charges also alleged discrimination under another statute enforced by the Commission (e.g. discrimination based on sex, disability, race).
In 2000, 17,070 ADEA charges were received (21% of total charge receipts). Slightly less than half of these charges also alleged discrimination under another Commission statute.

B. Discrimination Issues

Discriminatory discharge was by far the most frequent issue in ADEA charges (40% of all charges in each year). This is consistent with experience under all Commission statutes. Other significant ADEA issues, in order of frequency, were: Terms and Conditions of Employment; Harassment; Hiring; Promotion; Layoff; Compensation; Disciplinary Actions and Demotion. In 2000, there were a considerable number of concurrent ADEA charges (those filed under ADEA and another statute) that also alleged sexual harassment discrimination under Title VII of the Civil Rights Act, and concurrent charges alleging failure to provide reasonable accommodation under the Americans with Disabilities Act (ADA).

C. Charge Resolutions

The Commission resolved 18,611 ADEA charges in 1999, comprising 18% of all charge resolutions for the year. In 2000, there were 18,633 ADEA resolutions – 20% of total resolutions for the year.

D. FEPA Receipts and Resolutions

The Commission has dual filing agreements with state and local fair employment practices agencies (FEPAs) who process charges filed under the ADEA and laws that they enforce. These agencies received 10,102 ADEA charges in 1999 and resolved 8,958 charges. In 2000, FEPAs received 9,847 ADEA charges and resolved 8,987.

E. Monetary Benefits

In 1999, EEOC obtained total monetary benefits of $49,514,087 under the ADEA for 2,286 individuals, through settlements, conciliations and withdrawals with benefits. The average benefit per ADEA charge ($21,650) was significantly higher than the average benefit per charge under all EEOC statutes ($15,030).

In 2000, total ADEA monetary benefits of $56,208,331 were obtained for 2,590 persons. As was the case in 1999, the average ADEA benefit per charge ($21,702) was considerably higher than the average benefit per charge under all EEOC statutes ($9,733).
EEOC and FEPA Charge Activity

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*Benefits rounded to nearest million.

F. Mediation Accomplishments

In 1999, the Commission fully implemented its nation-wide expanded mediation program. Thanks to the support of the President and the Congress, the Commission received a $37 million dollar increase in its budget, the largest in the agency’s history. This increase in funding enabled the agency to substantially expand the mediation program, building on the successes the agency achieved during the previous three years under a modest mediation program. Mediation offers a neutral, less formal and faster means of resolving charges of discrimination.

The Commission had several objectives for the mediation program in 1999.

- **Expand the Program** - One of the objectives was to expand the mediation program so that a greater number of charges could be resolved through the program. The agency’s experience with mediation demonstrated that it is a fair and efficient means of resolving charges. Furthermore, the parties like the mediation process because they, rather than a third party, decide whether and how to resolve the charge. The Commission’s goal was to double the number of charges referred to the mediation program over the number that were mediated in fiscal year 1998.
Implement a National Program - A second objective was to develop and implement a consistent national mediation program, based on core principles adopted by the Commission in its 1995 policy statement. The agency also wanted to develop and implement nationwide standards and procedures for the operation of the program, and various changes to ensure confidentiality, neutrality, and consistent mediator qualification standards.

Outreach and Education - Another objective was to conduct an extensive outreach and education program to publicize the new expanded mediation program in order to increase charging party and respondent acceptance rates. While most charging parties are interested in mediation, only 35% of the employers opt for this method of resolving charges.

The mediation program has been a tremendous success. Mediations of ADEA charges significantly increased from only 299 in 1998 to 1,131 in 1999 and 1,333 in 2000. Total monetary benefits in ADEA mediated cases rose from $5.4 million in 1998, to $16.9 million in 1999 and $26.7 million in 2000. The average monetary benefit in 2000 ADEA mediated cases was $20,774.

Most significantly, the average resolution time from charge filing to final resolution was much shorter for mediated cases. In 2000, the average time for ADEA mediated cases was 138 days, compared to an average of 191 days for all ADEA charge resolutions.

G. Examples of ADEA Mediated Resolutions

The charging party, a 58 year old salesman/trainer, alleged that his employer, a retailer, failed to promote and discharged him because of his age. The charging party alleged that the younger employees he was training were being promoted ahead of him. When he sought promotion to either of two available positions, he was told "you don't understand, those jobs are for younger men." The mediated settlement included back pay in the amount of $30,000 and an agreement to provide positive information to prospective employers, including specifically that charging party was a "valued employee... and is recommended for rehire."

The agency successfully mediated a charge filed by a 64 year old applicant for the position of Art Director for a cruise line. The charging party alleged that his interview with the Recruiter lasted only three minutes and that the first thing the Recruiter said to him was "How old are you? This job is too labor intensive for someone your age." The charge was successfully mediated for $3,500.

The agency successfully mediated a charge filed by a woman who alleged that her wages were reduced and a cap was placed by her commissions because of her age. The mediation resulted in an agreement to pay the charging party $15,000 in
bonuses; increase her annual pay by $5,000, and pay attorney fees amounting to $2,500.

* The Charging Party alleged that after many years of outstanding job performance, he was discharged from his position as a Sales Manager because of his age. Mediation resulted in a monetary settlement of $85,000.

* The Charging Party alleged that he was denied a promotion to a supervisory position on the basis of age, in favor of an individual with less experience. Mediation resulted in a monetary settlement of over $68,000 in salary and benefits plus attorneys fees. In addition, the Respondent gave the Charging Party written assurance that he could remain employed with the Respondent until retirement, or if a reduction in force occurred, he would be entitled to two years of severance pay and benefits valued at over $450,000.

H. Other Examples of ADEA Administrative Charge Resolutions

The following is a sampling of other non-mediated resolutions of age discrimination charges in EEOC field offices during 1999 and 2000. Consistent with the agency Priority Charge Handling Procedures (PCHP) and national/local enforcement plans, innovative strategies and techniques were frequently utilized in the processing and resolutions of these charges.

* The Atlanta District Office successfully settled an ADEA charge for $100,000 in total monetary benefits. The Charging Party filed a charge alleging that his employer, a large petroleum company, laid him off because of his age. During the course of the investigation, the employer agreed to settle the charge prior to the issuance of a determination.

* The Baltimore District Office successfully conciliated an ADEA charge in which the Charging Party alleged that his job was eliminated and he was denied a promotion because of his age. The employer agreed to provide the charging party a temporary position so that he could complete the time needed for retirement, and monetary benefits totaling $40,799.

* The Birmingham District Office conducted an investigation against an employment agency that placed an advertisement in various local newspapers seeking "recent college graduates." The district office found that the ad violated the ADEA and successfully conciliated the charge.

* The Cleveland District Office settled an ADEA charge in which the Charging Party, a full professor at a university, alleged that the Respondent reassigned his lab research to a younger employee and gave him a minimal pay increase in order to force him to retire. The charge was settled for $227,000 in monetary benefits.
The Denver District Office successfully conciliated an ADEA charge in which the Charging Party alleged discriminatory failure to hire on the basis of age for $29,288.

The Los Angeles District Office settled an age discrimination charge in which the Charging Party alleged that older workers were discriminated against in a company-wide layoff. The charge was settled with monetary benefits totaling over $230,000, including an upward adjustment in the Charging Party's pension benefits and a lump sum payment.

The Memphis District Office conciliated an ADEA directed case filed against a major interstate package carrier with nation-wide facilities. The company had targeted college students in its advertisements for package handlers and its written policies suggested that recruitment efforts should be made at colleges and high schools. Respondent agreed to pay $300,000 to an estimated 227 affected class members. Significantly, although the investigation included only the company's facilities located in two states within the jurisdiction of the Memphis District Office, the respondent agreed to make employment data available from facilities in ten other cities (where the illegal advertising was done). The respondent also agreed to advertise in those areas for older workers who may have been discouraged from applying previously. The company also agreed to make job offers as employment opportunities become available, cease the student preference in its advertising, change its personnel manual relating to recruitment, distribute the changes to all manual holders, and create and maintain a reporting form for purposes of tracking its progress in complying with the ADEA.

The Miami District Office successfully resolved an ADEA charge alleging discriminatory discharge on the basis of the Charging Party's age, 55. After extensive negotiations with the Respondent, the charge was resolved for $35,000.

The Milwaukee District Office investigated and successfully resolved a charge filed by a female manager who alleged that the Respondent discriminated against her on the basis of her sex and age when it subjected her to different terms and conditions of employment. Specifically, the Charging Party alleged that as the only female manager, she was not given the level of authority, profit-sharing benefits, and salary increases as male managers. The charge was settled for $110,000 and other non-monetary benefits.

The New Orleans District Office began an investigation as a result of an inquiry from an individual about a waiver and release agreement used in a layoff that prohibited employees from filing charges with EEOC. After an investigation, the district office determined that the employer's waiver and release agreement violated the Older Workers Benefit Protection Act. The District Office successfully conciliated the charge by requiring the employer to remove the
discriminatory language, notifying individuals who were affected by the layoff and offer them an opportunity to contact the EEOC to allege violations of the ADEA.

- The Philadelphia District Office successfully conciliated a class case in which a company and union agreed to give laid off employees who are not eligible for an immediate company pension and Social Security benefits priority for job vacancies at other plants in the company. The case was resolved for $925,000 in monetary benefits, and the elimination of the discriminatory policy.

- The Phoenix District Office settled an ADEA case against a major corporation alleging discriminatory evaluations because of age. The settlement provided monetary benefits of $178,000.

- In a San Antonio District Office case, the charging party alleged that he was involuntarily retired because of his age. The case was resolved and monetary relief of $125,000 was obtained for the charging party.

- The Seattle District Office successfully conciliated an age and sex discrimination charge for $52,000 in backpay and compensatory damages.

I. Cash Balance Pension Plans

In 1999, the Commission established a national task force of EEOC experts to address the issue of whether older workers who are closer to retirement are discriminated against on the basis of age when employers convert from traditional pension plans to cash balance plans, which may reduce the expected retirement benefits of older workers while increasing the benefits allotted to younger workers. The task force was established to intensify the agency's analysis of the issues, and to facilitate coordination with other agencies with authority over pension plans, such as the Departments of Treasury and Labor and the Internal Revenue Service. As of year end 2000, the agency had received 873 charges challenging the legality of cash balance pension plans.

J. Outreach, Education and Technical Assistance

Field office outreach, education and technical assistance expanded significantly during 1999 and 2000. During these two years combined, field staff participated in more than 4900 outreach activities reaching more than 390,000 persons. These activities included speeches, workshops, training seminars, representing EEOC at events of other organizations, and dissemination of informational materials.

During calendar years 1999 and 2000, the Commission participated in 63 educational, training and outreach events that specifically addressed the issues and concerns of older workers. Nearly 2,000 (1,978) older workers attended these events. In addition, the Commission provided information concerning the Age Discrimination in Employment Act (ADEA), including
involuntary retirement, early retirement incentives, pension benefits, and waivers of ADEA rights at an additional 363 events.

Field offices also expanded contacts with a broad range of stakeholders to obtain their views on issues and customer service. Several offices established mechanisms for regular input and communication with employer, advocacy and community based organizations. Regular meetings, Advisory Councils and Task Forces brought EEOC information on stakeholder concerns and provided them with information on EEO law, policy and procedures.

- The Albuquerque office made a presentation on age discrimination at the New Mexico Women's Conference.
- The Birmingham office provided an overview of the Age Discrimination in Employment Act to the annual conference of the Alabama Commission on Aging.
- The San Jose office made a presentation at the Elder Law Program in Santa Clara County, California. This office provided information on age discrimination at conferences addressing the "Digital Divide."
- Several offices, including Albuquerque, Birmingham, Charlotte, Cleveland, Denver, Indianapolis, Philadelphia, San Francisco, St. Louis and Washington, D.C., provided information and counseling to advocates for older workers and/or to potential charging parties who were older workers while conducting "expanded presence" activities, i.e., events in areas which have been identified as underserved. For example, the St. Louis office included older worker groups in its Community Forums in Godfrey, IL and Independence, KS, and the Philadelphia office included older worker groups in its "Creating an Informed Community" program in Erie, PA. The Denver office made a presentation on Disability Discrimination and the Aging Workforce in Missoula, Montana.
- Albuquerque, Charlotte and Detroit, have partnered with advocacy groups such as the NAACP, the Urban League and the Hispanic/Latin Forum, as well as the United Auto Workers (UAW) to address the concerns of older workers. The New Orleans office made a presentation on the rights of older workers in conjunction with the Hispanic Apostolate.
- Many offices conducted stakeholder input activities with groups representing the interests of older workers to establish and maintain ongoing contact with and to obtain input from this group of stakeholders. Activities included advisory councils, open houses, community meetings, and regular stakeholder meetings.
Several offices have partnered with state and local government agencies to reach older worker groups. For example, the San Francisco office made a presentation on age discrimination in conjunction with an event sponsored by the California Department of Fair Employment and Housing.
V. OVERVIEW OF THE OFFICE OF THE GENERAL COUNSEL

A. Mission

The Office of General Counsel (OGC) was established by the Equal Employment Opportunity Act of 1972, which amended Title VII of the Civil Rights Act of 1964 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 (EPA) and the Age Discrimination in Employment Act (ADEA). With the enactment of the Americans with Disabilities Act (ADA) in 1990, the General Counsel was granted responsibility for Commission litigation under that statute as well.

The mission of the Office of General Counsel is to conduct litigation on behalf of the Commission to obtain relief for victims of employment discrimination and to ensure compliance with the statutes that EEOC is charged with enforcing. Under Title VII and the ADA, the Office of General Counsel is empowered to bring suit against private employers with 15 or more employees. The General Counsel's authority under the ADEA and the EPA includes state and local government employers as well as the private sector.

B. Responsibilities of the General Counsel

The General Counsel is responsible for managing, coordinating and directing the Commission's enforcement litigation program. He or she also provides overall guidance and management to all the components of the Office of General Counsel, including 23 legal units located in field offices. In directing the litigation program, the General Counsel is responsible for developing litigation strategies designed to attain maximum compliance with federal laws prohibiting discrimination in employment. The General Counsel recommends authorization of litigation to the Commission and approves litigation for filing under the Commission's delegation of authority to the General Counsel under the National Enforcement Plan. The General Counsel also reports regularly to the Commission on litigation activities, including issues raised in litigation which may affect Commission policy, and advises the Chairperson and Commissioners on litigation, policy, and other matters affecting the enforcement of the statutes the Commission is responsible for enforcing.
C. District Office Legal Units

The Commission currently has 24 District Offices, each containing a legal unit which conducts Commission litigation and provides advice and other legal support to the District Office enforcement units, which are responsible for investigating charges of discrimination. Legal unit attorneys work closely with the enforcement units in receiving and investigating charges as well as responding to Freedom of Information Act requests. Each District Office legal unit is under the direction of a Regional Attorney (GS-15). The Regional Attorney manages a staff of one to two supervisory attorneys, five to fifteen attorneys, and support staff. Since 1999, the Regional Attorneys also manage attorneys stationed in nineteen local or area offices. In addition, some Regional Attorneys supervise a Hearings Unit, which is composed of administrative judges who conduct hearings on claims of discrimination in federal employment.

VI. ADEA LITIGATION HIGHLIGHTS

A. Litigation Statistics

In Calendar Year (CY) 1999, the Commission filed 41 ADEA lawsuits. Twelve or 29.3% of these cases were filed on behalf of multiple aggrieved parties. Seven were filed under another statute concurrent with ADEA. During the same time period, the Commission resolved 42 ADEA cases; 15 or 35.7% had been on behalf of multiple aggrieved parties and ten had been filed under another statute concurrent with ADEA. Through these resolutions, the Commission obtained monetary benefits in 1999 in the amount of $45.8 million.

In CY 2000, the Commission filed 30 ADEA lawsuits. Thirteen or 43% were filed on behalf of multiple aggrieved parties and seven were filed under another statute concurrent with ADEA. During the same time period, the Commission resolved 42 ADEA cases, of which 12 or 28.5% had been filed on behalf of multiple aggrieved parties and eight under another statute concurrent with ADEA. The Commission obtained monetary benefits in the amount of $3,949,987 in 2000 from ADEA lawsuits.

B. Supreme Court ADEA Decisions

Reeves v. Sanderson Plumbing Products, No. 99-536 (S. Ct. June 12, 2000). In this private ADEA action, the Supreme Court unanimously reversed the Fifth
Circuit and upheld a jury verdict of willful age discrimination in favor of Roger Reeves. Consistent with the position urged by the Solicitor General and the EEOC as *amicus curiae*, the Court held that "a plaintiff's prima facie case, combined with sufficient evidence to find that employer's asserted justification" for a challenged employment action "is false, may permit the trier of fact to conclude that the employer unlawfully discriminated." The court of appeals "erred in proceeding from the premise that a plaintiff must always introduce additional, independent evidence of discrimination."

C. Significant Appellate and Amicus Briefs Filed

In 1999, the Commission filed six briefs in ADEA cases on appeal and in 2000 filed 14 ADEA briefs, nine as *amicus curiae* and five in cases on appeal. The following appellate and *amicus curiae* briefs were filed in calendar years 1999 and 2000 in appellate courts on significant issues under the ADEA.

**EEOC v. AT&T Co., et al.**, Nos. 98-4348 and 98-4367 (6th Cir. Filed December 23, 1998 as appellant and February 12, 1999 as Reply)

**Background:** The Commission brought this public enforcement action pursuant to §7(b) of the ADEA, claiming that the company unlawfully relied on age in determining eligibility for a post-termination employee benefit. The lower court granted summary judgment in favor of the defendants.

**Argued:** The Commission argued that it was entitled to summary judgment on liability because the evidence showed that the defendants relied on an age-defined factor - pension eligibility - in denying a post-termination benefit to the charging party and other laid-off workers. Every circuit court to consider the issue has agreed that an employer engages in age discrimination as a matter of law when the employer bases a decision on a factor that is explicitly defined, in part, by age because age is then a but-for cause of the decision. The Supreme Court has also indicated that reliance on pension status constitutes age discrimination where pension status is age-defined. Reliance on a factor that is defined in part by age constitutes age discrimination as a matter of law.

**Decided:** A divided panel of the Sixth Circuit, in an unpublished opinion, affirmed the grant of summary judgment against the Commission. The court rejected the argument that the defendant's reliance on pension eligibility constituted age discrimination as a matter of law, seeing no distinction between a case in which the factor relied upon is defined exclusively by years of service (as was the case in *Hazen Paper Co. v. Biggins*) and a case in which the factor is defined by age and years of service (as was true in the instant case).

**Lee and EEOC v. California Butchers' Trust Fund**, Nos. 96-16408, 96-1652 and 97-15272 (9th Cir. Filed January 8, 1999)
**Background:** The EEOC as intervenor alleged that the Pension Fund violated the ADEA by reducing Lee's pension benefits because of his age. In calculating his benefits, the Fund cut off the date of accrual as of 1990, when Lee was 70 ½ even though he continued to work until 1992. Rejecting the Fund's argument that it was not covered by the ADEA, only by ERISA, the Court of Appeals found that the Fund was liable under both statutes. Agreeing with the Commission, the court determined that the Fund, established by employers and unions, is covered by the ADEA as a "combination," a special coverage term applicable only in §623(i), which prohibits the reduction of pension benefits on the basis of age. The Fund petitioned for rehearing arguing in part that the court's decision is inconsistent with Ninth Circuit law and will disrupt the uniform application of ERISA.

**Argued:** The Commission argued that the Court of Appeals need not rehear the case because it had correctly held that the Fund is covered as a "combination" of employers and unions, consistent with the plain meaning and purpose of the provision. Further, the Court's holding will not disrupt the application of ERISA. The Supreme Court has held that ERISA does not preempt federal anti-discrimination law. Finally, the Fund has not indicated that it could not comply with the parallel provisions of the ADEA and ERISA.

**Decided:** Rehearing en banc denied.

_EEOC v. McDonnell Douglas Corp._, No. 98-3897 (8th Cir. Filed February 23, 1999).

**Background:** During an 18 month period beginning in May 1991 and ending in February 1993, the company laid off approximately 1500 employees. Statistical studies showed that employees 55 and older were more than 2 ½ times as likely to be laid off as younger employees. Witness testimony indicated that older workers were selected for layoff because of their age, because they were eligible to retire and/or because they had received lower merit raises, while higher merit raises had historically been given to younger employees. The district court dismissed the EEOC's disparate impact claim, ruling that to be viable, the claim must allege an impact against the entire protected class, rather than only against employees 55 and older. The court found insufficient evidence to allow the disparate treatment claim to go to a jury, rejecting the statistical evidence and ruling that the "most significant statistic" was the difference in the percentage of older employees in the workforce before and after the RIF. The court also found irrelevant the evidence that employees were terminated because they were eligible to retire. According to the court, laying off retirement eligible employees is legal under the ADEA.

**Argued:** Because the ADEA prohibits discrimination because of age, not membership in the protected class, a practice that has a significant disparate impact on individuals 55 and older may violate the law. Second, EEOC's statistics, comparing the layoff rates for comparably performing older and younger employees, were probative. Contrary to the lower court's holding, the difference between the percentage of older employees in the workforce before and after the RIF is the kind of bottom line statistic that courts have found is not conclusive evidence in a discrimination case. Finally, an employer violates
the ADEA when it terminates employees because they are eligible to retire, particularly in this case where retirement eligibility is based on age and years of service.

**Decided:** The Court held that, to be viable, disparate impact claims under the ADEA must allege an impact against all employees age 40 and older and that, despite evidence that employees 55 and older were much more likely to be RIF'd than younger employees, there was insufficient evidence to support a claim for disparate treatment.


**Background:** The plaintiff signed a settlement agreement in which he agreed to leave his job with Gustafson and to release it from any and all claims that he had or may have against it. Subsequently, he applied for another job with the company. When Gustafson rejected him, he filed a charge of age and disability discrimination with the EEOC. In response, Gustafson sued him for breach of the settlement agreement. The district court ruled that the company had not engaged in retaliation cognizable under the ADEA or the ADA by filing its lawsuit, reasoning that retaliation is only actionable if it is an “adverse employment action, defined within the Fifth Circuit as an “ultimate employment decision.” Shortly after, in an unrelated case, the Fifth Circuit ruled that “the filing of a lawsuit cannot be an ‘adverse employment action’ . . . because it is not an employment action at all.” *EEOC v. R.L. Gallagher Co.*, 181 F.3d 645, 657 (5th Cir. 1999). The plaintiff then file a petition for hearing en banc on the portion of his retaliation counterclaim challenging the validity of the company’s lawsuit.

**Argued:** The federal anti-discrimination laws prohibit retaliation for the filing of an EEOC charge even when the retaliation does not involve any form of employment action. The Fifth Circuit’s rule is wrong because the federal anti-retaliation provisions say nothing about requiring an “adverse employment action.” The Court should consider this issue en banc because the EEOC’s enforcement cannot function properly if reduced statutory protection makes individuals afraid to file charges.


**Background:** The district court dismissed this case for failure to state a claim, ruling that the plaintiff could not establish a prima facie case of discrimination under the ADEA because at the time he applied for a job with the defendants, he “was not authorized to work in the United States” and thus was not qualified for employment as a matter of law. Additionally, the defendant argued that the ADEA does not cover the decision of an American employer to deny employment to a foreign national who tenders his application in his country of origin but seeks a job in the United States.

**Argued:** The district court erred in ruling that the plaintiff’s claim was defeated on the issue of prima facie qualifications. The plaintiff cited direct evidence that he was screened out of the hiring process because of his age. Further at the time of the alleged
discrimination, the plaintiff was lawfully seeking employment within the United States under an H2-A visa program codified in the IRCA. Finally, the ADEA covers a decision by an American employer to deny a job to a foreign national applying for employment in the United States, even when tendering his application in another country.

D. Significant District Court and Appellate Court Resolutions by Issue

1. Mandatory Retirement

**EEOC v. Johnson & Higgins.** No. 93 Civ. 5481 (LBS) (S.D.N.Y. July 29, 1999). In this ADEA case, the district court earlier held that the defendant, an insurance brokerage and employee benefits consulting firm, had unlawfully requiring that its employee-directors retire at the earlier of age 62 or age 60 with 15 years of service. See 887 F. Supp. 682 (S.D.N.Y. 1995). That decision was affirmed on appeal. See 91 F.3d 1529 (2d. Cir. 1996). In 1999, the parties entered into a consent decree, which required the defendant to rescind its mandatory retirement policy and which provided $28 million to a class of 13 individuals.

**EEOC v. California State University.** No. 97-35772 PJI (N.D. Cal. August 13, 1999). The EEOC alleged in this suit that the university violated the ADEA by requiring participants in its early retirement program to stop part-time teaching when they reached age 70. The case was resolved through a settlement agreement in which the university agreed to pay $90,000 in back pay and offer reinstatement into its part-time teaching program to the one former faculty member whose complaint had not been previously resolved. The university also agreed to cease enforcing a mandatory retirement age for employees participating in the program.

**EEOC v. Memorial Park Cemetery Asso.,** No. 99:CV-049.-B (E) (N.D. Okla. January 28, 2000). The Commission alleged in this ADEA action that defendant discharged charging party pursuant to a mandatory retirement policy when he reached age 70. The case was resolved through a consent decree providing charging party with a total of $49,960 in back pay and liquidated damages. Defendant also agreed to guarantee charging party employment for two years as a consultant, which will provide him with an additional $53,459 in compensation. Defendant further agreed to rescind its mandatory retirement policy.

**EEOC v. Webb County.** No. CA-L-98-44 (S.D. Tex. April 24, 2000). This case was filed in Laredo, an underserved town in southern Texas bordering Mexico, and involved claims that five low wage employees - golf course maintenance workers - were fired because of their age and retaliated against after they filed charges of discrimination when the county refused to rehire them. The county paid the five individuals $125,000 and rescinded its policy requiring workers to retire when they reached age 70.
2. Benefits

**EEOC v. Thomson Consumer Electronics, Inc.,** No. IP 99-0884 C/T/G (N.D. Ind. August 17, 1999). This ADEA case alleged that the company, a manufacturer of television sets and components, provided lower severance payments to older workers than those provided to its younger workers when closing a plant. The consent decree resolving the case provided $7.1 million dollars in monetary relief to the 800 claimants.

**EEOC v. AT&T, et al.,** No. 98-4348 (6th Cir. March 22, 2000). In this case, the Commission alleged that the defendants engaged in unlawful age discrimination by basing eligibility for a post-termination benefit on a factor, pension-eligibility, that is explicitly defined, in part, by age. The company laid off several of its Communications Technicians in 1991. When the union protested, the company agreed to allow some individuals to return to work; for those who elected not to return, the company agreed to provide “a Period of Absence Option Payment.” In addition, those employees who were not pension-eligible received a “Non-Return Incentive,” while pension-eligible employees were excluded from receiving this benefit. A divided panel of the Sixth Circuit, in an unpublished opinion, affirmed the grant of summary judgment against the Commission.

The court rejected the argument that the defendant’s reliance on pension eligibility constituted age discrimination as a matter of law, seeing no distinction between a case in which the factor relied upon is defined exclusively by years of service (as was the case in *Hazen Paper Co. v. Biggins*) and a case in which the factor is defined by age and years of service (as was true in the instant case).

**EEOC v. Commonwealth of Massachusetts.** No. 99 CV 11233 RGS (D. Mass. January 27, 2000). The EEOC alleged that the State of Massachusetts denied accidental disability retirement allowances to otherwise eligible employees because of their age. A Massachusetts statute provided that employees permanently unable to work because of an on-the-job injury are eligible for accidental disability retirement unless they have reached the “maximum age for [their] group.” The maximum ages range from 55 to 70, depending on the employee’s job classification. The court granted summary judgment on liability to the Commission, holding that the State’s use of maximum ages to limit an individual’s eligibility for and entitlement to benefits under the statute has violated the ADEA since October 16, 1992, the date the Older Workers’ Benefit Protection Act became applicable to the States. The court permanently enjoined the State from using any individual’s age to restrict or otherwise limit his or her entitlement to benefits under the statute. The court retained jurisdiction to determine questions concerning individual damages claims and the availability of liquidated damages.

**EEOC v. Deer Park Union Free School District,** No. 95 CV 0092 (E.D.N.Y. March 29, 2000). The EEOC alleged that defendant’s collective bargaining agreement (cba) contained a provision which discriminated against older workers by reducing the amount of accumulated sick leave teachers would receive upon retirement, depending on the year of eligibility in which a teacher retired. The court granted summary judgment on liability to the Commission. The cba permitted teachers to retire upon reaching age 50 with at least
10 years of retirement credit. Teachers retiring in their first year of eligibility were compensated for 100% of their accumulated sick leave, those retiring in the second year 80%, those retiring in the third year 75%, and those retiring from the fourth year on 70%. Rejecting defendant's argument that the reductions in accumulated sick leave were based on years of service rather than age, the court found that age was the trigger for the reduction in compensated sick leave of teachers because any teacher with ten or more years of retirement credit became eligible at age 55 for retirement. The court also concluded that although the retirement incentive offered in the CBA was voluntary, the reduction of sick leave benefits as the age of the participants increased conflicted with the purposes of the ADEA and thus arbitrarily discriminated on the basis of age.

**EEOC v. Hickman Mills Consolidated School District No. 1, No. 98-1296-CV-W-3** (W.D. Mo. May 24, 2000). This case alleged that early retirement incentive plans (ERIPs) administered by defendant school district from 1989 through 1996 discriminated on the basis of age. The court granted summary judgment on liability to EEOC. Defendant's ERIPs for teachers, administrators and support staff during 1989-91 reduced an employee's lump sum retirement benefit by 5% of the employee's base pay for each year he or she worked beyond the first year of eligibility; the plans during 1992-96 conditioned eligibility on an employee's eligibility for full unreduced retirement under a separate plan that permitted unreduced retirement only during the first year of eligibility. The court found the 1989-91 plans facially discriminatory and, relying on statistical evidence presented by EEOC's expert, found that the 1992-96 plans had a disparate impact on older employees ("as age at retirement went up, the average percent and dollar amount of benefits went down"). The court also found evidence of intentional discrimination based on language that stated one of the plans' purposes was to "provide for a more balanced staff age blend."

**EEOC v. New York State and Local Retirement System, No. 98-CV-966** (N.D.N.Y. June 21, 1999). The lawsuit alleged that the state agencies which administered the retirement system for New York state employees used age-based factors in calculating death benefits and disability retirement benefits that resulted in lower benefits for older individuals. The parties resolved the dispute through an Agreed Order that required the state of New York to retroactively pay $20.8 million in additional death benefits and $193,258 in additional disability retirement benefits to bring its benefits payments into compliance with the ADEA.

**Arnett et al. v. California Public Employees' Retirement System, et al., No. 98-15574** (9th Cir. June 2, 1999). The Commission filed an amicus brief in this ADEA case to argue that when a policy on its face requires the employer to consider an employee's age in determining the level of disability benefits, it constitutes unlawful disparate treatment (absent a statutory defense), regardless of whether plaintiffs can show age-based animus in the adoption of the policy. The Ninth Circuit agreed that the policy required a lower level of benefits solely because of the plaintiffs' older age at hire and, accordingly, reversed and remanded the case.
Erie County Retirees Ass'n v. County of Erie, 220 F.3d 193 (3d Cir. Aug. 1, 2000). In this case, the Commission filed an amicus brief, arguing that the ADEA covers retirees who are subjected to discrimination in the provision of employer-provided retiree health benefits by virtue of their status as former employees. The employer had required its retired employees who were Medicare-eligible to join an HMO-only plan while allowing retired employees who were not yet Medicare-eligible the choice of remaining in an arguably more favorable traditional indemnity plan. The Commission also argued that, because Medicare eligibility is an age-defined factor, an employer engages in age discrimination as a matter of law when it relies upon Medicare eligibility in making distinctions in the provision of retiree health benefits. The Third Circuit agreed with both arguments, ruling that an employer's adverse actions taken against someone who has ceased actively working for that employer may constitute discrimination against an "employee." The court also decided that because Medicare-eligibility is explicitly defined at least in part by age, the defendant had discriminated on the basis of age as a matter of law by relying on Medicare-eligibility to make distinctions in providing employment-related health benefits.

Solon, et al. v. Gary Community School Corp., 1999 WL 384162 (7th Cir. 1999). In this ADEA case, the Commission filed an amicus brief in support of the plaintiffs-appellees, arguing that the Seventh Circuit should affirm the district court's holding that defendant Gary Community School Corporation's ("Gary Schools") early retirement incentive plans ("ERIPS") violated the ADEA. The Commission argued that the early retirement incentive plans discriminated against older workers in violation of the ADEA, and added that the plaintiffs had Article III standing to maintain this lawsuit. The Seventh Circuit agreed with the Commission on both points, and affirmed the district court's decision almost in its entirety, reversing only the district court's decision to deny relief to plaintiff Paul Bohney.

3. Hiring

EEOC v. Enterprise Rent-A-Car, No. SA99CV1088EP (W.D. Tex. June 7, 2000). The Commission alleged that the rental car company refused to hire applicants 40 years of age and older for management trainee positions. The case was resolved through a consent decree in which the company agreed to a goal of hiring 30 protected age group (PAG) individuals over the next three years and to pay a total of $300,000 in monetary relief to approximately 600 PAG applicants denied employment.

EEOC v. Kroger Co., No. 3-98CV0242-L (N.D. Tex. August 10, 1999). This action alleged violations of both the ADEA and the Americans with Disabilities Act. The grocery store required applicants for warehouse positions at a distribution facility to undergo medical tests before receiving a job offer and to pass a step test that used age as a scoring factor. To resolve allegations that the step test violated the ADEA, the store agreed to consider alternative physical ability tests that do not use age in the scoring formula; if the company and the EEOC cannot agree to an alternative test, they will submit the dispute to an expert panel in the fields of ergonomics, exercise physiology, medicine,
and/or test measurement and evaluation. To resolve the ADA allegations, the company agreed to conduct its physical abilities test after offering applicants conditional employment in writing. Additionally, the store agreed to provide $240,000 in monetary relief to 21 applicants who failed the step test in 1994.

In this ADEA action, EEOC alleged that the university refused to rehire charging party as an advisor in its office of student athlete support services because of his age, 47. The case was resolved through a consent decree providing charging party with $50,000 in monetary relief. The decree also provides that charging party and his dependents will be covered under the university’s health and dental insurance plan for three years, that charging party’s dependent child and spouse will be eligible for the course fee courtesy program, and that the university will assist charging party in obtaining another job.

**EEOC v. Village of Somerset, Wisconsin**, No. CA-00-C-5845 (W.D. Wis. November 17, 2000). The EEOC alleged that the Village refused to hire the charging party for a public works laborer position because of his age, 59, instead hiring a 21-year old with much less experience. The charging party had worked for 35 years drilling wells and repairing pumps. Additionally, he had been chairman of the Village’s Department of Public Works for six years and had even supervised the Department’s work crew while the Village searched for a Leadperson. During the charging party’s interview for the position, Village officials focused on how long he intended to continue working and indicated their preference for a younger employee whom they assumed would stay longer on the job. After the Commission filed suit, the Village agreed to settle the case by providing the charging party with $108,000 in monetary relief and by training its officials and Board of Trustees on lawful interviewing and hiring procedures.

4. Layoffs

This ADEA case alleged that defendant, a manufacturer of aircraft engines and parts, engaged in a pattern or practice of age discrimination against employees age 40 and older during its 1993-94 layoffs at two plants. The case was resolved through a consent decree providing $3 million in back pay, interest and liquidated damages, $3 million in increased monthly pension benefits to 48 charging parties; and $1 million in increased monthly pension benefits to approximately 3,000 affected individuals who did not file charges. Prior to resolution of the suit, defendant had rehired approximately 150 of the protected age group individuals laid off.

5. Termination

**EEOC v. Promus Hotel Corp.**, No. CV95-1860 (W.D. Wash. April 24, 2000). The EEOC alleged in this ADEA action that the hotel fired its catering manager because of her age, 54. The case was resolved through a settlement agreement providing the manager with $50,000 for EEOC’s ADEA claim and an additional $28,750 for private claims.
6. Promotion

**EEOC v. Tharaldson Employee Management Co.** No. H-00-2711 (S.D. Tex. June 6, 2000). This suit, dually filed under the ADEA and Title VII, alleged that the company failed to promote an employee from a guest service agent position at a Hampton Inn to assistant general manager because of her age, 45, and her race, black. The case was resolved through a consent decree providing the employee with $75,000 in monetary relief and an offer of the first available assistant general manager position in the geographic area near her residence.

7. Retaliation

**EEOC v. Lee County.** No. 99-248-CIV-FTM-24D (M.D. Fla. July 24, 2000). This case resulted from outreach efforts toward a local plaintiffs’ bar association and a local legal educational organization. The EEOC alleged that the county had fired an employee in retaliation for claiming that he was not promoted because of his age and then fired his supervisor who testified on his behalf in an internal proceeding. Subsequently, the county refused to hire the spouses of each employee, who had applied for different jobs with the county, because their husbands had filed charges of discrimination with the EEOC. The parties resolved this case by consent decree which required the county to provide $500,000 in monetary relief for the four individuals. The county also agreed to train its managers in the requirements of the laws prohibiting employment discrimination.

**EEOC v. Shopko Stores, Inc.** No. 97-C-119 (E.D. Wis. March 31, 1999). This suit involved allegations that the company fired a loss prevention district manager because of his age (52) and subsequently refused to hire him as a loss prevention manager because he had filed a charge of age discrimination regarding his discharge. Although the court found for the company on the discharge claim, the parties resolved the retaliation claim by a consent decree that provided the manager with $75,000 in monetary relief.

**EEOC v. Tempel Steel Co.,** No. 98 C 7542 (N.D. Ill. June 15, 1999). The EEOC filed suit against this company claiming that it had fired four security guards because they had contacted the Commission about filing age discrimination charges. The company agreed to resolve this case by providing the guards with $255,000 in nonpecuniary compensatory damages.

8. Disparate Impact Theory

**EEOC v. Forest Grove School District No. 15.** No. 98-497-KI (D. Or. February 3, 1999). This school district adopted a policy for teachers’ salaries that used academic credit hours as a factor. The formula for determining the salaries, however, excluded academic hours earned before November 1972, which the EEOC claimed had an unlawful disparate impact on older teachers. Granting summary judgment to the defendant, the district court determined that the disparate impact theory of discrimination was not cognizable under the ADEA. After finding that the Supreme Court’s decision in *Hazen*
Paper Co. v. Biggins raised doubts about the theory's viability under the ADEA, the court noted that the Ninth Circuit had also shown hesitancy on the issue and determined to look to other Circuit Courts for guidance. Although the district court acknowledged that two circuits (the Second and the Eighth) continued to recognize the theory after Hazen Paper, it found they did so based on precedent developed before Hazen. The lower court found more persuasive the four circuits (the First, Sixth, Seventh and Tenth) which had ruled that the theory was not available under the ADEA. Citing the First Circuit's reasoning in Miller v. Rantheon Co., the district court agreed that disparate impact liability under the ADEA would nullify the statute's "reasonable factor other than age" defense.

EEOC v. McDonnell Douglas Corp., No. 98-3897 (8th Cir. Sept. 14, 1999). A panel of the Eighth Circuit affirmed the judgment dismissing the Commission's disparate impact and disparate treatment claims in this ADEA action alleging that McDonnell Douglas discriminated against employees 55 and older because of their age in a reduction in force. The Court held that, to be viable, disparate impact claims under the ADEA must allege an impact against all employees age 40 and older and that, despite evidence that employees 55 and older were much more likely to be RIF'd than younger employees, there was insufficient evidence to support a claim for disparate treatment.

9. Mandatory Arbitration

Rosenberg v. Merrill Lynch, Pierce, Fenner & Smith, Inc., 170 F.3d 1 (1st Cir. February 24, 1999). In this case, the Commission filed an amicus curiae brief arguing that the plaintiff could not be required to arbitrate her ADEA or Title VII claims pursuant to a mandatory arbitration agreement she was forced to sign as a condition for working for the employer. The First Circuit agreed with the Commission that the arbitration agreement was unenforceable as to the claims under both statutes. The First Circuit reasoned that the waiver of rights was not "knowing" as required under the 1991 Civil Rights Act because the agreement did not refer specifically to employment claims.
ITEM 19—FEDERAL COMMUNICATIONS COMMISSION

SUMMARY OF 1999 AND 2000 ACTIVITIES AFFECTING OLDER AMERICANS

This report summarizes the significant activities in 1999–2000 of the Federal Communications Commission ("FCC" or "the Commission") affecting older Americans.

The Commission continued to take actions to implement statutory requirements or Commission policies on behalf of the general public and all telecommunications consumers. These include the millions of Americans with some kind of hearing, vision, speech or other disability, many of whom are older Americans. Since many older and aging Americans may experience some loss in one or more sensory function, such as in hearing, speech or vision, they may benefit greatly from the various disability-specific, consumer protection actions undertaken by the Commission in 1999–2000.

Consumer Information Bureau (CIB)

CIB is a new bureau created in 1999 to enhance the public's understanding of the Commission's programs. The new bureau represents a consolidation of functions that had been scattered across several other Commission units, including the Commission's Gettysburg National Call Center, the Public Service and Reference Operations Divisions of the former Office of Public Affairs, the informal complaint functions in the Wireless Telecommunications and Common Carrier Bureaus, and the various offices which previously handled public information requests throughout the Commission. The Commission created CIB based on the conviction that consumers, including senior citizens, can only benefit from increased competition and the resulting proliferation of new services and devices if they have information that is adequate to enable them to make informed choices on which a free market system depends.

Outreach and Consumer Education.—CIB provided extensive outreach and consumer education in 1999–2000 on Commission programs and policies in a variety of ways. CIB hosted several major forums providing a unique opportunity for consumers, including older Americans, and industry to share best practices on a number of issues, including those concerning telephone billing and customer service. For example, in June 2000, CIB held a national forum on telephone company customer service. The forum was designed to provide feedback to telephone companies' top management on the effectiveness of their customer service centers, and to receive a commitment from these carriers to improve their customer service. Panelists at the forum included representatives from the senior citizen, Hispanic and disability communities, all of whom shared their customer service experiences and challenged
local, long distance, and wireless telecommunications service providers to initiate efforts to better serve consumers.

In addition, CIB in 1999–2000 made special efforts to convey the Commission's message beyond the "beltway" by addressing consumer, industry, and governmental audiences at over 40 conferences across the nation. One of these conferences was the national conference of the American Association of Retired Persons held in Florida. CIB took special care to make senior citizens aware of these fora and conferences by distributing written materials and contacting senior citizen organizations directly.

Revised Fact Sheets.—CIB also undertook a project to consolidate and revise all of the Commission's nearly 200 "Fact Sheets" about various issues, practices and policies to make them more reader friendly. It also provided easy access to these documents through its Consumer Centers and on the Commission's website. CIB also broke new ground in initiating the translation of its documents into multiple languages to reach consumers, including seniors, from various cultures. In addition to its own initiatives, CIB provides technical and writing support to other FCC bureaus and offices in their efforts to expand consumer education about FCC regulatory programs.

CIB is continuing to explore new ways to reach out to and meet the needs of all Americans. These include mechanisms that will help senior citizens realize the benefits of an increasingly competitive telecommunications marketplace.

Creation of Disabilities Rights Office (DRO)

In 1999, the FCC created as part of the Consumer Information Bureau the Disabilities Rights Office ("DRO"). The DRO consolidates disability-related activities and policy matters previously spread among the various Bureaus and Offices of the FCC.

The DRO works to protect consumers with disabilities, provides technical assistance to consumers and entities on their rights and responsibilities with regard to disability accessibility provisions in telecommunications law, and provides comprehensive policy analyses to ensure access to persons with disabilities.

In the 1999–2000 period, the DRO provided service to consumers in all 50 states and the District of Columbia, Puerto Rico and the Virgin Islands. It also provided technical assistance to consumers in Australia, Canada, Denmark, Italy, the Netherlands, Nigeria, South Africa, Sweden, and the United Kingdom. In 2000, the first year the DRO maintained statistics, it processed nearly 1,200 inquiries and complaints on disability-related telecommunications matters.

Disability Initiative: An Accessible FCC.—A key prong of the FCC's disability initiative is to ensure access to FCC documents and processes by people with disabilities and other functional limitations, such as individuals who are aging. Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability in federally assisted programs and activities. It was amended in 1978 to extend its coverage to programs and activities conducted by federal executive agencies. The DRO led FCC compliance with Section 504 which also benefits many older Americans seeking access to FCC services.
Compliance with Section 504 in providing accessible information for consumers and employees requires that the Commission convert printed materials into accessible, alternative formats, and provide sign language interpretation of spoken or audio information.

**Accessible Documents.**—During 2000, the Commission processed approximately 200 requests for accessible documents or sign language accessibility. These documents were provided in Braille format or put on audiocassette for either an employee of the agency or an interested customer of the FCC with a disability or sensory limitation. Older Americans made many of these requests. The kinds of documents made accessible included legal documents, such as releases of FCC reports and statutory rules and regulations, general FCC documents, such as public notices, announcements or statements, as well as specific consumer-oriented information documents, such as fact sheets and consumer guides.

Other material made accessible included publicly available FCC documents such as employee orientation and training materials, the FCC phonebook, and correspondence to and from the Commission. Access was provided in alternate formats such as Braille, large print, audiocassette, electronic disk format and sign language interpretation. For example, the FCC reformatted the Commission's Part 97 Rules for Amateur Radio Services into Braille, ASCII text and large print for many individuals with vision disabilities. Sign language interpretation is more usually carried out by the Office of the Managing Director; however, DRO provides a specialized interpreter for *ex parte* meetings, and for small conferences and meetings where sign language interpretation requires extensive knowledge of the technical background of the subject under discussion.

**"One-Stop Shop" Access.**—In 1999, the DRO aggregated disability-specific telecommunications information on a dedicated and accessible FCC web site at [http://www.fcc.gov/etb/dro](http://www.fcc.gov/etb/dro) that includes agency rules, recent actions, and consumer information. This web site is usable by people with vision disabilities who use adapted equipment and is designed to be consumer-friendly for any person, including older Americans. Examples of items on the DRO web site include DRO's release, in May 2000, of "A Consumer's Guide to Relay Services" and, in September 2000, of "Consumer Tips on Filing a Section 255 Complaint." These materials translate legal documents into plain English and are more usable by individuals experiencing loss of hearing, speech and vision, common among older Americans.

Additionally, to ensure broader access and to open up FCC processes to consumers with physical limitations, the DRO established an electronic listserve, DRO INFO, for the disability community and interested others. This provides free updates on any disability-related item at the FCC via routine electronic mailings. Similarly, the creation of a single E-mail address (access @fcc.gov) as a point of entry for inquiries also assists in providing a "one-stop shop" for access to FCC activities and events for people with disabilities and with other functional limitations resulting from aging.

**Rulemakings.**—Rulemakings were a critical prong of the FCC's disability initiative in 1999–2000. Rules providing for disability access benefit individuals with hearing, speech, vision and other dis-
abilities, and benefit many individuals with functional limitations as a result of aging. The 1999–2000 rulemakings in which the DRO participated addressed requirements for consumers with hearing, vision, speech and other disabilities across communications modes such as telephony and television. Described below are the FCC's new rules and other actions adopted in 1999–2000 for: (1) telecommunications manufacturers and service providers for disability access, pursuant to Section 255 of the Communications Act, as amended by the Telecommunications Act of 1996; (2) expansion of closed captioning into digital television; (3) video description of video programming; (4) emergency access for E911–TTY digital wireless connections; (5) emergency access to video programming; (6) telecommunications relay services that include new services such as Spanish Relay, Speech To Speech and Video Relay Services; and (7) new 711 nationwide access. Other items described below include (8) carrier of choice; (9) hearing aid compatibility rules; and (10) reports and a Notice of Inquiry on advanced telecommunications services that will facilitate access to electronic communications for older Americans.

Rulemaking efforts involved FCC staff from multiple bureaus such as the Common Carrier Bureau and its Network Services Division, the Cable Services Bureau, the Wireless Telecommunications Bureau and staff from the Office of Engineering and Technology. Additionally, FCC rulemakings involve consultation with members from industry, the disability community and other communities, such as from organizations and individuals representing the needs of older Americans. Rules issued by the agency in this two-year period, 1999–2000, establish the United States as a world leader in ensuring access to telecommunications for people with disabilities, sensory limitations, and other problems of older Americans in the 21st century.

1. Section 255.—In August 1999, after an extended, proposed rulemaking period, the agency released final rules to implement Section 255 of the Communications Act of 1934, as amended by the Telecommunications Act of 1996. Section 255 requires all manufacturers of telecommunications equipment and providers of telecommunications services to ensure that, if “readily achievable,” telecommunications equipment and services must be designed, developed and fabricated to be accessible to, and usable by, individuals with disabilities. If it is not readily achievable to do this, telecommunications equipment manufacturers and service providers must make their equipment and services compatible with the equipment commonly used by individuals with disabilities. The rule included a Notice of Inquiry (NOI) to aid understanding of the access issues presented by communications services and equipment not covered by the rules adopted in the Order. The inquiry seeks input on aspects of communications technology that may present new accessibility issues, such as telephony that uses computer-based equipment that replicates telecommunications functionality and any other innovations in telecommunications that may present accessibility challenges for people with sensory or physical limitations.

As part of its implementation of Section 255, the FCC launched a new web page on the DRO web site, www.fcc.gov/cib/dro, listing
the disability contact persons at telecommunications manufacturing and services provider companies covered by the Section 255 rules. This listing makes for easy access to the industry by individuals with functional limitations who have inquiries and complaints about products and services. Additionally, to ensure greater understanding of the statutory provisions for access, the Commission held an in-house enforcement training session in May 2000 for all FCC employees and has conducted training with its staff of Consumer Advocacy Mediation Specialists (consumer center representatives) on disability access and Section 255.

The Report and Order on Section 255 ensures that most agency rulemakings and activities are reviewed for disability accessibility implications. For example, a June 2000 Public Forum on telephone customer service included as a panel topic the disability usability obligations under Section 255.

2. Closed Captioning of Digital Television.—In July 1999, the Commission proposed standards for closed captioning on digital television so that people who use captioning due to their sensory limitations will be able to choose the color, font, size, and language of their captions. After comment and review, the Commission on July 21, 2000, issued Closed Captioning Requirements for Digital Television Receivers in a Report and Order on Video Programming Accessibility. In this action, the Commission amended its rules to require closed captioning display capability in digital television receivers. This will ensure that closed captioning services will continue to be available to consumers as the transition from analog to digital video progresses in the television industry.

3. Video Description.—In September 1999, the Commission released a Notice of Proposed Rulemaking on Video Description. Video description refers to the narrated description of key visual elements in a television program, inserted at natural pauses in the dialogue of the program. It is designed to make a program more accessible to people with visual disabilities. “Closed” video description is provided on the Second Audio Program (SAP) channel, which is a standard feature of stereo TV sets. Viewers can activate the channel at will in order to control whether they hear the main audio program without video description, or the SAP with video description.

Video description is a service that benefits older Americans in particular. Estimates of the number of Americans with visual disabilities are as high as twelve million. Older Americans are disproportionately represented among this group. This is because declining vision often accompanies the aging process. As more and more Americans live longer, and consequently the population ages, video description should also benefit increasingly older Americans.

Public television stations have provided “closed” video description on the SAP channel for over a decade, but commercial television stations have not. In order to begin to bring the benefits of video description to the commercial video programming marketplace, the Commission adopted rules in July 2000 to require the largest television broadcast stations and multichannel video programming distributors (MVPDs), such as cable television system operators and direct broadcast satellite operators, to provide a limited amount of
video description. The FCC adopted these rules concurrent with the 10th anniversary of the Americans with Disabilities Act ("ADA"). In response to petitions for reconsideration, the Commission clarified and refined these rules in January 2001.

The video description rules require television broadcast stations affiliated with the four largest networks (i.e., ABC, CBS, Fox, and NBC) and licensed to communities in the 25 most populous television markets (i.e., Nielsen Media Research's "Designated Market Areas") to provide 50 hours per calendar quarter of programming with video description. The rules also require MVPDs with 50,000 or more subscribers to provide the same amount of programming with video description on each of the five highest-rated national nonbroadcast networks they carry that also reach 50 percent or more of MVPD households. The affected television broadcast stations and MVPDs must provide the programming with video description during prime time or during children's programming. The new rules also require all television broadcast stations and MVPDs that have the technical capability to "pass through" video description they receive from their programming suppliers to, in fact, do so. The first calendar quarter these rules become effective is April-June 2002.

The new rules also require all television broadcast stations and MVPDs that provide emergency information to make that information accessible to people with visual disabilities. The rules require that television broadcast stations and MVPDs that provide emergency information during a regularly scheduled newscast, or during a special news bulletin that interrupts regularly scheduled programming, make the critical details of that information accessible to people with visual disabilities. In addition, the rules require that television broadcast stations and MVPDs that provide emergency information as part of a crawl or scroll accompany that information with an aural tone to alert people with visual disabilities that they are providing such information.

4. Emergency Access: E911 Digital Wireless.—To ensure compatibility with enhanced 911 emergency calling, on December 11, 2000, the Commission adopted an Order to ensure that persons with hearing and speech disabilities using text telephone (TTY) devices will be able to make 911 emergency calls over digital wireless systems. Although the Commission had required covered carriers operating digital wireless systems to pass through TTY E911 calls in October 1997, carriers had been unable to comply because the Baudot-encoded audio tones produced by TTY devices were unable to pass through digital systems. (Such tones were successful in passing through many analog wireless networks.)

In May 2000, the Commission issued a Public Notice setting an implementation deadline by which TTY access to digital wireless systems for 911 calls will be required. Based on technological advances related to TTY/digital compatibility, the Commission has now established June 30, 2002, as the deadline by which digital wireless service providers must be capable of transmitting 911 calls made using TTY devices. This Order includes a rule to monitor the development and implementation of this capability by carrier networks.
5. Access to Emergency Video Programming.—In April 2000, the FCC increased accessibility of televised video programming to viewers with hearing disabilities. It did so by requiring programmers to make local emergency information accessible to persons with hearing disabilities when this information is provided through a regularly scheduled newscast, or during an unscheduled newscast that interrupts regularly scheduled programming. Emergency information is information about a current emergency and must include the critical details on issues affecting life, health, safety, or property, and how to respond to the emergency. This access can be provided through closed captioning, or by using another method of visual presentation, such as a text scroll or crawl. Examples of emergencies include events such as toxic gas spills, floods, civil unrest, hurricanes, school bus changes resulting from these events and similar emergency situations. In determining which particular details about the emergency need to be made accessible, programmers may rely on their own good faith judgments.

6. Telecommunications Relay Services (TRS).—The FCC also undertook several actions in 1999–2000 to improve telecommunications relay services (TRS), a critical component of telephone service to the community of persons who are deaf, hard-of-hearing or with speech disabilities, many of whom are older Americans. Title IV of the ADA, codified at section 225 of the Communications Act of 1934, requires the Commission to ensure that TRS is available, to the extent possible and in the most efficient manner, to individuals with hearing and speech disabilities in the United States. TRS is a telephone transmission service that provides the ability for an individual with a hearing or speech disability to engage in communication by wire or radio in a manner functionally equivalent to the experience of someone without such a disability.

The FCC first adopted rules and policies to implement section 225 in 1991. These rules required common carriers to provide TRS in the areas they served beginning July 26, 1993. On March 6, 2000, the Commission released a Report and Order expanding the scope of relay services and creating new mandates for improved relay service quality.

The March 2000 Order requires improved quality standards, provides for Speech-To-Speech (STS) relay, and a funding mechanism for video relay services (VRS). The March 2000 Order also included a Further Notice of Proposed Rulemaking to ensure that TRS keeps up with the Information Age. It asked for comments on: (1) the establishment of a national outreach and education campaign to increase awareness of relay services; (2) whether outreach efforts should be supported by the interstate TRS fund through establishment of guidelines for funding a coordinated national outreach and education campaign to be developed by the fund administrator; and (3) the extent to which new technologies should be mandated for TRS, including the extent to which providers should have access to SS7 technology to better handle emergency calls, be compatible with Caller ID and more efficiently bill for and deliver relay services.

The FCC also held a TRS Fair to demonstrate relay services equipment concurrent with the public meeting that adopted the revised relay services rules. To address some of the issues raised in
the TRS NPRM, the DRO held an additional public forum on TRS in March 2000 to share information on new technology trends involved in relay services and outreach to underserved populations, including older Americans. Later, in June 2000, the FCC adopted an Order on Reconsideration on Telecommunications Relay Service and Speech-to-Speech Relay that clarified the effective dates for STS and VRS and the annual submission of complaint log summaries by states, in addition to other technical clarifications. On February 23, 2001, the FCC released another Order further amending the implementation dates for the new TRS rules.

7. TRS—711 Access.—In 1999, the agency held a public forum on how to implement 7-1-1 access for relay services nationwide during its review of a proceeding on the allocation of N11 numbers. 7-1-1 dialing permits 3-digit access to relay services, advantageous to relay services users with manual dexterity limitations, such as older Americans with arthritis or other fine motor disorders. In July 2000, after a period of comment on the technical feasibility of using this type of dialing, the Commission issued a Report and Order on Implementation of Nationwide 711 Access to TRS. This new dialing arrangement will supplement existing systems in most states that require 7- or 10-digit numbers in order to initiate relay calls. 711 nationwide access, affecting wireline, wireless and payphones, is required on or before October 1, 2001. It is expected to make relay services usage easier for persons with and without disabilities and should go a long way to ensuring that older Americans take advantage of this telephony service.

8. TRS—Carrier of Choice.—Other public notices and actions in the 1999–2000 period addressed TRS concerns. For instance, in August 1999, the FCC, through a widely disseminated Public Notice, reminded telecommunications carriers of their obligation to provide choice to TRS users. This Public Notice reminded carriers that users of relay services have the same right to select a long distance telephone services carrier as other telephone users.

9. Hearing Aid Compatibility and Volume Control.—To serve consumers with hearing and speech disabilities, the Commission released a public notice in April 1999 reminding wireline telephone manufacturers of their obligation to have all telephones hearing aid compatible. A telephone is hearing aid compatible if it provides internal means (i.e., without the use of external devices) to enable individuals who use hearing aids to use the telephone (the technical standard is codified at 47 C.F.R. §68.316). This is usually accomplished by inserting a telecoil in telephones that detects, or is compatible with, a similar telecoil in the hearing aid, and thus allows the hearing aid to “couple” with the telephone through an electromagnetic field.

In October 2000, the Wireless Telecommunications Bureau issued a public notice seeking comment on the re-opening of a petition that requested a rulemaking on hearing-aid compatible phones. Petitioners asked that the exemption for personal communication services (certain wireless) devices from the Hearing Aid Compatibility Act of 1988 (HAC Act) be revoked. Significant numbers of older Americans and others with hearing loss have told DRO that the lack of hearing aid compatibility with, and interference from, digital wireless telephones is still an ongoing prob-
lem. As more and more wireless networks become digital, the needs of hearing aid and cochlear implant users will need to be addressed.

10. Advanced Telecommunications.—In January 1999, the FCC adopted a Report and Order and Notice of Inquiry on the Deployment of Advanced Telecommunications Capability to All Americans in a Timely Fashion, and Possible Steps to Accelerate Deployment. This notice specifically sought comment on the disability access needs of persons with disabilities. Later, in February 2000, the FCC issued a Notice of Inquiry on the FCC’s second report on advanced telecommunications capability. In particular, this sought data to determine the rate of deployment especially in rural and inner city areas and to persons with disabilities, which includes aging populations.

Advisory Councils and White Papers.—The FCC made other policy efforts in 1999–2000 to ensure that issues and concerns of people with disabilities, including those disabilities that result from aging, were addressed. For example: the DRO spearheaded efforts to create a Consumer/Disability Federal Advisory Committee, designed to gather feedback on telecommunications issues affecting consumers, including older consumers. A Public Notice announcing creation of the advisory committee was released in November 2000, and the Committee’s first meeting was scheduled to occur in March 2001. Older Americans are represented through various consumer groups on this committee.

Similarly, other policy activities were undertaken to continue to raise the profile of the telecommunications needs of persons with functional limitations in speech, hearing and vision. Examples include sending letters in May 2000 to Federal agency heads reminding them of the obligation to caption public service announcements that are funded in whole or in part by Federal agencies.

Another FCC policy action was to seek comment on expanding the Telecommunications Advisory Council of the National Exchange Carriers Administration, the organization that manages the interstate funds for carriers’ contributions to relay services, to include a member who would represent consumers with speech disabilities. This resulted in the appointment of a person with severe speech disabilities to this advisory body.

Cable Services Bureau (CSB)

The FCC bureau which regulates the cable television industry, the Cable Services Bureau, focused on three issues in 1999–2000 that affect older Americans:

Senior Citizen Discounts.—Senior citizen discounts benefit older Americans who often have limited incomes. By enacting Section 623(e)(1) as part of the system of rate regulation pursuant to the 1992 Cable Act, Congress intended to encourage cable operators to offer, and to continue to offer through existing franchise agreements, reasonable discounts to senior citizens or other economically disadvantaged groups. In response to a Petition for Declaratory Ruling, the Commission upheld a previously issued informal letter ruling stating that it would not interfere with senior citizen discounts previously allowed for in local franchise agreements.
Video Accessibility.—Older Americans with hearing and visual disabilities can now be helped by a number of technologies related to television, especially closed captioning and video description. These two technologies are designed to increase “video accessibility.” Closed captioning provides important benefits primarily for individuals with hearing disabilities by displaying the audio portion of a television signal as printed words on the television screen. Video description benefits individuals with visual disabilities by providing audio descriptions of a program's key visual elements that are inserted during the natural pauses in the program’s dialogue.

Closed Captioning.—In the 1996 Act, Congress directed the Commission to report on the availability of closed captioning to persons with hearing disabilities and to assess the appropriate method for phasing video description into the marketplace to benefit persons with visual disabilities. The Commission submitted a Report to Congress addressing these issues on July 29, 1996. In that Report to Congress, the Commission indicated that there was a lack of experience with video description because it is a newer service than closed captioning. Since the record on video description before the Commission at the time of the 1996 Report was insufficient to assess appropriate methods and schedules for phasing in video description, the Commission provided Congress with additional information and comment in the context of the 1997 Annual Report to Congress on the Status of Competition in Markets for the Delivery of Video Programming. This issue continued to be monitored by the CSB during 1999–2000.

The 1996 Act also directed the Commission to prescribe rules and implementation schedules for the closed captioning of video programming regardless of the entity that provides the programming to consumers or the category of programming. In August 1997, the Commission established rules to ensure that video programming is made accessible through closed captioning. In September 1998, in response to petitions for reconsideration, the Commission modified and clarified the closed captioning rules to better comply with the statutory mandate to provide accessibility to persons with hearing disabilities.

The rules establish timetables that gradually increase the amount of closed captioning provided on programs. For programming first published or exhibited on or after January 1, 1998, the effective date of the rules, the Commission established benchmarks to be met every two years until 100 percent of such programming is required to be captioned as of January 1, 2006. Beginning on January 1, 2000, the benchmarks generally require 450 hours of captioned new programming on each channel during each calendar quarter. For programming first published or exhibited prior to January 1, 1998 (“pre-rule programming”), mandatory captioning is phased-in over a 10-year period. As of January 1, 2008, the end of this transition period, 75 percent of the pre-rule programming on each channel must include closed captioning, with at least 30 percent of such programming required to be captioned as of January 1, 2003. The rules also require video programming distributors (e.g., television station operators or cable operators) to generally pass through to consumers any captions they receive with the pro-
gramming they distribute. Video programming distributors also must continue to provide captioned programming at substantially the same level as the average level of captioning that they provided during the first six months of 1997, even if that amount of captioning exceeds the requirements under the transition schedules.

**Common Carrier Bureau (CCB)**

Some of the most important policy actions of the FCC in 1999–2000 affecting older Americans were initiated by the Commission’s Common Carrier Bureau (CCB). This FCC bureau regulates wireline communications in the telecommunications industry.

"Slamming."—“Slamming” is the practice of switching a person’s telephone company without that person’s permission. Older Americans are especially vulnerable to such anti-consumer activity. In 1998, the Commission adopted new rules to ensure that carriers do not use misleading or confusing forms that consumers sign to change their long distance service and to ensure that consumers do not pay any charges to a slamming company.

In 2000, the Commission modified the slamming liability rules to take the profit out of slamming and also gave state commissions the opportunity to become the primary forums for resolving slamming complaints filed by their citizens. As of January 2001, 34 states had opted to administer the revised slamming rules, which took effect on November 28, 2000. The Commission also made several other improvements in its rules and procedures that protect consumers against slamming, such as the rules governing preferred carrier freezes, i.e., rules which allow a customer to “freeze” the choice of long distance carrier so that it can only be changed with the direct, written permission of the customer.

*Truth in Billing and “Cramming.”*—“Cramming” is the inclusion of unauthorized or unexplained charges on a person’s phone bill. To further protect consumers against cramming and other billing-related fraudulent practices, the FCC adopted rules in the 1999–2000 reporting period that require telephone bills to be more clear and better organized, and to highlight charges from new service providers. These rules give customers, including older Americans, the tools they need to make sure they have not been improperly charged.

*Consumer Information.*—The Common Carrier Bureau continued during 1999–2000 to produce customer information to help all consumers better understand and make choices regarding their telephone service. The Bureau made available information on such matters as how to select a carrier, how to get the best rates, and which companies have the worst complaint records.

*Universal Service.*—The Telecommunications Act of 1996 established certain principles for the Commission to follow in revising and expanding the scope and definition of “universal service” in telecommunications services for all Americans, including older Americans. During 1999–2000, the Bureau continued to implement these principles of universal service through its work to assure access to advanced telecommunications services for health care providers, including hospitals, health clinics, and libraries, all of which serve many older Americans.
Lifeline/Link Up Services.—The Commission during this time period also continued to implement the FCC's "Lifeline" and "Link Up" programs. The federal Lifeline program provides between $3.50 and $7.00 a month to reduce low-income consumers' monthly telephone bills. The amount of federal support varies depending on decisions made by state public service commissions. All eligible low-income consumers receive at least a $3.50 reduction per month on their telephone bills from the federal universal service program. The reduction applies to a single telephone line at a qualifying consumer's residence.

The Link Up program offers eligible low-income consumers a reduction in the local telephone company's charges for starting telephone service (the reduction is one-half of the telephone company's charge, or $30, whichever is less); and a deferred payment plan for the remaining charges.

Additional Lifeline and Link Up support is also available for service to Indian lands as part of the Commission's initiative in this time period to enhance telecommunications services on native American, Indian lands.

Mass Media Bureau (MMB)

See above for discussion of video description, the major matter during 1999–2000 affecting the elderly on which the Mass Media Bureau focused. (The MMB regulates the radio and television industries.)

Office of Engineering and Technology (OET)

The Commission's chief office for engineering and technical policy advice is the Office of Engineering and Technology or "OET." During 1999–2000, OET focused on the following issues of interest to and impact on older Americans:

Medical Telemetry.—In June 2000, the FCC allocated spectrum to ensure the protection of medical telemetry devices from radio frequency interference caused by other services. Medical telemetry devices are typically used in health care institutions to monitor the vital signs of critically ill patients, a disproportionate number of whom are elderly. OET works closely with the Federal Drug Administration (FDA), the medical community and equipment manufacturers to ensure the continued technical viability of these valuable medical monitoring services.

Closed Captioning.—In July 2000, the FCC adopted rules to provide for closed captioning of digital television programming, to ensure continued access to closed captioning during the transition from analog to digital television transmission. (See also above for further discussion.)

TRS and 711.—Telecommunications Relay Service permits a speech- or hearing-impaired user of a TTY to communicate with speaking and hearing persons. (711 is the national free number for TRS.) Many elderly persons can and do use TRS. Through OET's familiarity with industry practices, the FCC was able to institute a procedure for gathering simple industry documentation which enables it to monitor progress of the implementation of the 711 feature for wireless-initiated calls and make the industry accountable for its handling of problems that may arise during implementation.
OET's technical expertise also guided the Commission in issuing accurate and precise rules, so that service providers and manufacturers provide the desired services for TTY users when they follow the letter of the law. The FCC's new rules in this area assure that performance measurements are appropriate, for example, by measuring "wait time" from the placing of a call rather than from the time a call is answered (an answer could be considerably delayed), and by insisting that counts are made not just of calls blocked, but also of those dropped or indefinitely held. (See also above for further discussion.)

Office of Managing Director (OMD)

The FCC's chief management office, the Office of Managing Director ("OMD"), reports that in 1999–2000, as part of the Commission's ongoing efforts to recruit its staff from many diverse sources, the FCC sought out older Americans by, for example, sending vacancy announcements to organizations whose membership consists of older Americans.

Wireless Telecommunications Bureau (WTB)

The Commission's wireless telecommunications policies are developed by the Wireless Telecommunications Bureau ("WTB"). In 1999–2000, the WTB helped older Americans by encouraging more competitors and decreasing wireless prices, thereby making wireless service more affordable to the elderly. The WTB in this time period focused on:

Wireless Enhanced 911.—In 1999 and 2000, the Commission continued its efforts to promote public safety by adjusting the rules requiring wireless carriers and manufacturers to implement technologies needed to bring emergency assistance to wireless callers throughout the United States. The Commission modified its wireless 911 rules to allow covered wireless carriers to use handset-based technology to provide public safety authorities with information about the location of the 911 caller. By allowing carriers to choose among different E911 location methods, the Commission expects to foster competition among various technologies, ultimately resulting in the deployment of the best and most efficient technologies. In 2000, the Commission also adopted a deadline of June 30, 2002, by which digital wireless systems must be capable of transmitting 911 calls placed by individuals with speech and hearing disabilities using text telephone (TTY) devices. Although the Commission required all covered wireless carriers to be capable of transmitting these calls as part of its original E911 rules, operators of digital systems have been unable to comply with this requirement because they have not been able to accurately pass the Baudot-encoded audio tones produced by TTY devices. In light of the industry's progress in developing solutions to the TTY-digital incompatibility, setting a deadline for compliance will ensure that TTY users on digital systems will receive the benefits of E911 at the earliest possible time. (See also above for further discussion.)

Spectrum for Public Safety.—The WTB authored a number of items in 1999–2000 to promote the use of radio by public safety entities. The primary item during this period were new rules for the 700 MHz public safety band, as directed by the Balanced Budget
Act of 1997. The Commission's Federal public safety advisory committee, the National Coordinating Committee for Public Safety, completed recommendations for technical and operational standards for use of this spectrum. Specifically, these standards will allow interoperable radio communications between all public safety systems used by local, state, and Federal public safety organizations during emergencies. The Commission also designated a portion of the spectrum for use by States to build statewide systems in this new 700 MHz spectrum.

Amateur Radio.—The Commission amended its amateur service rules to reduce the number of telegraphy examination elements in the amateur radio license structure from three elements to one. These rule changes became effective April 15, 2000. These changes have allowed many amateur radio service licensees, including many older Americans, to qualify for additional operating privileges without requesting credit for higher speed telegraphy examination elements on the basis of physical limitations, particularly hearing loss due to aging processes. These changes also eliminated the need and expense for an applicant to go to his or her doctor and request a Physician's Certification of Disability if the applicant desired to receive credit for the higher speed examination elements. The rule changes eliminating the higher speed telegraphy Morse code examinations greatly assisted older individuals to take full advantage of the benefits the amateur service has to offer.

Wireless Medical Telemetry Service.—The Wireless Medical Telemetry Service (WMTS) was established by the Commission on June 12, 2000, to enhance the reliability of equipment that is vital to the effective care of patients with acute and chronic health problems. Medical telemetry equipment is used in health care facilities to transmit patient measurement data, such as pulse and respiration rates, to a nearby receiver. By permitting such remote monitoring of patients' vital signs, medical telemetry equipment provides significant benefits to patients in terms of mobility and comfort. In addition, because wireless medical telemetry equipment allows remote monitoring of several patients simultaneously, it might be a significant tool in reducing health care costs. (See also above for further discussion.)

Application Licensing.—The Universal Licensing System (ULS) fundamentally changes the way the Commission receives and processes wireless applications. ULS enables all wireless applicants and licensees to file all licensing-related applications and other filings electronically, thus increasing the speed and efficiency of the application process. The enhanced information collection capabilities of ULS also enables the Commission staff to easily monitor spectrum use and competitive conditions in the wireless marketplace and will promote effective implementation of spectrum management policies. Finally, ULS enhances the availability of licensing information to the public, which has access to all wireless licensing data on-line, including maps showing licensing areas and service providers.

To further improve application processing and access to licensing information the ULS is continually being enhanced. Recent enhancements to the ULS include a complete redesign of the ULS homepage. This redesign has made it easier for applicants and re-
searchers to locate information using the ULS website. In redesigning the homepage, the Commission improved access for individuals with disabilities. The new homepage is compatible with various screen readers. Additionally, in January 2001, we began real time processing for applications filed by Amateur Radio Licensees. Previously, these applications were processed once nightly; now they are processed every 30 minutes.

Future planned enhancements to ULS include redesigning the public access interface to the ULS Antenna Structure Registration (ASR) database. This will provide easier search capabilities to anyone using the Commission ASR data. This new interface will also include an on-line interactive training module, which will provide general overview of ASR and assistance regarding individual data elements. These changes and enhancements improve service to all ULS users, including older Americans.

Additional Information

Anyone who wants more information on any of these activities, especially on how they impact older Americans, can contact the FCC through its National Call Center at 1–888–CALL–FCC (225–5322), or the Commission's web site on the Internet at www.fcc.gov. For more information about this report, please contact Steve Klitzman, Associate Director, Office of Legislative and Intergovernmental Affairs (OLIA), 202–418–1900, fax: 202–418–2806; or at sklitzma@fcc.gov.
The Federal Trade Commission is the federal government's principal consumer protection agency, with broad jurisdiction extending over nearly the entire economy, including business and consumer transactions on the telephone, the Internet, and elsewhere. Under the Federal Trade Commission Act, Congress has directed the Commission to prohibit unfair or deceptive acts or practices (its consumer protection mission) and unfair methods of competition (its competition mission). Much of the Commission's work addresses practices or industries that are of particular significance to older consumers. This Report describes those aspects of the Commission's work from January 1999 through August 2001. Section One describes recent Commission law enforcement initiatives within its consumer protection mission which are of particular importance to older consumers, including health care initiatives, financial practices initiatives, sales and promotional practices initiatives, and enforcement initiatives against fraud. Section Two highlights the Commission's consumer education program. Section Three describes Commission law enforcement initiatives within its competition mission, with a particular focus on law enforcement and other initiatives in the health care sector, the energy sector, the retail sector, and the funeral homes and cemeteries sector. Finally, Appendix I describes a comprehensive and ongoing initiative conducted by the Commission's Regional Offices during the October 2000 - August 2001 period — in conjunction with other law enforcement agencies, AARP, Better Business Bureaus, social service agencies, media, and business and consumer groups — to help educate and empower senior citizens to protect themselves from fraudulent operators. To provide a more general overview of Commission efforts to provide information to and secure information from both Congress and the general public, Appendix II lists Congressional testimony the Commission delivered from January 1999 to August 2001, while Appendix III lists Commission workshops and conferences conducted during the same period.
THE CONSUMER PROTECTION MISSION

HEALTH CARE INITIATIVES

It is critical that all consumers have accurate information about the costs and benefits of health care services, devices, drugs and related products. While health care is a subject of concern for all consumers, it is of particular concern to older consumers, their families and caregivers, and the Commission devotes substantial resources to preventing the dissemination of unsubstantiated or otherwise deceptive claims about the health benefits of particular products or services.

Cases Addressing Health Claims for OTC Drugs, Devices, Foods, and Dietary Supplements

The Commission is responsible for making sure that advertising about the health benefits of over-the-counter drugs, devices, foods, and dietary supplements is truthful, not misleading and substantiated by solid scientific support. The Commission closely coordinates its efforts in these areas with the Food and Drug Administration, which has primary responsibility for the safety and labeling of these products. The most dramatic growth in health-related marketing has been in the dietary supplement industry, a category that includes vitamins, minerals, herbs and hormones. It is estimated that more than 100 million U.S. consumers use supplement products for a wide variety of health-related benefits.

Older consumers may be particularly vulnerable to false or misleading claims about the safety and health benefits of OTC drugs, devices, foods, dietary supplements, and health care services because the marketing of such products and services often relates to conditions associated with aging. From January 1999 to August 2001, the Commission conducted a number of initiatives as part of its continuing efforts to ensure that consumers are presented with truthful and accurate information about the health benefits of such products. In June 1999, the Commission launched Operation Cure.all—a comprehensive law enforcement and consumer education campaign directed at protecting consumers from Internet health fraud—and announced settlements of allegations that four sets of respondents made deceptive and unsubstantiated health claims concerning "miracle cures" for serious illnesses.

- In Arthritis Pain Care Center (APCC), et al., Docket No. C-3896 (consent order issued on Sept. 7, 1999), the Commission complaint challenged as unsubstantiated claims that CMO, purportedly a fatty acid derived from beef tallow, cures most forms of arthritis by permanently modifying the immune system, and alleged that claims about certain scientific studies, including studies at the National Institutes of Health, were false. The consent order prohibits APCC from making any unsubstantiated claims for CMO or any food, drug, dietary supplement or program and from misrepresenting the results of any tests or research.

- In Body Systems Technology, Inc. (BST), Docket No. C-3895 (consent order issued on Sept. 7, 1999), the Commission complaint alleged that the company lacked substantiation for its claims that shark cartilage capsules and products containing Cat’s Claw were
effective treatments for cancer, arthritis, and other diseases, and falsely represented that scientific studies established their efficacy. The consent order prohibits similar unsubstantiated claims for any product or program and requires the company to make refunds to all purchasers of these products during a proscribed time period.

- In Magnetic Therapeutic Technologies, Inc., et al., Docket No. C-3897 (consent order issued on Sept. 7, 1999), the Commission complaint challenged as unsubstantiated claims that MTI's magnetic therapy devices could alleviate medical problems and diseases such as cancer and high blood pressure. The consent order prohibits the respondents from making similar unsubstantiated claims for such products, and from making other unsubstantiated claims about the health benefits, performance, or efficacy of any product or program.

- In Pain Stops Here! Inc., et al., Docket No. C-3898 (consent order issued on Sept. 7, 1999), the Commission complaint alleged that PSH made unsubstantiated claims that its magnetic therapy devices were effective in treating ailments such as cancer, liver disease and arthritis, and that their efficacy was supported by scientific studies. The consent order prohibits those claims and any other unsubstantiated claims about the performance, safety, efficacy, or health benefits of any product or program.

In April 2000, as the second part of Operation Cure.all, the Commission announced settlements with three sets of internet companies arising from the firms' marketing of certain products as effective treatments or cures for diseases such as arthritis, cancer, diabetes, and AIDS.

- In Michael D. Miller, d/b/a Natural Heritage Enterprises, Docket No. C-3941 (consent order issued on May 16, 2000), the Commission complaint alleged that the respondents made unsubstantiated claims on Internet sites that Essiac Tea is effective in curing diseases such as cancer, diabetes and AIDS/HIV. The consent order, inter alia, required the respondents to pay $17,500 in consumer redress, and to send notices to all consumers who purchased their Essiac Tea products that Essiac Tea has not been demonstrated to be an effective remedy in fighting cancer or any other disease. The consent order also prohibits the respondents from making unsubstantiated claims for Essiac Tea and any food, drug, dietary supplement or program, and from misrepresenting the results of any tests, study or research.

- In CMO Distribution Centers of America, Docket No. C-3942 (consent order issued on May 16, 2000), the Commission complaint alleged that the respondents made unsubstantiated claims that CMO™ (cetylmyristoleate) capsules would regulate and normalize the immune system, cure arthritis and reverse the effects of the disease, and be effective in treating other conditions such as asthma and cancer; and made false claims about certain scientific studies. The consent order requires the respondents to offer refunds to consumers who purchased the product for personal use or that of their families, and prohibits the respondents from making unsubstantiated health claims for CMO, or for any other food, drug, dietary supplement or program, and misrepresenting the results of any tests, study or research.

- In EHP Products, Docket No. C-3940 (consent order issued on May 16, 2000), the
Commission complaint alleged that the respondent made unsubstantiated efficacy claims for its CMO product, Myristin® -- including claims that the product provides long term relief from arthritis symptoms and may prevent rheumatoid arthritis and osteoarthritis -- and misrepresented that scientific studies or the issuance of patents prove the effectiveness of Myristin®. The consent order required the respondent to offer refunds to consumers who purchased the product for personal use or that of their families, and in addition prohibits the respondents from making unsubstantiated health claims for CMO, or for any other food, drug, dietary supplement or program, and from misrepresenting the results of any tests, study or research.

In June 2000, as the third part of Operation Cure.all, the Commission announced the filing of a complaint in FTC v. Lane Labs-USA, Cartilage Consultants, Inc., I. William Lane, and Andrew J. Lane, Civ. Action No. CV-00-3174(WGB) (D. New Jersey)(announced on June 29, 2000). The U.S. District Court complaint alleged, inter alia, that the defendants made unsubstantiated claims about the efficacy of "BeneFin," a shark cartilage product, and "SkinAnswer," a skin cream, to prevent, treat and cure cancer. The Commission approved two stipulated final orders for permanent injunction settling the complaint; both prohibit the defendants from representing without substantiation that BeneFin or any other shark cartilage product prevents, treats or cures cancer -- or that SkinAnswer, or any other glycoalkaloid product, prevents, treats or cures skin cancer -- and from making any unsubstantiated health-related claims about any food, drug or dietary supplement. The orders also prohibit the defendants from misrepresenting the existence, content or results of any tests, studies, or research in connection with the marketing of any food, drug or dietary supplement; and from misrepresenting that any government agency has evaluated the efficacy or safety of any food, drug or dietary supplement when marketing such product. In addition, the order against Lane Labs requires the firm to pay a $1 million judgment, with $550,000 to be devoted to consumer redress or disgorgement, and the remaining $450,000 to be used to pay for shark cartilage and a placebo in a clinical study of shark cartilage sponsored by the National Cancer Institute and Lane Labs.

In June and July 2001, Operation Cure.all continued with the announcement of eight cases targeting companies marketing a variety of devices, herbal, products, and other dietary supplements as purported treatments or cures for cancer, HIV/AIDS, arthritis, hepatitis, Alzheimer's, diabetes, and many other diseases.

* In Panda Herbal International, Inc., et al., Docket No. C-4018 (consent order issued on July 30, 2001), the complaint alleged that the respondents made unsubstantiated efficacy claims for "Herbal Outlook" -- a dietary supplement containing St. John's Wort -- and for "Herb Veil 8," a topical ointment, and falsely claimed that Herbal Outlook has no known contraindications or drug interactions. The consent order requires the respondents to pay full refunds to certain Herb Veil 8 purchasers, and to include -- in advertising for products containing St. John's Wort -- warnings about the potentially dangerous interaction between St. John's Wort and certain prescription drugs, including drugs prescribed to treat HIV infections.

* In ForMor, Inc., et al., Docket No. C-4021 (consent order issued on July 30, 2001), the
complaint alleged that the respondents made false and unsubstantiated safety and efficacy claims for dietary supplement products containing St. John’s Wort, colloidal silver and shark cartilage. The consent order requires the respondents to pay refunds to certain colloidal silver and “Ultimate II Shark Cartilage Concentrate” purchasers, and to include - - in advertising for products containing St. John’s Wort -- warnings about the potentially dangerous interaction between St. John’s Wort and certain prescription drugs, including drugs prescribed to treat HIV infections.

- In MaxCell BioScience, Inc., et al., doing business as Oasis Wellness Network, Docket No. C-4017 (consent order issued on July 30, 2001), the complaint alleged that the respondents made false and unsubstantiated anti-aging claims for a dietary supplement product containing the hormone DHEA, and for an at-home urine test which purportedly permitted consumers to gauge their overall health and youthfulness. The consent order requires the respondents to pay $150,000 in consumer redress, and prohibits them from making any unsubstantiated representations about the health benefits of their products or any other food, dietary supplement or drug.

- In Robert C. and Lisa M. Spencer, doing business as Aaron Company, Docket No. C-4019 (consent order issued on July 30, 2001), the complaint alleged that the respondents made false and unsubstantiated safety and efficacy claims for dietary supplement products called Colloidal Silver and Chitosan with Vitamin C, and made unsubstantiated claims that “Ultimate Energizer” -- a product containing ephedra (ma huang) -- is safe and has no side effects. The consent order prohibits the respondents from making any unsubstantiated claims about the health benefits, performance, safety, or efficacy of any covered product or service, and requires all future advertising and labeling for products containing ephedra to disclose that they contain “ephedra or ephedrine alkaloids, which can have dangerous effects on the central nervous system and heart and can result in serious injury.”

- In Michael Forrest, doing business as Jaguar Enterprises of Santa Ana, also known as Jaguar Enterprises, Docket No. C-4020 (consent order issued on July 30, 2001), the complaint alleged that the respondents made unsubstantiated claims that their electronic therapy devices would cure or prevent cancer and other serious diseases and false and unsubstantiated efficacy and safety claims for “Miracle Herbs,” an herbal product they promoted as a treatment for all types of cancer, AIDS and bacterial and viral infections. The consent order requires the respondent to offer refunds to purchasers of the products at issue, and prohibits him from making unsubstantiated claims about the health benefits, performance, safety, or efficacy of their products or services and from misrepresenting the results of any test, study or research.

- In FTC v. Western Dietary Products Co., et al. (W.D.Wash.) (announced on June 14, 2001), the Commission alleged in a U.S. District Court complaint that the defendants made unsubstantiated representations that their herbal formulas and herbal cure packages could treat and cure Alzheimer’s, diabetes, arthritis, HIV/AIDS, and cancer -- and make surgery and chemotherapy unnecessary for persons with cancer -- and that their “Zapper Electrical Unit” could treat and cure Alzheimer’s and HIV/AIDS. The defendants agreed to entry of a preliminary injunction, and the litigation continues.
In **FTC v. Western Botanicals, Inc., et al., Civ. Action No. CIV.S-01-1332 DFL GGH** (E.D.Cal.)(announced on July 13, 2001), the Commission filed a U.S. District Court complaint alleging, *inter alia*, that the defendants made unsubstantiated claims that dietary supplement products containing comfrey were beneficial in the treatment of a variety of serious diseases and health conditions, and false claims that the products were safe. Subsequently, the Commission approved a stipulated permanent injunction that prohibits the defendants from marketing comfrey products for internal use or use on open wounds; requires the defendants to possess substantiation for all safety and efficacy claims; and requires a safety warning on all the company's other products containing comfrey.

In **FTC v. Christopher Enterprises, Inc., et al., Civ. Action No. 2:01 CV-0505 ST** (D.Utah)(announced on July 6, 2001), the Commission filed a U.S. District Court complaint alleging that these defendants also made allegedly false safety claims and unsubstantiated efficacy claims for products containing comfrey. The Commission approved a stipulated preliminary injunction which, *inter alia*, prohibits the defendants from marketing comfrey products for internal use or use on open wounds; requires them to have substantiation for all safety and efficacy claims; and requires a safety warning on all the company’s other products containing comfrey.

The Commission effected a number of other law enforcement actions addressing allegedly unsubstantiated or otherwise deceptive claims for dietary supplements during the period from January 1999 through August 2001.

- In **American Urological Corp., et al., Civ. No. 1:98-CV-2199(JOF) (N.D. Ga.)** (settlement announced on May 3, 1999), the Commission filed a U.S. District Court complaint alleging that the defendants made false and unsubstantiated claims for various supplement products, including one called "Vaegra," to treat impotence. In particular, the defendants claimed that the products had been developed by legitimate medical firms and that they had been proven effective in eliminating impotence in 68 to 94 percent of men. The stipulated permanent injunction imposed an $18.5 million judgment on the defendants, required the individual defendant to post a $6 million performance bond for 10 years before marketing any impotence treatment, and barred all defendants from making unsubstantiated health-related claims about any food, drug or dietary supplement.

- In **FTC v. Rose Creek Health Products, Inc., Civ. No. CS-99-0063-EFS** (E.D.Wash.) (settlement announced on May 1, 2000), the Commission alleged in a U.S. District Court complaint that the defendants made false and unsubstantiated health claims in advertisements for a nutritional supplement called "Vitamin O". The Commission sought preliminary and permanent injunctions to halt dissemination of the defendants' advertisements and resulting consumer injury. Subsequently, the Commission approved a consent decree which, among other things, requires the defendants to pay $375,000 in consumer redress.

- In **FTC v. Rexall Sundown, Civ. Action No. 00-706-CIV-Ferguson** (S.D.Fla.)(announced on July 20, 2000), the Commission filed a U.S. District Court complaint alleging that the defendant made false and unsubstantiated claims while marketing its dietary supplement,
Cellasene™, as a purported cellulite treatment.

In Med Gen, Inc., et al, File No. 002 3211 (announced on March 29, 2001) and Tru-Vantage International, File No. 002 3210 (announced on March 29, 2001), the Commission complaint alleged that the respondents — respectively the marketer of "Snorenz," a throat spray, and the producer of infomercials about the product — made unsubstantiated representations that the spray is an effective treatment for snoring and sleep apnea. In addition to requiring the respondents to have scientific evidence for these and other claims, the consent orders require the respondents to include warnings in their advertisements for snoring remedies that have not been shown to be effective in treating sleep apnea.

From January 1999 through August 2001, the Commission also continued to pursue law enforcement initiatives against firms making unsubstantiated or otherwise deceptive claims for products other than dietary supplements, and for particular health care services. For example, in Novartis Corp., et al., Docket No. 9279, the Commission issued a complaint alleging that the respondents made unsubstantiated, material, and therefore deceptive representations that Doan's Pills -- nationally advertised analgesic tablets -- were more effective in relieving back pain than other over-the-counter pain relievers. Thereafter, the Commission issued an Opinion finding liability and a Final Order requiring the respondents, inter alia, to disseminate corrective advertising. On August 18, 2000, the Court of Appeals for the District of Columbia Circuit issued an opinion affirming the Commission Decision and Final Order.

Similarly, in American College for Advancement in Medicine, Docket No. C-3882 (consent order issued on June 22, 1999), the Commission accorded final approval to a consent order — settling allegations in an accompanying administrative complaint — which, inter alia, prohibits the respondents from making unsubstantiated and false advertising claims that nonsurgical, EDTA “chelation therapy” is effective in treating atherosclerosis, and that the effectiveness of the therapy has been proven by scientific studies. The consent order also prohibits ACAM from misrepresenting the existence, validity, results, or contents of any test, study or research in connection with the advertising or promotion of chelation therapy.

Last year, the Bayer Corporation launched a $1 million consumer education campaign to settle the allegations in a U.S. District Court complaint filed at the behest of the Commission in United States v. Bayer Corp., Civ. Action No. 00-132 (NHP) (D.N.J.) (settlement announced on Jan. 11, 2000). The complaint alleged that Bayer represented -- without substantiation and in violation of a previous FTC order -- that a regular aspirin regimen is appropriate for the prevention of heart attacks and strokes in the general adult population. The complaint alleged, in particular, that the claims at issue were unsubstantiated because some adults are less likely to benefit from a daily aspirin regime and because some may suffer adverse health effects from taking aspirin on a daily basis. Under the resulting consent decree, Bayer distributed a free brochure entitled “Aspirin Regimen Therapy: Is It Right For You?”, more than 500,000 copies of the brochure were distributed through doctors' offices. In addition, Bayer disseminated full-page print advertisements in major magazines promoting a toll-free number (1-800-332-2253) that consumers could call to order the brochure. The consumer education campaign was in part intended to help clear up possible confusion about the proper use and safety of aspirin in the
prevention of heart attack and stroke. In addition, the consent decree requires Bayer to include—
in advertising that makes claims about the benefits of regular aspirin use for prevention of heart
attacks or strokes—a disclosure that states, “Aspirin is not appropriate for everyone, so be sure
to talk to your doctor before you begin an aspirin regimen.”

The Commission pursued a number of other law enforcement actions against marketers of
particular types of health care products and services. For example, in The Quigley Corporation,
Docket No. C-3926 (consent order issued on Feb. 10, 2000), and QVC, Inc., Docket No. C-3955
(consent order issued on June 14, 2000), the Commission issued consent orders settling
allegations that the respondents—respectively the manufacturer of Cold-Eeze and Cold-Eeze
brand zinc lozenges and the operator of the Home Shopping Network—represented, without
substantiation, that the lozenges can prevent colds and alleviate allergy symptoms. The consent
orders prohibit the respective respondents from making the challenged representations without
substantiation, for the products at issue or any other food, drug or dietary supplement. In
addition, the consent order against Quigley prohibits the respondent from representing, without
substantiation, that any food, drug or dietary supplement can or will treat, cure or prevent disease,
or have any effect on the structure or function of the human body; the consent order against QVC
imposes the same prohibition with respect to dietary supplements.

Similarly, in FTC v. Worldwidemedicine.com et al., Civ. Action No. CV-S-00-0861-JBR
(D.Nev.) (announced on July 12, 2000), the Commission approved stipulated final judgments and
orders settling allegations in a U.S. District Court complaint that the defendants promoted Viagra
and Propecia prescriptions by making false medical claims. The orders prohibit the defendants
from misrepresenting medical and pharmaceutical arrangements; prohibit them from
misrepresenting their use of credit card information; and prohibit them from misrepresenting any
other material fact about the scope or nature of defendants’ goods, services or facilities.

In SmartScience Laboratories, Inc., et al., Docket No. C-3980 (consent order issued on
Nov. 2, 2000), the Commission issued a consent order resolving allegations that the respondents
made unsubstantiated claims that their topical skin cream, “JointFlex,” would eliminate
significant pain due to disabling joint conditions, crushed vertebrae, herniated disks, and other
conditions. The consent order prohibits the respondents from making claims about the efficacy
of JointFlex or any drug or dietary supplement in reducing, relieving or eliminating pain from
any source, or about the health benefits, performance, safety or efficacy of a product, unless they
have competent and reliable scientific evidence to substantiate the claims. The consent order
also prohibits misrepresentations about the results of tests, studies, surveys and research with
respect to any product and would require that testimonials be truthful and not deceptive.

22, 2001), the Commission issued a consent order settling complaint allegations that the
respondent, a cable shopping service, made unsubstantiated claims for a variety of weight loss,
cellulite treatment, and anti-hair loss products on television and over the Internet. The consent
order requires ValueVision to offer credit or refunds to certain purchasers of the covered
products, and prohibits the respondent from making a variety of unsubstantiated representations
for any food, drug, dietary supplement, cellulite-treatment product, or weight loss program.
Cases Addressing Claims For Diet and Weight Loss Products and Services

As part of its continuing effort to ensure that consumers get accurate and reliable information about weight loss products and programs, the Commission continued to implement "Operation Waistline," a coordinated, long-term consumer education and law enforcement program designed to alert consumers to misleading and deceptive weight loss claims, to steer them to accurate information about healthy weight loss, and to stop those promoters in the industry who violate the law.

- In *FTC v. SlimAmerica, Inc., FTC v., No. 97-6072-Civ-Ferguson* (S.D. Fla.) (announced on July 19, 1999), the Commission alleged in a U.S. District Court complaint that the defendants made a variety of deceptive claims for their purported weight loss products, including that the "Super-Formula" diet product could "blast" up to 49 pounds off a user in only 29 days, "obliterate" 5 inches from waistlines, and "zap" 3 inches from thighs, without dieting or exercising. Thereafter, the District Court issued a final judgment which, *inter alia*, requires the defendants to pay $8,374,586 in consumer redress.

- In *Fitness Quest, Inc., Docket No. C-3886* (consent order issued on July 26, 1999), the Commission issued a consent order settling allegations in an accompanying administrative complaint that the respondents made unsubstantiated weight loss and weight maintenance claims in infomercials and on the Internet. The consent order prohibits such unsubstantiated claims and provides that testimonials or endorsements in the respondent's advertising materials must either represent the typical or ordinary experience of consumers or disclose the generally expected results or state that consumers should not expect similar results.

- In *Weider Nutrition International, Inc., Docket No. C-3983* (consent order issued on Nov. 15, 2000), the Commission issued a consent order against a leading manufacturer and marketer of nutritional supplements, vitamins and sports nutrition products. The consent order resolved allegations in an accompanying administrative complaint that the respondents made unsubstantiated efficacy and safety claims in their advertisements for weight loss dietary supplement products called "PhenCal" and "PhenCal 106," including claims that the products had been proven to cause weight loss and prevent the regaining of lost weight. The consent order requires Weider to pay $400,000 in consumer redress and have competent and reliable scientific evidence when making any weight loss, safety, disease benefit, or comparative claim in the promotion of its products or programs. It prohibits him from misrepresenting the existence, contents, validity, results, conclusions or interpretations of any test, study or research.

The Commission also initiated a law enforcement initiative addressing representations made for two dietary supplements — "Fat Trapper" and "Exercise In A Bottle"— in two infomercials. In *FTC v. Enfonna Natural Products, Inc., et al., CV 04376-JSL (CWx) (C.D. Cal.)* (settlements announced on April 26, 2000), the Commission alleged in a U.S. District Court complaint that the defendants made false and unsubstantiated weight loss claims for the two supplements. The Commission simultaneously approved two stipulated final orders settling the complaint allegations, one of which required the defendants to pay $10 million in consumer redress. Both orders also: (1) prohibit the defendants from making unsubstantiated claims that
any product, service or program causes or maintains weight loss or avoids weight gain without
dieting or exercise, prevents fat absorption, increases metabolism, burns fat, or allows weight
loss even if users eat high fat foods; (2) require the defendants to include with future weight loss
claims a clear and prominent disclosure that reducing calorie intake and/or exercising more is
necessary to lose weight; (3) require the defendants to have scientific substantiation for any
claims about the health or weight loss benefits, performance, safety or efficacy of any product,
service or program; and (4) prohibit the defendants from making false claims about the existence
or results of any tests, studies or research.

In a subsequent U.S. District Court complaint in FTC v. Steven Patrick Garvey, Garvey
Management Group, Inc., Lark Kendall, Mark Levine, David Richmond, and Modern Interactive
Technology, Inc., CV 00-09358-GAF (CWx) (C.D. Cal.)(announced on Sept 1, 2000), the
Commission alleged that Garvey and Kendall -- who appeared as co-hosts in infomercials for
Enforma Natural Products such as the "Fat Trapper" and "Exercise in a Bottle" -- made deceptive
weight loss claims for the products. Thereafter, the Commission approved a Stipulated Final
Order and Settlement of Claims for Monetary Relief as to Lark Kendall (Nov. 15, 2000), which
required her to assign to the FTC for consumer redress her right to collect money she is owed for
her appearance in the first Enforma infomercial and which contains injunction provisions similar
to those used in the Enforma Natural case. Recently, the Court granted in part defendants’
motion for summary judgment on res judicata grounds. The Court was persuaded that the
Commission’s settlement in the Enforma Natural case precluded the Commission’s case against
defendants Modern Interactive, Levine and Richmond in the Garvey case. The Commission has
moved for reconsideration of this ruling. The Court denied defendants’ summary judgment
motion as to defendants Garvey and Garvey Management Group, so that part of the case
continues.

FINANCIAL PRACTICES INITIATIVES

The Commission enforces several federal credit statutes that affect more than 113 million
consumers with credit cards and many millions more who apply for credit and loans. Credit fraud
and other violations of credit statutes continue to affect consumers of all ages and income levels.
Such abuses can be particularly devastating to seniors who rely on credit to augment their
income, and who may be more receptive to credit offers that are "too good to be true."

Home Equity Lending Abuses Cases

Abuses in subprime home equity markets may disproportionately affect elderly borrowers
because they are more likely to have equity in their homes. The Commission has been active in
challenging lenders who are engaged in abusive lending practices. These efforts include filing
complaints and consent orders for alleged violations of the Home Ownership and Equity
Protection Act ("HOEPA"), the Truth in Lending Act ("TILA") and its implementing regulation,
Regulation Z, and the FTC Act. The Commission also has been working with the States to
increase and coordinate enforcement efforts, and continues to implement extensive consumer
education efforts designed to help consumers avoid potential home equity lending abuses.

In January 1998, in FTC v. Capital City Mortgage Corporation (D.D.C.) (announced on
Jan. 30, 1998), the Commission filed a U.S. District Court complaint against Capital City and its president, Thomas K. Nash, alleging that the defendants violated the FTC Act, the Equal Credit Opportunity Act ("ECOA"), the TILA, and the Fair Debt Collection Practices Act ("FDCPA"). The complaint alleges that the defendants engaged in deceptive and unfair practices against borrowers at the beginning, during, and end of the lending relationship, in violation of Section 5 of the FTC Act. The complaint alleges that those deceptions included:

- representing that a loan was an amortizing loan that would be paid off by making payments each month, when in fact, the loan was an interest-only balloon loan with the entire loan principal amount due after all of the monthly payments were made;
- inflating monthly payment amounts, overdue balances, arrears, service fees, and advances with phony charges;
- misrepresenting the amount of money needed to pay off the loan;
- charging the borrower interest on the entire loan amount, even though a portion of the principal was withheld;
- foreclosing on borrowers who were in compliance with their loan terms; and
- failing to release the company’s liens on title to borrowers’ homes even after the loans were paid off.

The complaint further alleges that, after foreclosing, Capital City would buy the properties at auction for prices much lower than the appraised value of the properties. The complaint also alleges that Capital City violated the TILA in various ways, including by understating the finance charge and annual percentage rate for particular loans. The litigation in this matter continues.

In July 1999, the Commission approved consent judgments in seven cases against subprime mortgage lenders around the country for alleged violations of the HOEPA, the TILA, Regulation Z, and the FTC Act. See FTC v. Cooper (C.D.Cal.); FTC v. Capitol Mortgage Corp. (D.Utah); FTC v. CLS Financial Services, Inc. (W.D.Wash.); FTC v. Granite Mortgage, LLC (E.D.Ky.); FTC v. Interstate Resource Corp. (S.D.N.Y.); FTC v. LAP Financial Serv., Inc. (W.D.Ky.); and FTC v. Wasatch Credit Corp. (D.Utah) (all announced on July 29, 1999). These cases were part of "Operation Home Inequity," a Commission law enforcement and consumer education campaign seeking to enforce HOEPA and curb abusive practices in subprime mortgage lending. The court orders in these cases included injunctive provisions prohibiting violations of the HOEPA, the TILA, Regulation Z, and the FTC Act. Moreover, six of the orders together require the defendants to pay consumer redress totaling $572,500. In addition, two of the orders require the covered defendants to obtain performance bonds before they offer or extend specified credit in the future; a third order bans the covered defendants from any future involvement with high-cost loans secured by consumers’ homes.

In October 1999, in Fleet Finance, Inc. and Home Equity U.S.A., Inc., Docket No. C-3899 (consent order issued on Oct. 5, 1999), the Commission issued a consent order settling charges that Fleet Finance violated the TILA, Regulation Z, and the FTC Act by failing to provide accurate, timely disclosures of the costs and terms of home equity loans and other consumer credit transactions to consumers and by failing to provide or to provide accurately information to consumers about their home equity rescission rights. In transactions in which Fleet Finance
acquired or retained a security interest in the consumers’ principal dwellings, the complaint alleged that the company failed to provide consumers with the right to rescind the credit transaction by, *inter alia*, (1) failing to provide consumers with notice of the right to rescind, and (2) waiving consumers’ right to rescind, and disbursing funds, based on oral or other insufficient waivers. The complaint also alleged that Fleet Finance failed to provide consumers with all TILA required disclosures of the cost and terms of credit prior to the consummation of credit transactions, and failed to provide or provide accurately certain TILA disclosures, including the annual percentage rate. In addition, the complaint alleged that Fleet Finance failed to retain disclosures and rescission notices for two years, in violation of Regulation Z. The order required Fleet Finance and its successor companies, Home Equity U.S.A, to pay $1.3 million for consumer redress and administrative costs. The order also prohibited the entities from future violations of the TILA and Regulation Z and from various misrepresentations of credit costs and terms.

In March 2000, in *United States v. Delta Funding Corporation and Delta Financial Corporation* (E.D.N.Y)(settlement announced on March 30, 2000), the Commission secured a stipulated federal court order settling allegations in an accompanying U.S. District Court complaint against Delta, a national subprime mortgage lender. The Commission filed the complaint in conjunction with the Department of Justice and the Department of Housing and Urban Development, and it included allegations that this mortgage lender engaged in a pattern or practice of asset-based lending; that is, extending high cost loans based on the borrower’s collateral -- in determining whether the borrower would be able to make the scheduled payments to repay the obligation — rather than by considering the borrower’s current and expected income, current obligations, and employment status. The complaint also alleged that the defendants included prohibited terms in HOEPA loans, such as certain prepayment penalties and increased interest rates after default; the complaint alleged that these practices violated the HOEPA, the TILA and Regulation Z. The stipulated order, *inter alia*, makes consumers harmed by Delta’s HOEPA violations eligible for redress under an agreement between Delta and the New York State Banking Department; pursuant to this agreement, $12.25 million is available to compensate borrowers for various alleged state and federal law violations. The stipulated order also imposes injunctive relief under the HOEPA, the TILA, and Regulation Z.

In July 2000, in *FTC v. Nu West, Inc., et al.* (W.D.Wash.) (settlement announced on July 18, 2000), the Commission settled charges that another subprime mortgage lender, Nu West, and its principal violated the HOEPA, the TILA, Regulation Z, and the FTC Act. The complaint alleged that the defendants failed to disclose to consumers material loan costs and other information at least three days before closing; included prohibited balloon payments and increased interest rate provisions in loan documents; and made prohibited direct payments to home improvement contractors, in violation of the HOEPA, the TILA, and Regulation Z. The complaint further alleged that the defendants failed to disclose or disclose accurately various loan terms, including the annual percentage rate, the finance charge, and information about the right of rescission. The stipulated consent decree enjoined future law violations, and required the defendants to pay more than $160,000 in consumer redress and to reform open loans to nullify prohibited provisions.

In October 2000, in *FTC v. First Alliance Mortgage Co., et al.* (C.D.Cal.) announced on
October 4, 2000), the Commission filed a U.S. District Court complaint against First Alliance and two affiliate companies, which are among the nation's largest subprime home equity lenders. The complaint charged these companies with violations of the TILA, Regulation Z and the FTC Act. According to the complaint, the defendants target, through telemarketing and direct mail solicitations, homeowners with poor credit histories who may experience difficulty securing conventional home equity financing. The complaint alleges that the defendants' loan officers, through use of the "Track" -- a lengthy, thirteen-step sales presentation -- made misleading statements about material terms of the loan and the meaning of material information used in the TILA disclosure, in violation of the FTC Act. The complaint also alleges that the defendants misrepresented that the total amount borrowed, upon which interest accrues, is the amount financed that appears on the TILA disclosure statement, when, in fact, that amount does not include any fees financed by the borrower. In addition, the complaint alleges that the defendants misled consumers about the existence and amount of origination fees (typically 10 percent of the loan) and about the interest rate and monthly payments of their short-term "teaser rate" adjustable rate mortgages ("ARMs"). The complaint further alleges that the defendants did not have a reasonable basis to substantiate their claims that consumers will save money when consolidating debts through their loans. In addition, the complaint alleges that the defendants have failed to provide borrowers with ARM loans with information required by the TILA and Regulation Z which explains the ARMs. The complaint seeks an order awarding consumer redress and injunctive relief.

In December 2000, in *FirstPlus Financial Group, Inc. Docket No. C-3984* (consent order issued on Nov. 28, 2000), the Commission issued a consent order settling charges that FirstPlus's now bankrupt subsidiary, FirstPlus Financial, Inc., made misrepresentations in its advertisements for various credit products, including "high-loan-to-value" second mortgage loans and home equity loans. The Commission alleged that the advertisements misrepresented the amount of money that consumers would save when consolidating existing debts into a FirstPlus home equity loan. The Commission also alleged that the advertisements failed to adequately disclose key information about the loans. The consent order prohibited FirstPlus from misrepresenting its loan products, and required the company to use reasonable assumptions when creating savings comparisons, and to fully disclose all information necessary to evaluate those comparisons.

In March 2001, in *FTC v. Citigroup Inc., et al.* (N.D.Ga.) (announced on March 6, 2001), the Commission filed a U.S. District Court complaint alleging that The Associates and successors Citigroup and Citifinancial engaged in systematic widespread abusive lending practices. The complaint alleges, in particular, that the defendants lured consumers into high cost debt consolidation loans through misleading statements and half-truths about what the costs would be; and engaged in numerous deceptive practices and other violations of law to induce consumers to take out or refinance loans with high interest rates, costs and fees, and to purchase high-cost credit insurance.

The complaint alleges that the defendants used deceptive marketing practices, in violation of the FTC Act, by, in particular, representing that consumers would "save money" based on the false
assumption of monthly payment savings for the entire loan term (even though current debts being consolidated were short term); comparing payments without taxes and insurance to current mortgage payments with taxes and insurance; failing to adequately disclose high fees and costs; and failing to adequately disclose balloon payments. The complaint also alleges that The Associates engaged in credit insurance packing in violation of the FTC Act by: automatically quoting a loan amount with a package of single-premium credit insurance products, called "total payment protection," added to the principal amount of the loan and financed (at rates usually more than 10 percent); misleading consumers into believing "total payment protection" was offered without additional cost (when in fact it sometimes involved thousands of dollars in extra costs); making misrepresentations about insurance coverage (such as failing to disclose that, in many instances, the length of coverage was shorter than the loan term); and making misrepresentations that consumers could cancel the insurance and secure a full refund (when only the cost of the premium is credited, not extra points paid or interest paid to date).

In addition, the complaint alleges that The Associates used abusive and unfair debt collection practices in violation of the FTC Act, including disclosing the debt to third parties; calling the debtor at work after having been told not to do so; and making repeated phone calls. The complaint also alleged violations of the TILA (splitting a loan in two to avoid providing the right of rescission); the ECOA (failing to retain records); and the FCRA (using credit reports for impermissible marketing purposes). The case is now being litigated.

Equal Credit Opportunity Act Cases

Among other things, the Equal Credit Opportunity Act ("ECOA"), 15 U.S.C. § 1691 et seq., prohibits creditors from discrimination based on age in determining whether or not to extend credit. The ECOA's implementing Regulation B prohibits creditors from discounting or refusing to consider an applicant's income from a pension or other retirement benefit or from denying credit because an applicant, on the basis of age, does not qualify for credit-related insurance. The ECOA also prohibits discrimination based on the fact that an applicant's income is derived from a public assistance source, including Social Security, which is more likely to be received by the elderly. To help detect discrimination in mortgage credit based on age or other prohibited factors (such as sex or race), Regulation B requires mortgage lenders to take written applications for credit and to record the race/national origin, sex, marital status, and age of applicants. The ECOA also requires written notice to consumers of the reasons for a denial of credit. Where the adverse action is based on a report from a consumer reporting agency, the Fair Credit Reporting Act ("FCRA") requires the creditor to disclose this as well. The TILA requires that all borrowers receive accurate disclosure of the cost of credit.

As noted above, in January 1998 the Commission filed suit in FTC v. Capital City Mortgage Corporation against a Washington, D.C. area mortgage lender. In addition to alleging violations of the FTC Act, the TILA, and the FDCPA, the complaint filed in that case also alleges that the defendants violated the ECOA and Regulation B. The complaint alleges, in particular, that “[i]n many instances, defendants’ borrowers are minority and/or elderly persons living on fixed or low incomes in Washington, D.C., Maryland, and Virginia, who borrow primarily for personal, family, or household purposes.” The complaint alleges that Capital City makes high interest rate (20 to 24 percent) loans to those borrowers and that the loans are often
interest-only balloon loans in which a borrower, after making payments for the term of the loan, still owes the entire amount of the loan principal. These loans often are secured by the borrowers' homes and typically are made based on the worth of the home rather than on the borrowers' creditworthiness or income.

The Commission complaint alleges that the defendant company and its president violated the ECOA and Regulation B by failing to take written applications for mortgage loans; failing to collect required information about the race/national origin, sex, marital status, and age of applicants; failing to provide written notice of adverse action; or -- when providing notice of adverse action -- failing to provide the applicant with the correct name and address of the Federal Trade Commission, the federal agency that administers compliance with the ECOA with respect to Capital City. The lawsuit is pending in the U.S. District Court for the District of Columbia, and in addition to the other relief described above, the Commission is seeking civil penalties and injunctive relief for ECOA violations.

In May 1999, in United States v. Franklin Acceptance Corporation (E.D.Pa.)(settlement announced on May 13, 1999), the Commission approved a consent decree resolving allegations in a U.S. District Court complaint that Franklin, an automobile finance company, discriminated against applicants on the basis of the fact that an applicant's income derived from public assistance sources -- including certain Social Security benefits -- as well as on the basis of sex and marital status, and when taking adverse action on an application, failed to provide notice as required under the ECOA and the FCRA. The complaint in particular alleges that Franklin discriminated against applicants who derived their income from public assistance by discounting or refusing to consider such income. The complaint also alleges that, when taking adverse action on an application, Franklin failed to provide the applicant with written notification of the action taken, failed to disclose the specific reasons for the action taken or to disclose the applicant's right to request such reasons, and, when adverse action was based on a report from a consumer reporting agency, failed to provide notice as required under the FCRA. The defendants agreed to pay a civil penalty of $800,000, and to the entry of a permanent injunction.

Debt Collection Practices Cases

Each year, the Commission receives a large number of consumer complaints alleging harassing and abusive behavior by debt collectors. During the January 1999-August 2001 period, the Commission filed a number of law enforcement actions, and continued a number of other actions initiated in prior years, against debt collectors for violations of the Fair Debt Collection Practices Act ("FDCPA"), 15 U.S.C. §§ 1692-1692o.

In February 1999, in United States v. Perimeter Credit, L.L.C. and Account Portfolios, Inc. (E.D.Pa.)(settlement announced on May 13, 1999), Account Portfolios and its Perimeter Credit subsidiary agreed to pay a $300,000 civil penalty to settle Commission allegations that Perimeter violated the FDCPA by, among other things, making false and misleading statements and impermissibly contacting third parties about consumers' debts. In December 1999, in United States v. National Financial Systems, Inc. (E.D.Pa.)(settlement announced on May 13, 1999), the Commission secured a stipulated federal court order against a New York-based collection agency that allegedly violated the FDCPA through practices such as continuing to contact consumers at work after learning that the consumers' employers prohibited such contacts, and falsely implying
to consumers that failure to pay their debts could result in arrest or imprisonment. The stipulated order required NFS to pay a civil penalty of $20,000, contained broad prohibitions against future FDCPA violations, and required NFS to inform consumers that they may stop the company from contacting them about the debt.

In March 1999, the Commission amended the complaint in FTC v. Capital City Mortgage Corporation described above -- against Capital City and its owner, Thomas K. Nash -- to add in-house attorney Eric J. Sanne as a defendant. The original complaint alleged among other things that Capital City and Nash violated the FDCPA by falsely representing that letters from Sanne were from a third-party collector, making false and misleading representations when collecting loan payments, and engaging in unfair or unconscionable debt collection practices. The court permitted the Commission to add Sanne as a defendant based upon the Commission’s discovery during litigation of hundreds of additional debt collection letters sent by the attorney. The Commission is seeking injunctive relief for the FDCPA violations, and while discovery in the case has now ended, a trial date has not yet been set.

In August 1999, in Federated Department Stores, Inc., Docket No. C-3893 (consent order issued on Aug. 20, 1999), the Commission issued a consent order against one of the nation’s largest retailers, settling allegations in an accompanying complaint that the company induced consumers who filed for bankruptcy protection to agree to reaffirm their Federated credit account debts in order to keep their Federated credit card and merchandise. According to the Commission’s complaint, Federated falsely represented that these “reaffirmation agreements” would be filed with the bankruptcy courts, as required by law, and that consumers would be legally obligated to pay. Although the FDCPA does not apply to creditors such as Federated collecting their own debts, the Commission alleged that these practices violated Section 5(a) of the Federal Trade Commission Act. At the time Federated settled with the Commission, the company had recently entered into a settlement with a number of State Attorneys General. The consent order permitted the Commission to file an action to seek full redress if the refunds pursuant to the State settlements totaled less than $8.2 million, or if the Commission believed that Federated had failed to fulfill its obligations to make payments under its agreement with the States. The consent order also prohibits Federated from, among other things, misrepresenting that any reaffirmation agreement it obtains will be filed with the bankruptcy court. This matter is the most recent in a series of Commission cases involving major, nationwide retailers. The respondents in the other cases included Sears, Roebuck and Company; General Electric Capital Corporation; and May Department Stores Company. Consumers have received full redress for all monetary injury in these cases; the total redress provided exceeded $183 million in direct payments or reductions in cash owing.

In July 2000, in United States v. North American Capital Corporation (“NACC”)(W.D.N.Y.)(settlement announced on July 12, 2000), the defendant agreed to pay a $250,000 civil penalty as part of a settlement to resolve Commission allegations that NACC violated the FDCPA by, among other things, discussing consumers’ debts with third parties such as the consumers’ employers and co-workers; harassing consumers with obscene or profane language; and making false and misleading representations, such as that consumers’ wages would be garnished and their property seized if they failed to pay. In addition to the civil penalty, the consent decree settling the Commission charges includes broad prohibitions of future FDCPA
violations, and requires NACC to inform consumers it contacts in writing that they may stop the company from contacting them about the debt.

SALES AND PROMOTIONAL PRACTICES INITIATIVES

Mail Or Telephone Order Merchandise Rule Cases

In issuing its initial Rule relating to mail order sales, the Commission noted that consumers with mobility problems, including older consumers, frequently order by mail. In 1994, the Commission extended the coverage of the Rule to include telephone sales; it is now called the Mail Or Telephone Order Merchandise Rule. During that rulemaking proceeding, AARP testified that, according to its consumer survey data, 27 percent of people aged 65 and older ordered products and services by telephone over a given six-month period. The Rule requires sellers to make timely shipment of orders; give options to consumers to cancel an order and receive a prompt refund or to consent to any delay; possess a reasonable basis for any promised shipping dates; and make prompt refunds. The Commission staff works closely with industry members and trade associations to obtain compliance with the Rule, and the Commission initiates law enforcement actions where appropriate.

As part of "Project Toolate.com," the Commission staff initiated an investigation to determine whether online retailers failed to deliver goods when expressly promised during the 1999 holiday season, in violation of the Mail Or Telephone Order Merchandise Rule. As noted above, the rule requires retailers to ship goods by the date promised, or if no date is promised, within 30 days of receiving the order. If a company cannot ship as promised, it is required to provide notice to the buyer with a revised shipping date, giving the buyer the opportunity to agree to the delay or to cancel the order. The U.S. District Court complaints announced as part of Project Toolate.com alleged that seven "etailers" -- CDnow, Inc.; KBkids.com LLC; Macys.com, Inc.; Franklin W. Bishop d/b/a Minidiscnow.com; The Original Honey Baked Ham Company of Georgia, Inc.; Patriot Computer Corp.; and Toysrus.com, Inc.-- violated the Rule by failing to send the required delay option notices, sending notices that were deficient, and in some cases making shipping representations without a reasonable basis. Six of the complaints also alleged that the defendants (except CDnow) failed to deem certain orders canceled in the absence of a notice, in violation of Section 435.1(c) of the Rule. In addition, four of the complaints (against KBkids.com, Macys.com, Toysrus.com, and Minidiscnow.com) alleged that the defendants took orders without a reasonable basis for their shipping representations, in violation of Section 435.1(a)(1) of the Rule.

The consent decrees settling the complaints against six of the defendants required the payment of the following civil penalty amounts: Macys.com ($350,000), KBkids.com ($350,000), Toysrus.com ($350,000), CDnow ($300,000 (with $200,000 waived because of the firm's poor financial condition)), Patriot Computers ($200,000), and The Original Honey Baked Ham Co. ($45,000). The consent decree against the seventh defendant, Minidiscnow.com, required the firm to fully reimburse each consumer who had ordered, but not received, any of the company's products. In addition, Macys.com was required to fund an Internet consumer education campaign about the Mail Or Telephone Order Merchandise Rule consisting of banner
ads that alert consumers that they have certain rights when shopping online. The decrees also
contain injunctive provisions prohibiting future Rule violations.

**Funeral Services Cases and Other Initiatives**

A funeral can cost $10,000 or more. This expensive consumer purchase is often made at
an emotionally difficult time, and often is a first-time purchase. The Commission’s Funeral
Industry Practices Rule (16 CFR Part 453) is designed to ensure that funeral providers give
consumers timely information relating to the range of funeral goods and services offered and the
prices charged. The Rule also requires funeral providers to make important disclosures to
consumers inquiring about funeral goods or services.

The FTC has used various enforcement approaches since the Rule became effective in
1984, including traditional investigations and test-shopping sweeps of funeral homes in various
geographic areas. Over the last six years, in cooperation with State Attorneys General and
AARP, the FTC has test-shopped more than 1,350 funeral homes. Since 1999, the FTC has
organized test-shops of almost 500 funeral homes — in New York, New Jersey, Connecticut,
Illinois, West Virginia, Florida, New Mexico, Texas, and California, among others — with the
test-shopping being performed by FTC investigators, by state and local agency investigators, and
in some instances by AARP volunteers. These test-shops are ongoing, and to date, 70 violators
have been offered the opportunity to bring their funeral homes into compliance by enrolling in
the FTC’s non-litigation alternative, the Funeral Rule Offenders Program (FROP).

The Commission, which reviews each of its rules and guides every 10 years, is currently
reviewing the Funeral Rule. The Commission initiated the Rule review by publishing in the
Federal Register a request for comment on many issues, including the continued need for the
Rule, the Rule’s costs and benefits, and whether substantial changes to the rule are necessary.
In response to the Federal Register Notice, 153 comments were submitted from industry
members, consumers, consumer groups, law enforcement agencies, and others. FTC staff are
carefully reviewing the comments and other information contained in the Rule review record, and
are preparing a recommendation for the Commission’s consideration. In connection with the
Rule review, the Commission held a public workshop, at which individuals representing a wide-
range of interests and organizations, including AARP, participated. The FTC has also
participated in other meetings and workshops relating to the funeral industry, such as the Senate
Aging Committee hearings in April 2000, and AARP’s Death Care Symposium in May 2000.

**Energy and Home Appliance Representations Cases**

One way older consumers try to save on expenses is by cutting down on energy use in
their homes. In May 2000, Intermatic — one of the country’s largest manufacturers of consumer
and industrial energy control products, including appliance timers and low-voltage outdoor
lighting — agreed to pay a $250,000 civil penalty to settle FTC charges that the company violated
a 1979 Commission consent order. The 1979 order prohibited the company from making
unsubstantiated claims that the use of its electric water heater timer (the "Little Gray Box")
results in substantial savings on water heating bills. In United States v. Intermatic, Inc. Civ.
Action No. 00-C50178 (N.D.Ill.) (announced on May 24, 2000), the U.S. District Court complaint alleged that Intermatic violated the 1979 order by making unsubstantiated energy savings claims regarding the Little Gray Box; omitting the required dishwasher disclosure on the package and in advertisements; and omitting the required disclosure on the instruction sheets for the Little Gray Box. The complaint also alleged that Intermatic made false or misleading claims that tests prove the energy savings. The consent decree settling the complaint allegations required Intermatic to pay $250,000 in civil penalties, and prohibits the firm from making any energy efficiency, efficacy, benefits, mechanism of action or performance claims about appliance timing devices unless it possesses and relies upon competent and reliable scientific evidence to support such claims. The consent decree also prohibits the firm from misrepresenting the results of scientific tests in connection with any appliance timing device.

The Commission also ensures that consumers can secure accurate information about energy usage levels for home appliances by actively enforcing its Appliance Labeling Rule. The Rule requires manufacturers to disclose energy information about certain major household appliances, so that consumers can compare the energy use and efficiency of competing models. In particular, manufacturers of all covered appliances must disclose specific energy consumption or efficiency information at the point of sale in the form of an EnergyGuide label that is affixed to the covered product. Required labels for appliances and required fact sheets for heating and cooling equipment must include an energy consumption or efficiency disclosure and a "range of comparability" bar that shows the highest and lowest energy consumption or efficiencies for all similar appliance models. Labels for refrigerators, refrigerator-freezers, freezers, clothes washers, dishwashers, water heaters, and room air conditioners also must contain a secondary disclosure of estimated annual operating cost based on a specified national average cost for the fuel the appliances use. The FTC Web site includes a number of brochures which explain to consumers the ways in which they can use the EnergyGuide labels to determine the energy efficiency of the appliances they purchase.

Older consumers also are interested in devices that can improve their home environment, including those that address allergies or other health problems. In December 1997, in United States v. Alpine Industries, Inc., et al. (E.D. Tenn.) (announced on Jan. 5, 1998), the Department of Justice filed a U.S. District Court complaint on the Commission’s behalf alleging that Alpine and its principal, William J. Converse, violated a 1995 Commission consent order. The 1995 order settled allegations that Alpine and Converse had misrepresented the effectiveness of the Alpine ozone generating “air cleaning” machines, and prohibited the respondents from making unsubstantiated claims for the devices. In November 1999, the District Court jury unanimously found that Alpine and Converse had claimed that Alpine products would prevent or provide relief from various health or medical conditions -- including allergies, asthma, sinus and breathing problems, emphysema, lupus, migraine headaches and an unspecified incurable eye disease -- without having competent and reliable scientific substantiation for these claims, and therefore had violated the 1995 order. In April 2001, the District Court issued a civil penalty judgment for $1.49 million plus interest and costs against Alpine and Converse.
**Living Trusts**

On July 11, 2000, the Commission presented testimony before the United States Senate Special Committee on Aging about scams involving living trusts. The testimony stemmed from an AARP study showing that ownership of living trusts among low income seniors is growing dramatically and disproportionately among middle- and upper-income seniors. Although living trusts are a legitimate estate planning tool, typically consumers with low income and small estates would not ordinarily need them. The Commission testimony described how living trust scams work, and how state and local bar associations may consider sellers of living trusts to be violating state Unauthorized Practice of Law statutes and state consumer protection laws. A new Consumer Alert, prepared for issuance with the testimony, warns about living trust scams and encourages consumers who believe they may have fallen for a scam to come forward and report their experience to the FTC or other authorities.

**ENFORCEMENT INITIATIVES AGAINST FRAUD**

The Commission’s extensive law enforcement experience with fraud indicates that the elderly constitute a disproportionate number of consumer fraud victims; in some scams, 80 percent or more of the victims are 65 or older. The elderly often are the deliberate targets of fraudulent operators who take advantage of the fact that many older people have cash reserves or other assets to spend on seemingly attractive offers.

Survey research conducted in 1998 by the National Consumers League’s National Fraud Information Center (“NFIC”) -- in cooperation with AARP -- provides a breakdown of the types of fraud which appear to be directed in particular to older consumers. In particular, NFIC found that while consumers aged 50 and older accounted for about 38 percent of the telemarketing fraud reported overall in 1997, the percentages were even higher in certain categories: magazine sales fraud [40%]; travel offers fraud [46%]; lotteries fraud [53%]; and credit card loss protection plans fraud [71%].

More recently, at the request of the FTC’s Northeast Region, NFIC reviewed its year 2000 data, and indicated that it received a total of 1100 complaints from consumers aged 60 and older in 2000, and that the five largest categories of their complaints concerned Internet auctions [239]; prizes/sweepstakes [200]; magazines [182]; credit card loss protection [87]; and credit card issuing [46].

From January 1999 through August 2001, Commission enforcement activities have addressed traditional frauds -- including telemarketing fraud, prize promotion and sweepstakes fraud, advance fee loan scams, credit card loss protection fraud, and lottery scams and other cross-border frauds -- as well as those that are more contemporary, including Internet fraud and identity theft. The Commission is able to bring many of these schemes to a halt quickly, and often to obtain restitution for the defrauded consumers.

The following discussion describes Consumer Sentinel and econsumer.gov -- two crucially important mechanisms for identifying fraudulent or otherwise deceptive schemes so that
they can be targeted as quickly as possible — and Commission law enforcement initiatives against a number of the most common types of fraud.

**Consumer Sentinel**

A cornerstone of the FTC’s ability to act quickly and effectively against fraud is access to up-to-date consumer complaint information. In late 1997, the FTC established Consumer Sentinel as a web-based law enforcement network. The network provides law enforcement agencies in the United States, Canada and Australia with secure, password-protected access to more than 300,000 consumer complaints about telemarketing, direct mail and Internet fraud. Law enforcement agencies and private organizations contribute consumer complaints to the Consumer Sentinel database, which is searchable by criteria including the name, address and telephone number of a firm; the type of fraud; and the country and state or province of the consumer. The National Association of Attorneys General, the National Consumers League, Better Business Bureaus, the U.S. Postal Inspection Service, and Canada’s Phonebusters are leading partners with the FTC in this project. One part of Consumer Sentinel, accessible only to law enforcement officials, provides free consumer complaint data and other intelligence about particular firms or individuals. More than 320 United States, Canadian, and Australian law enforcement agencies have signed up for access, which enables them to share information, avoid duplication of efforts and formulate rapid responses to new fraud schemes. In addition to the site available only to law enforcers, Consumer Sentinel also has a website for the public; consumers can file complaints electronically at www.ftc.gov, and thus channel information about potential scams directly to the FTC’s Consumer Response Center (“CRC”) and the fraud database. In addition, CRC counselors, who process both telephone and mail inquiries and complaints, enter complaints in Consumer Sentinel.

Since Consumer Sentinel went online, the Commission has upgraded the capacity of the database and enhanced the agency’s complaint-handling systems by creating and staffing a new toll-free consumer helpline at 1-877-FTC-HELP, and by adding several new functions to Consumer Sentinel. The “Top Violators” report function allows a law enforcement officer to pull up the most common suspects and schemes by state, region or subject area. The “Auto Query” function permits an investigator to create an automatic search request, which can be set to run daily, weekly, or monthly. If new complaints come into Consumer Sentinel that match the search criteria, Consumer Sentinel automatically alerts the investigator via email. The “Alert” function allows law enforcers to communicate with each other and minimize duplication of their efforts. Yet another new function enables searches of Commission court orders online. In 2000, Consumer Sentinel received more than 100,000 consumer complaints, and the database now holds more than 300,000 consumer complaints.

Consumer Sentinel receives data from other public and private consumer organizations, including 64 local offices of the Better Business Bureaus across the nation, the National Consumers League’s National Fraud Information Center, and Project Phonebusters in Canada. Additionally, a U.S. Postal Inspector has served as the program manager, and the U.S. Postal Inspection Service just signed an agreement to share consumer complaint data from its central fraud database with Consumer Sentinel. Finally, the FTC recently signed an agreement with the
Department of Defense to collect consumer complaints from men and women serving in the military through a project called “Soldier Sentinel.”

econsumer.gov

Building on Consumer Sentinel, and as an important part of its effort to protect seniors and other consumers, the FTC works closely with foreign governments. One example is a pilot project called econsumer.gov, a joint effort of the Commission, agencies from 12 other countries and the Organization for Economic Cooperation and Development (“OECD”) to gather and share cross-border e-commerce complaints. This project will allow law enforcers from around the world to access a database of consumer complaints specifically about cross-border Internet transactions. It has two parts: a public Web site at www.econsumer.gov, and a restricted access law enforcement site.

Consumers worldwide can visit the public Web site and use one of four languages (English, French, German, and Spanish) to enter e-commerce complaints about foreign companies; to secure important consumer information on topics such as shopping safely online; and to secure contact information for consumer protection agencies in the participating countries. Moreover, links to the site provided by other organizations substantially enhance its accessibility to consumers. Thus, for example, AARP provides a direct link from the Web Resources section of its Web site to econsumer.gov, noting that it provides consumers with “tips for shopping online, advice on Internet auctions, links to many international consumer protection agencies, and more.”

Law enforcement agencies from participating countries will have access to the complaints through the restricted access, password-protected law enforcement Web site. This site also will allow government officials to communicate with consumer protection law enforcers from other countries, to notify each other of ongoing investigations, and to receive information about recent actions.

Telemarketing Fraud Cases

In conjunction with Section 5 of the FTC Act, the Telemarketing and Consumer Fraud and Abuse Prevention Act gives the FTC specific additional powers to combat telemarketing fraud. As prescribed by the Act, in 1995 the Commission promulgated the Telemarketing Sales Rule (“TSR”), implementing the requirements of the Act; imposing a number of general requirements upon all telemarketers; and prohibiting specific fraudulent or potentially fraudulent practices. From January 1996 through September 4, 2001, the Commission (or the U.S. Department of Justice, acting on its behalf) filed 124 law enforcement actions alleging Rule violations, including 66 filed during the January 1999-September 4, 2001 period. Approximately 75 percent of the 124 cases have been concluded, producing injunctions against misrepresentations and future violations of the Rule; outright bans on some or all forms of telemarketing in some cases; monetary judgments totaling approximately $155 million for consumer redress; and civil penalties totaling approximately $777,000. Through these efforts, the Commission has stopped major fraudulent telemarketing and related operations that have
bilked consumers out of hundreds of millions of dollars.

Moreover, the Commission conducted extensive law enforcement "sweeps" with State Attorneys General, State securities officials, the FBI, the United States Postal Service, and other agencies, and has developed alliances with new law enforcement authorities to coordinate additional actions against fraudulent actors. An important component of these cooperative efforts is the ability to pursue both civil and criminal law enforcement actions against particularly egregious telemarketing scams. Under this approach, once the FTC concludes its civil case against a group of telemarketers engaged in particularly egregious practices, it refers the matter to state and federal prosecutors, who may determine whether to file criminal charges against the defendants as well.

**Prize Promotion and Sweepstakes Fraud Cases**

Older Americans often are the targets of fraudulent prize promotions and sweepstakes, egregious types of fraud usually conducted through telemarketing or direct mail. In 1999, approximately 24 percent of the complaints logged into Consumer Sentinel pertained to prize promotions, sweepstakes, and gifts. In a typical scheme, telemarketers 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. Consumers are told that before they can redeem their prize, they must purchase certain products and submit payment for nonexistent shipping, taxes, customs, or bonding fees. Some schemes never provide consumers with any prize or gift; others provide inexpensive items, often called "gimme gifts" or "cheap gifts." These schemes clearly violate the TSR, which requires telemarketers, in any prize promotion, to disclose that no purchase or payment is required to win a prize, and to provide information about the odds of winning the prize and how to participate in the promotion at no cost.23

Prize promotion fraud continues to be a significant problem for seniors and other consumers, and remains one of the top five categories of complaints reported in Consumer Sentinel.24 The Commission continues to address this type of fraud through efforts such as Project Prize Fighter, a Commission sweep targeting bogus prize promoters which was publicly announced on July 13, 2000. The sweep produced 24 law enforcement actions against more than 40 defendants in 9 states.25 In one of the cases, FTC v. Cory Banks, Civ. Action No. CV-0011218-CM (RZx)(C.D. Cal. Announced July 13, 2000), the Commission filed a complaint alleging that the defendants contacted and represented to consumers that the defendants were holding prize winnings for them; and advised the consumers that to secure the winnings, they would have to pay a fee for research, reporting, confirmation and document delivery. The Commission also alleged that the defendants failed to provide anything to consumers who sent in their money; and refused to make refunds to the victims. The Commission secured a temporary restraining order, preliminary injunction, and asset freeze against the corporate and individual defendants, and is seeking consumer redress.

More recently, on January 5, 2001, the FTC announced Project Mailbox IV, a nationwide coordinated law enforcement effort and consumer education initiative targeting deceptive mail
offers, unsolicited faxes and e-mail "spam." This initiative produced a total of more than 300 law enforcement actions during the October 1999 - September 2000 period. During that period, offers using deceptive sweepstakes and prize promotions led the list of the Project's law enforcement actions. The FTC and its partners in this project -- 49 State Attorneys General, the Postal Inspection Service and the SEC -- thus far have filed a total of more than 180 lawsuits against these types of scams. As a result, millions of dollars have been returned to consumers, many of them elderly, who had been taken in by such offers. Since the Commission and its law enforcement partners began their annual Project Mailbox efforts in October 1997, the Project has thus far resulted in a total of approximately 500 law enforcement actions.

Advance Fee Loan Cases

In advance-fee loan cases, telemarketers seek out people with bad credit and offer them loans or credit cards in exchange for fees paid up-front. Most advance-fee loan telemarketers persuade consumers to pay the up-front fee by telling them that they are certain or nearly certain to receive loans. Fees range from $25 to several hundred dollars. Telemarketers often assure consumers that they will receive a refund in the unlikely event that a loan is not forthcoming. After paying the fee, however, those who are offered loans typically never receive them, and those who are offered credit cards usually receive only a standard application form or generic information on how to apply for credit cards. Consumers often have difficulty contacting the telemarketers for a refund. The Telemarketing Sales Rule prohibits these practices. 26

From January 1999 to August 2001, the Commission initiated and conducted two phases of "Operation Advance Fee Loan," a law enforcement program targeting corporations and individuals that promise loans and credit cards for an advance fee but never deliver them. 27 On August 12, 1999, the Commission announced that it had filed four U.S. District Court complaints addressing alleged advance fee loan scams. For example, in FTC v. American Consumer Membership Services, Inc., and Darryl Smith, (N.D.N.Y. 1999), the complaint alleged that the defendants fraudulently telemarketed advance fee credit cards to low income consumers and those with credit problems, but provided consumers who paid a $69 fee nothing more than credit card applications with lists of banks to which they could apply for secured or unsecured credit cards. 28 In this case, the Commission filed a motion for a preliminary injunction; in the other cases discussed in note 28, the District Courts involved issued temporary restraining orders to halt the deceptive practices at issue and freeze the defendants' assets, pending trial.

On June 20, 2000, the Commission announced the second phase of Operation Advance Fee Loan, which included five cases filed by the Commission, 13 actions taken by State Attorneys General and/or other State officials, and three criminal cases filed by Canadian law enforcement authorities against Canadian advance fee loan scam operators who preyed on Canadian and American citizens. For example, in FTC v. Financial Services of North America, the complaint alleged that the defendants misrepresented that consumers who paid a fee of $69 to $99 in advance would receive a guaranteed credit card -- and that the consumers' bank accounts would not be debited, or would be debited only for authorized amounts -- but provided consumers who paid the fee nothing more than discount purchasing club memberships and credit card applications. 29
Credit Card Loss Protection Fraud Cases

Unscrupulous telemarketers pitching worthless credit card "protection" packages often prey on unwary consumers, including many older consumers, who fear that their credit cards are at risk. In fact, the TILA and Regulation Z provide that consumers cannot be held liable for more than $50 for any unauthorized charges submitted to a credit card account.30 To address these types of misrepresentations, on October 30, 2000, the Commission filed complaints against six groups of companies and their principals as part of a nationwide enforcement sweep called "Operation Protection Deception."31 For example, in FTC v. Consumer Repair Services, Civ. Action No. 00-11218 CM (RZx)(C.D. Cal. Announced Oct. 30, 2000), the Commission complaint alleged that the defendants used boiler rooms nationwide, or in Canada, to sell consumers credit card protection packages that in fact, provided no protection at all; misrepresented to consumers that they could be liable for hundreds, if not thousands, of dollars in unauthorized charges; and misrepresented that thieves could secure consumers' credit card numbers over the Internet and use these numbers to rack up unauthorized charges. The complaint further alleged that the defendants billed consumers between $259 and $400 for the "service" when they accepted the offer; charged those consumers who declined the offer; and refused to grant refunds to consumers who attempted to cancel the "protection." In this case and in the cases against five other sets of defendants in Operation Protection Deception, the Commission secured temporary restraining orders with asset freezes against each defendant, their associated businesses and their principals, and the appointment of temporary receivers; and sought consumer redress, including the refund of all illegally billed charges.

More recently, following an investigation coordinated with the British Columbia Ministry of Attorney General, the Federal Bureau of Investigation ("FBI") and the Royal Canadian Mounted Police ("RCMP"), the Commission filed a Section 13(b) complaint in FTC v. OPCO International Agencies, Inc., Civ. Action No. COJ-2053R (W.D. Wash. Announced Feb. 7, 2001), alleging that the defendants fraudulently marketed credit card loss protection and debt consolidation services, primarily to seniors, in violation of the FTC Act and the TSR. The complaint alleges that when marketing credit card loss protection services, the defendants misrepresented their identity to imply an affiliation with a consumer's credit card issuers; used scare tactics to market their programs -- such as telling consumers that their credit card numbers were accessible to criminals via the Internet, and that unless they purchased "protection" services, they could be held liable for unauthorized charges -- and typically charged $299 for their "protection" services. When marketing debt consolidation services, the defendants allegedly told consumers that for $397, they would obtain a low-interest loan that could be used to consolidate their credit card debt; instead, however, consumers received only a list of banks offering low-interest credit card loans. The complaint further alleged that, in addition to telemarketing directly through their own call centers, the defendants provided products, scripts, customer service and credit card processing services to others engaged in deceptive telemarketing. Finally, the complaint alleged that the defendants often posted charges on consumers' credit cards without their authorization; misrepresented their refund policy; and failed to promptly, clearly and conspicuously state, as required by the TSR, that the purpose of their call was to sell goods or services. The District Court granted the FTC request for preliminary relief by issuing an ex parte temporary restraining order and asset freeze against the defendants. The Commission is further seeking a permanent injunction and other equitable relief, as the court deems warranted.32
Lottery Scams and Other Cross-Border Fraud Cases

In the mid 1990s, senior citizens in the United States began receiving increasing numbers of solicitations from fraudulent telemarketers operating from Canada. Telemarketing fraud perpetrated against U.S. consumers by Canadian telemarketers has become a serious problem. In 2000, 71 percent of the cross-border complaints collected in Consumer Sentinel — more than 8,300 — were registered by U.S. consumers against Canadian companies. Such U.S. consumer complaints accounted for reported dollar losses of $5.3 million in 1999, $19.5 million in 2000, and a projected $36.5 million in 2001, based on the number of complaints received thus far in 2001.

The highest number of complaints from U.S. consumers against Canadian companies concern sweepstakes, advance-fee loans, lotteries, and Internet auctions. Sweepstakes and related prize promotion complaints accounted for 51 percent of the complaints; advance-fee loan complaints accounted for about 24 percent and lotteries accounted for about 6 percent. Moreover, 61 percent of the dollar loss U.S. consumers reported from sweepstakes, advance-fee loans, and lotteries overall involved Canadian companies. While Internet auctions also accounted for about 6 percent of these complaints, they accounted for only about 1 percent of the dollar loss. Of course, cross-border fraud is not a one-way problem. About 12 percent of the cross-border complaints added to Consumer Sentinel in 2000 were registered by Canadian consumers against U.S. companies; leading complaint categories included travel, Internet auction scams, and sweepstakes. In the past 10 years, FTC legal actions have resulted in the return of more than $730,000 in redress to more than 2,700 Canadian consumers.

The Commission has developed and implemented a number of strategies to combat cross-border fraud. The FTC Act gives the agency jurisdiction over cross-border consumer transactions; in particular, Section 5(a) of the FTC Act gives the Commission authority to prohibit unfair or deceptive acts or practices "in or affecting commerce," and Section 4 of the FTC Act defines "commerce" to include that "among the several States or with foreign nations." Commission jurisdiction under the FTC Act extends to the TSR, which the Commission can enforce "in the same manner, by the same means, and with the same jurisdiction, powers, and duties" it has under the FTC Act. As a result, in a number of instances, the Commission has enforced the TSR against Canadian telemarketers calling consumers in the U.S.

In the typical cross-border lottery scheme, telemarketers offer consumers the opportunity to "invest" in tickets in well-known foreign lotteries — such as those in Canada and Australia — without disclosing that buying and selling foreign lottery tickets is illegal in the U.S. Consumer Sentinel statistics indicate that 62 percent of U.S. consumer complaints about lottery scams are against Canadian companies, which reportedly caused more than $1.2 million in losses. In response, the Commission and Canadian authorities have initiated a number of law enforcement actions against cross-border lottery con artists that target elderly U.S. consumers. In November 1998, for example, the Commission and the Attorneys General of Arizona and Washington filed a civil complaint in Win USA Services Ltd., Civ. Action No. C98-1614Z (W.D. Wash. Nov. 1998), alleging that the Canadian telemarketers convinced consumers to send them hundreds or
thousands of dollars by promising them that they were likely to win, were "guaranteed" to win, or had already won a foreign lottery. The complaint sought a permanent injunction prohibiting the defendants' lottery telemarketing activities, and restitution to consumers or disgorgement of ill-gotten gains and civil penalties, where appropriate. The investigation was conducted in cooperation with the Royal Canadian Mounted Police and the British Columbia Ministry of Attorney General, which filed suit against the same defendants in a British Columbia court. That court later imposed an asset freeze and appointed a receiver, pending trial. In April 2001, the U.S. District Court issued a summary judgment order that, *inter alia*, prohibits the defendants from selling tickets, chances, interests or registrations in any lottery to U.S. residents, and from selling any product or service to U.S. residents in a way that violates the FTC Act, the Telemarketing Sales Rule, or the Arizona and Washington consumer protection statutes. Under a stipulated final judgment and order filed on February 5, 2001, the defendants will pay $500,000.

In a related development, Alvin Cordeiro, doing business as Quick-Checks, agreed to settle FTC charges that he violated the FTC Act and the TSR by providing "substantial assistance and support" to the Canadian telemarketers, including the WinUSA defendants. In *FTC v. Alvin Cordeiro*, Civ. Action No. C01-20109-EAI (N.D. Cal. filed Feb. 7, 2001), the FTC alleged that Cordeiro provided account debiting services to process demand drafts through U.S. banks, and that he knew, or consciously avoided knowing, that the telemarketing scheme was fraudulent and violated federal law. The TSR prohibits a person from providing substantial assistance to a telemarketer when the person "knows or consciously avoids knowing" that the telemarketer is violating certain provisions of the TSR. According to the FTC complaint, drafts representing more than 37 percent of the total dollar volume of Win USA sales presented to Quick-Checks for processing were rejected on submission to consumers' banks; moreover, of the amounts successfully debited from consumers' accounts, drafts representing another 30 percent were later returned or reversed at consumers' request. The complaint alleged that these high rejection and return rates "should have signaled to Cordeiro that there were fundamental problems with the Win USA telemarketing efforts."

Under the terms of the consent decree, Cordeiro is prohibited from providing substantial assistance or support -- including but not limited to customer payment processing services -- to anyone who offers or promotes foreign lottery sales to U.S. citizens. The decree also prohibits Cordeiro from assisting any telemarketer who violates the FTC Act or the TSR, including those who make false statements; fail to disclose material restrictions or conditions to receive goods or services; or fail to obtain customers' express verifiable authorization of payment.

Two additional Commission complaints filed in U.S. courts also challenged Canadian-based telemarketing companies selling foreign lottery tickets to U.S. residents. In *FTC v. Windemere Big Win International Inc.*, No. 98C 8066 (N.D. Ill. Sep. 7, 1999), the FTC's case was joined with a parallel case filed in Canadian courts by the Department of Justice's Office of Foreign Litigation, which sought and obtained an injunction freezing the defendants' assets in Canada (issued by an Ontario Provincial Court in December 1998). In October 2000, the U.S. District Court entered a redress judgment for $19.7 million, and Canadian litigation is pending for recovery of any available redress funds.

The FTC filed a second action in U.S. District Court against another Toronto-based
lottery scam in FTC v. Growth Plus International Marketing, Inc., et al., Civ. Action No. 00C7886 (N.D. Ill. Filed Dec. 18, 2000). The complaint alleges that the defendant telemarketers targeted elderly consumers, inducing them to buy shares in a Canadian lottery ticket or series of tickets at prices ranging from $39 to almost $600, by telling them that their chances of winning the lottery were very good, and by relating stories of U.S. consumers who purportedly played through their firm and won. The complaint also alleges that the defendants told consumers they were sponsored by, affiliated with or registered with the Canadian government to sell the lottery tickets. The complaint alleges that the defendants falsely represented that it is legal to buy and sell foreign lottery tickets in the U.S., a violation of the FTC Act and the Telemarketing Sales Rule, and failed to disclose -- prior to collecting money from consumers -- the material fact that the sale of and trafficking in foreign lotteries is a crime in the U.S., also a violation of the TSR. The Commission has asked the court for a permanent injunction against the illegal activity and for restitution for consumers.

In 1999, investigators for the Royal Canadian Mounted Police Project Emptor effort learned of a new lottery scheme, in which consumers were purportedly sold government savings bonds issued by the National Savings Bank of England. Bond holders were supposedly entered in a monthly lottery in which all the bond interest is awarded to a few bond holders. While such bonds do exist, telemarketers in Canada are not authorized to sell them and, because the bonds have a lottery feature, it is illegal to sell them in the United States. As a part of Project Emptor, the Commission filed U.S. District Court complaints in FTC v. B.B.M. Inv., Inc., No. C00-0062 (W.D. Wash. filed Jan. 13, 2000), and FTC v. Canada Prepaid Legal Serv., Inc., No. 00-CV-02080 (W.D. Wash. filed Dec. 11, 2000). Subsequently, in FTC v. NAGG Secured Investments, Civ. Action No. CV00-2080Z (W.D. Wash. Filed Dec. 11, 2000) the Commission filed a U.S. District Court complaint alleging that the defendant telemarketers, operating under a variety of names, called consumers and guaranteed substantial monthly payments between $5,000 and $12,000 in return for a one-time payment of up to $5,000. Alternately, the telemarketers called claiming to be marketing bonds -- in some cases British Premium Savings Bonds -- the purchase of which would purportedly qualify consumers for cash prizes, monthly cash payments or bond investments with the chance to participate in monthly drawings for cash prizes. Consumers then received mailings that included a purported British National Premium Savings Bond certificate and other documents indicating that their names or bond numbers would be entered into the Premium Savings Bond program's monthly drawings for cash winnings. In fact, the consumers who paid the defendants received nothing of value. The FTC also charged that some of the defendants placed unauthorized charges on consumers' credit cards and in some instances, simply charged consumers' credit card accounts without ever having contacted them.

Internet Fraud Cases

The growth of the Internet and ecommerce has been explosive; the number of American adults with Internet access increased from approximately 88 million in mid-2000 to more than 104 million by the end of the year. Increases of that magnitude have led to corresponding increases in ecommerce. The Census Bureau of the Department of Commerce estimated that in the fourth quarter of 2000 -- without adjusting for seasonal, holiday and trading-day differences -
- online retail sales totaled $8.686 billion, an increase of 67.1 percent from the fourth quarter of 1999. For all of 2000, ecommerce sales were an estimated $25.8 billion, some 0.8 percent of all sales.

An estimated 40 percent of Americans over the age of 50 own personal computers; of these, 72 percent can access the Internet. Senior citizens communicate with children and grandchildren through email, peruse websites for news and entertainment, and use the Internet to research travel, investment and business opportunities.

Not surprisingly, the boom in ecommerce also has produced an increase in online fraud and deception. While the Commission received fewer than 1,000 Internet fraud complaints in 1997, it received more than 8,000 in 1998, and more than 25,000 in 2000. Indeed, in 2000, roughly 26 percent of all fraud complaints that various organizations added to Consumer Sentinel related to online fraud and deception. Since 1994, the Commission has filed 182 Internet-related lawsuits against more than 593 defendants. Through these lawsuits, the Commission secured orders enjoining further operation of the illegal schemes at issue, requiring the payment of more than $180 million in redress or disgorgement, and freezing assets worth millions of dollars in cases that still are in litigation. The Commission's U.S. District Court actions alone have prevented further consumer injury from Internet schemes with estimated annual sales of more than $250 million.

The Commission and other law enforcement agencies face a host of novel challenges in their efforts to combat fraud and deception online. Traditional scams - such as pyramid schemes and false product claims - can thrive on the Internet; in addition, the Internet enables con artists to cloak themselves in anonymity. Law enforcement authorities must act much more quickly to stop newly-emerging deceptive schemes before the perpetrators disappear without a trace. And because the Internet transcends national boundaries, law enforcement authorities must be more creative and collaborative to successfully combat online fraud.

Operation Top 10 Dot Cons is one of the Commission's most recent examples of extensive and creative law enforcement to protect seniors and other consumers from Internet fraud. The initiative, publicly announced on October 31, 2000, was a broad "sweep" of fraudulent and deceptive Internet scams, carried out in a year-long law enforcement effort. Altogether, the FTC and four other U.S. federal agencies, and consumer protection organizations from nine countries and 23 states initiated and announced 251 law enforcement actions against online scammers. The FTC filed 54 of the cases.

The top 10 Internet or online scams, identified through an analysis of complaint data in the Consumer Sentinel database, were:

- Internet Auction Fraud
- Internet Service Provider Scams
- Internet Web Site Design/Promotions ("Web Cramming")
- Internet Information and Adult Services (unauthorized credit card charges)
- Pyramid Scams
- Business Opportunities and Work-At-Home Scams
- Investment Schemes and Get-Rich-Quick Scams
- Travel/Vacation Fraud
Telephone/Pay-Per-Call Solicitation Frauds (including modem dialers and videotext)\textsuperscript{51}

Health Care Frauds

Using complaint data from its Consumer Sentinel network (described on pages 13-14), the FTC and the other law enforcement agency participants to identify not only the top 10 types of online scams, but also the specific companies generating the largest numbers of complaints about each of those types of scams. These companies became the targets of investigations, and ultimately, the defendants. Consumer Sentinel data enabled the Commission and its partners to obtain and develop evidence against these targets from individual consumers whose complaints had been included in the database.

Four of the FTC complaints filed in U.S. District Court charged the defendants with operating Internet auction scams; that is, the defendants allegedly advertised computer software and electronic consumer goods at various online auction sites and took cashier’s checks or money orders in payment, but never delivered the goods. In three of those cases, the FTC secured orders freezing the defendants’ assets for consumer redress purposes; in all four, the FTC sought permanent injunctions against violations of the FTC Act and the Mail Or Telephone Order Merchandise Rule.

In a fifth FTC case, the U.S. District Court complaint alleged that the defendants mailed $3.50 “rebate” checks to consumers. When consumers cashed the checks, they unwittingly agreed to allow the defendants to serve as their Internet Service Provider. The complaint alleged that the defendants then placed monthly charges on the victims’ telephone bills, and made it nearly impossible for the victims to cancel future monthly charges and get refunds. The Commission secured a stipulated permanent injunction in this case prohibiting the billing behavior in the future, and initiated an effort to determine the amount of consumer redress that the defendants should be required to pay.

Five other U.S. District Court complaints filed by the FTC addressed “web cramming.” In that practice, firms bill consumers for website pages they don’t know they have. Typically, the scammers targeted small businesses and not-for-profit organizations, called them and offered “free” web pages, and then billed the victims, on their telephone bills, without authorization. Settlements with five of the defendants produced consent decrees prohibiting web cramming and related practices; a settlement with a sixth defendant also requires the payment of more than $3 million in consumer redress.

The FTC also announced the filing of a U.S. District Court complaint targeting a work-at-home medical billing scam that allegedly made deceptive earnings claims on the Internet and in print ads to promote its $369 package of “training, software and clients.” The agency asked the court to stop the deceptive practices, appoint a receiver and freeze the defendants’ assets, pending trial. In two other cases, the Commission filed lawsuits against Web site operators who deceptively promised quick riches with few risks to consumers who agreed to sign up for their day trading programs and products. The companies agreed to settle; the consent decrees require the defendants to have substantiation for any future earnings claims; bar future misrepresentations about day trading risks; require conspicuous disclosure of the high-risk nature of day trading; and prohibit the deceptive use of testimonials.
Online Pyramid Fraud Cases

Pyramid schemes are the most notable example of a fraud whose size and scope are magnified by the Internet. By definition, these schemes require a steady supply of new recruits, including senior victims, who almost inevitably become victims. Unfortunately, the Internet provides an efficient way to reach countless new prospects around the world and to direct funds more efficiently and quickly from the victims to the scammers at the top of the pyramid. As a result, the victims are more numerous and the fraud operator’s financial “take” is much bigger.

The Commission maintains a strong enforcement presence, obtaining orders for more than $70 million in redress for victims and pursuing millions more in ongoing litigation. In FTC v. Five Star Auto Club, Inc.54 the Commission prevailed at trial against a pyramid scheme that persuaded online consumers to buy in by claiming that an annual fee and $100 monthly payments would give investors the opportunity to lease their “dream vehicle” for “free” while earning up to $80,000 a month by recruiting others to join the scheme. The court issued a permanent injunction shutting down the scheme, barring for life the scheme’s principals from any multi-level marketing business, and ordering them to pay $2.9 million in consumer redress. Similarly, in FTC v. Equinox International Corp., No CV-S-990969-JBR-RLH (D.Nev. 1999), the complaint addressed a pyramid scheme promoted through many devices, including some use of the Internet, and the Commission ultimately secured a federal court order requiring, inter alia, the payment of at least $40 million in consumer redress.

Identity Theft Cases

Under the Identity Theft Assumption and Deterrence Act of 1998, the FTC is charged, with responsibility to create and maintain a central clearinghouse for identity theft complaints. Consumer Sentinel serves as the requisite clearinghouse, and victims of identity theft can call the FTC’s toll-free telephone number, 1-877-ID THEFT (438-4338), to report the crime and get advice on how to proceed. Counselors enter the victims’ information about their experience into the Identity Theft Data Clearinghouse, which immediately makes the information available, through the Consumer Sentinel web site, to 174 participating domestic law enforcement agencies. The Clearinghouse data is used to identify patterns of illegal activity, and to facilitate identification of organized or large-scale identity theft rings. The Clearinghouse has begun to enable the many agencies involved in combating identity theft to share data, and to work more effectively to track down identity thieves and assist consumers. To further facilitate the investigation and prosecution of identity theft, the U.S. Secret Service has detailed an agent to the Commission’s Identity Theft Clearinghouse program who helps develop and refer case leads from the Clearinghouse to law enforcers throughout the nation.

In FTC v. Jeremy Martinez d/b/a Info World,57 the Commission alleged that the defendant facilitated identity theft by using the Internet to offer fake ID templates for which there was no legitimate use. In particular, the FTC complaint alleged that Jeremy Martinez, doing business as Info World, maintained Web sites, including one located at a site called “newid” that: sold 45 days of access to fake ID templates for $29.99; contained “high quality” templates to use in creating fake drivers licenses from 10 states; and offered a birth certificate template, programs to generate bar codes (required in some states to authenticate drivers licenses) and a program to
falsify Social Security numbers. The complaint alleged that selling the fake ID templates violated Section 5 of the FTC Act; and that by providing false identification templates to others, Martinez provided the "means and instrumentalities" for others to break the law, a separate violation of Section 5. The Commission secured a temporary restraining order halting the alleged illegal activity; and soon thereafter, a stipulated preliminary injunction continuing the relief granted in the TRO. On May 17, 2001 the Court approved Martinez' stipulated settlement with the FTC; the consent decree, _inter alia_, permanently bans Martinez from selling false identification documents or identification templates, or assisting others doing so, and from providing others with the means and instrumentalities with which to make any false or misleading representations that conceal or alter a person's identity, or that falsely signify that a fake document is real. In addition, the consent decree requires Martinez to disgorge illegal earnings from the scheme in the amount of $20,000, and through an "avalanche" clause, makes him liable for more than $105,000 in the event that he misrepresented his financial condition to the Commission.

**Training**

As another part of its ongoing Internet fraud law enforcement initiative, the FTC has trained more than 700 law enforcement and consumer protection officials from 20 different countries -- including 17 federal agencies, 25 state governments and 14 Canadian consumer protection offices -- in online investigation and law enforcement techniques in locations ranging from Anchorage, Alaska to Paris, France. These efforts include proactive programs to uncover fraud and deception in broad sectors of the online marketplace through "Surf Days," by using new technologies to "surf" (that is, to search) the Internet to detect and analyze emerging Internet problems. While Consumer Sentinel provides data on broad trends and the volume of complaints prompted by particular Internet schemes, Surf Days allow the Commission to take a "snapshot" of a market segment at any given time. Surf Days also are an important vehicle for business education; they enable the Commission to identify and reach new entrepreneurs, and alert those who may be violating the law unknowingly to modify their practices. To date, the Commission has conducted 27 different Surf Days targeting problems ranging from "cure-all" health claims to fraudulent business opportunities and credit repair scams. More than 250 law enforcement agencies or consumer organizations around the world have joined the Commission in these efforts; collectively, they have identified more than 6,000 Internet sites making dubious claims. The law enforcement Surf Day strategy has proven so effective that it is now widely used by other government agencies, consumer groups and other private organizations.
CONSUMER AND BUSINESS EDUCATION INITIATIVES

Meaningful consumer protection depends on education as well as law enforcement. Consumers must be given the tools to identify potentially fraudulent or otherwise deceptive practices, and businesses must be advised about how to comply with the law.

To achieve these important education objectives, the Consumer and Business Education Program plans, develops and implements creative practical, plain English mission-related campaigns aimed at both broad and segmented consumer and industry audiences. These efforts encourage informed consumer choice and competitive business practices in the marketplace, and constitute a cost-effective way to help minimize consumer injury and obtain compliance with the law. To leverage expertise and limited resources, the program partners with businesses, trade associations, consumer groups and other government agencies when appropriate, exhibits at national conferences and conventions, and produces public service announcements for radio, print and the Internet. A consumer and/or business education component is included in each major Consumer Protection law enforcement initiative; some specific efforts are discussed below.

**Mission Promotion**

In an effort to help consumers recognize and avoid fraud and deception, give them a place to report fraudulent and deceptive practices, and build the Consumer Sentinel database, the Program works with public and private sector organizations, like the Administration on Aging, the Social Security Administration, the U.S. Postal Inspection Service, and the AARP to promote and market its information, toll-free telephone number and online complaint form.

**Publications**

Every year, the Program produces publications to alert consumers to their rights and businesses to their responsibilities. These publications are disseminated through a network of thousands of intermediaries who order bulk copies for their own constituents. The Program also logs millions of accesses to the consumer and business education on the FTC website. In addition to brochures and “news you can use” alerts, the Program produces feature stories that are released to thousands of broadcast, print and online media, and hosts abbreviated audio versions of its print publications on the Commission’s website. The number of Commission publications viewed online increased from 140,000 in 1996 to 2.5 million in 1999 to over 9 million in 2001. This dramatic increase highlights the importance of the Internet to any large-scale information dissemination effort.

In addition to placing publications on its own Web site, the FTC actively encourages partners -- government agencies, associations, organizations, media outlets, and web communities and corporations with an interest in a particular subject -- to link to its information from their sites and to place banner public service announcements provided by the FTC on their sites. Links from the banners allow visitors to click through to the FTC site quickly to get the information they’re looking for exactly when they want it. Among the organizations that have helped consumers find information on www.ftc.gov are Yahoo!, AOL, American Express, Circuit City, AARP, the North American Securities Administrators Association, the Alliance for
Investor Education, the Better Business Bureau, CBS, motleyfool.com, the U.S. Patent and Trademark Office, Shape Up America!, the National Institutes of Health, CNN.com, MSNBC.com and the Arthritis Foundation.

**Special Initiatives**

**Telemarketing Fraud** The FTC’s Consumer Education program has an ongoing initiative to alert consumers about the perils of telemarketing fraud. The FTC’s Partnership for Consumer Education is a cooperative effort among corporations, trade groups, consumer organizations and federal agencies to help provide effective information about telemarketing fraud. With the assistance of its partners, the Commission has arranged for messages about fraud to appear in such diverse locations as websites, sales catalogs, billing statements, classified advertising, and public transit systems. Our consumer information, which is available in print and online (in writing and in audio), advises consumers never to buy anything over the phone, especially if they haven’t initiated the call, not to divulge their credit card numbers or checking account numbers, and to be on the alert for high-pressure sales tactics. Brochures deal with prize promotions, advance fee loans, credit repair, travel offers, credit card loss protection offers, international lotteries, and magazine sales, and the “top 10 dot cons,” among other subjects.

**Identity Theft** Commission efforts with respect to identity theft, a subject of concern to older people, provide an example of the multi-pronged approach we take to issues affecting consumers. In addition to law enforcement, the Commission is conducting an extensive multi-media education campaign to raise awareness of identity theft, including distributing print materials through hundreds of “partners,” media mailings and interviews, and a website (www.consumer.gov/idtheft). The FTC literally wrote the book on ID Theft — *Identity Theft: When Bad Things Happen to Your Good Name*. It covers how identity theft occurs; how to protect personal information and minimize risk; what to do if you’re a victim; how to correct credit-related and other problems that may result from identity theft; and federal and state resources available to victims of identity theft. Through April 2001, the Commission had distributed directly more than 230,000 copies of the booklet; another 425,000 copies have been printed and are being distributed by the Social Security Administration. The Commission also has made the booklet available on CD for organizations to reprint on their own. To date, more than 700 CDs have been distributed to private sector companies and many local law enforcement agencies.

The identity theft website includes the booklet, descriptions of common identity theft scams, and links to testimony, reports, press releases, identity theft-related state laws, and other resources. The site also links to a complaint form, allowing consumers to send complaints directly to the Identity Theft Data Clearinghouse. By the end of April 2001, the website had received almost 350,000 hits, and more than 7,300 complaints had been submitted electronically.

**Non-Traditional Education Program**

The Program also uses a variety of creative, non-traditional methods to get its messages across to consumers. For example:

- **“Teaser” websites** mimic fraudulent sites in an attempt to reach web consumers at “the teachable” moment - when they are searching for a particular product or
The Program creates products and services that are "too good to be true" but that attract consumer attention. (www.wemarket4u.net)

- **Web "banner" public service messages** are posted on the FTC Website, distributed and marketed to partners and news media, and available for downloading; and
- **Classified ads** are run as public service messages when newspapers and websites have the space.

The Commission launched this "one stop" site for federal consumer information with four partner agencies (FDA, CPSC, NHTSA and SEC) in December 1997. Today, the site links to consumer information, arranged into 10 broad topic areas, from more than 170 federal agencies. More than 182,500 visits to the site were recorded from October 2000 through March 2001. The site has also become the consumer information portal for FirstGov.gov, the public-private partnership led by a cross-agency board and administered by the Office of FirstGov in the General Services Administration's Office of Governmentwide Policy.

The site continues to be used to implement special initiatives: For example, the President's Council on Y2K Conversion asked the FTC to establish a Y2K consumer information site in the months leading up to the turn of the century; the Quality Interagency Coordination Task Force requested a special site on health care quality; and the U.S. Postal Inspection Service asked that consumer.gov house the site supporting the know fraud initiative, an ongoing public-private campaign launched with the sending of postcards about telemarketing fraud to 115 million American households in the fall of 1999.

**National Consumer Protection Week**

Along with the AARP, the National Consumers League, the U.S. Postal Inspection Service, the National Association of Consumer Agency Administrators, and the National Association of Attorneys General, the FTC spearheads an annual National Consumer Protection Week to highlight consumer education efforts across the country. Traditionally held during the first week in February, NCPW has highlighted efforts on shopping from home (Armchair Armor: Shopping From Home), fair lending practices (Seeing Red? High Cost Loans are Danger Zones), and credit (Know the Rules, Use the Tools). All materials are downloadable from www.consumer.gov/ncpw

**Recent FTC Publications of Particular Relevance to Older Consumers**

Although the Program's publications are of interest to consumers of all ages, some have special relevance to older people. Below is a sample of our "Best Sellers."

- **Buying Gold and Gemstone Jewelry: The Heart of the Matter**

- **Cooling Your Home: Don't Sweat It**
Funerals: A Consumer Guide
http://www.ftc.gov/bcp/conline/pubs/services/funeral.htm

Gas-Saving Products: Facts or Fuelishness?
http://www.ftc.gov/bcp/conline/pubs/autos/gasave.htm

How To Be Penny Wise, Not Pump Fuelish
http://www.ftc.gov/bcp/conline/pubs/alerts/fuelalert.htm

Holiday Shopping Tips
http://www.ftc.gov/bcp/conline/edcams/holiday/

Holiday Shopping? Free Tips from the FTC
http://www.ftc.gov/bcp/conline/pubs/alerts/shopalert.htm

Holiday Shopping: Is a Sale Price Your Best Deal?
http://www.ftc.gov/bcp/conline/pubs/alerts/salealert.htm

High-Rate, High-Fee Loans (Section 32 Mortgages)
http://www.ftc.gov/bcp/conline/pubs/homes/32mortgs.htm

Need a Loan? Think Twice About Using Your Home as Collateral
http://www.ftc.gov/bcp/conline/pubs/alerts/homealert.htm

Home Insulation Basics: Higher R-Values = Higher Insulating Values
http://www.ftc.gov/bcp/conline/pubs/alerts/rvaluealert.htm

How to Buy An Energy-Efficient Home Appliance
http://www.ftc.gov/bcp/conline/pubs/homes/appliances.htm

Living Trust Offers: How to Make Sure They're Trust-worthly
http://www.ftc.gov/bcp/conline/pubs/services/livtrust.htm

Prenotification Negative Option Plans
http://www.ftc.gov/bcp/conline/pubs/products/negative.htm

Top 10 Dot Cons: Consumer Information
http://www.ftc.gov/bcp/conline/edcams/dotcon/

Trial Offers: The Deal Is in the Details

Weathering the High Cost of Heating Your Home
http://www.ftc.gov/bcp/conline/pubs/alerts/heatalert.htm

Y2K Consumer Protection Efforts
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THE COMPETITION MISSION

This section describes Commission antitrust enforcement activities during the January 1999-August 2001 period, with a focus on both mergers and allegedly anticompetitive agreements between and among firms whose products and services are of particular significance to senior citizens, particularly in the health care, energy, supermarket, and funeral service sectors.

Health Care Sector

Older Americans benefit from lower costs and higher quality health care services as a result of robust competition. During the January 1999-August 2001 period, the Commission's antitrust law enforcement actions addressed transactions and practices which the Commission had a reason to believe would substantially lessen competition among providers of health care goods and services. Commission antitrust enforcement activity in the health care area, while varied in detail, tends to address transactions which fall within one of three general categories: (1) mergers between pharmaceutical companies, and mergers between medical device/information technology companies; (2) allegedly anticompetitive agreements among pharmaceutical manufacturers and among health care providers; and (3) hospital mergers. Transactions in all of these categories are of particular importance to older consumers, because their health care needs are relatively greater than those of other groups, and a greater percentage of their income is likely to be devoted to health care expenditures.

Pharmaceutical and Medical Device/Information Technology Mergers

Pharmaceutical prices are of particular importance to older consumers. Although approximately 13 percent of the U.S. population is over the age of 65, people who fall within this age category consume more than 33 percent of all prescription drugs dispensed in the United States, and (excluding insurance premiums) medicines account for approximately 34 percent of the health care costs paid by people within this age category. Accordingly, addressing the potential anticompetitive effects of large mergers in the pharmaceutical industry is of special importance to older consumers, and the Commission has continued to carefully monitor merger and acquisition activity in both the manufacturing and the distribution contexts.

For example, in Glaxo Wellcome plc and Smith Kline Beecham plc, Docket No. C-3990 (consent order issued January 26, 2001), the Commission issued a consent order imposing a number of requirements upon the merging pharmaceutical manufacturers -- to address a number of competitive concerns arising from the transaction -- as a condition to permitting the merger to proceed. The complaint alleged that the merger of Glaxo Wellcome (Glaxo) and SmithKline Beecham (SB) would create the world's largest research-based pharmaceutical manufacturer, substantially lessen competition in nine separate pharmaceutical markets, and result in fewer consumer choices, higher prices and less innovation. The order required divestiture in six markets:

1) antiemetic drugs: Glaxo and SB accounted for 90 percent of the sales of these new generation drugs used in chemotherapy to reduce the incidence of side effects. The order required the divestiture of the worldwide rights of SB's drug Kytril to F. Hoffman
LaRoche;
2) the antibiotic ceftazidime: Glaxo and SB were the only two manufacturers of
ceftazidime, and Glaxo was the largest of three firms marketing ceftazidime. The order
required the divestiture of SB’s U.S. rights to manufacture and market ceftazidime to
Abbott Laboratories;
3) oral and intravenous antiviral drugs for the treatment of herpes, chicken pox and
shingles: Glaxo’s Valtrex and SB’s Famvir were the only second-generation antiviral
prescription drugs available on the market, and no other companies have similar products
in development. The order required the divestiture of SB’s antiviral drug Famvir to
Novartis;
4) topical antiviral drugs for the treatment of herpes cold sores: SB’s Denavir was the
only FDA approved prescription topical antiviral drug sold in the U.S., and Glaxo, the
only potential entrant into the market, was seeking FDA approval to market its European
antiviral Zovirax in the U.S. The order required SB to divest Denavir to Novartis;
5) prophylactic vaccines for the treatment of herpes: Glaxo and SB were the leading two
of only a few firms pursuing the development of a preventative vaccine. The order
required Glaxo to return to its British collaborator, Cantab Pharmaceuticals, all rights to
its technology for the development of a prophylactic herpes vaccine; and
6) over-the counter H-2 acid blocker relief products: Glaxo’s Zantac 75 and SB’s
Tagamet were two of the four branded OTC H-2 acid blockers on the market. The order
required the divestiture of Glaxo’s U.S. and Canadian Zantac trademark rights to Pfizer.

In three markets the order addressed competitive overlaps with other research and development
firms where the merger was likely to result in delay, termination, or failure to develop as a
competitor, by requiring the assignment of certain intellectual property rights:
1) topoisomerase I inhibitor drugs used to treat certain tumors: SB’s Hycamptin was a
second line therapy for non-small cell lung cancers and SB was developing a first line
therapy for colorectal and other solid-tumor cancers. Glaxo, through a collaboration with
Gilead Sciences, was developing a drug, GI147211C, which would have been in direct
competition with SB’s Hycamptin. Only one other company manufactured similar anti-
tumor drugs. The order required Glaxo to assign all of its relevant intellectual property
rights and relinquish all of Glaxo’s reversionary rights to GI147211C to Gilead Sciences;
2) migraine headache treatment drugs: Glaxo’s Immitrex and Atmerge were the leading
sellers of triptan drugs for the treatment of migraine headache. SB had an interest in
another triptan drug, frovatriptan, which was being developed and scheduled for launch
by Vernalis Ltd. in the second half of 2001. The order required SB to assign all of its
intellectual property rights and relinquish all options to regain control over frovatriptan to
Vernalis Ltd; and
3) drugs to treat irritable bowel syndrome: Glaxo owned and was conducting clinical
trials on Lotronex, which had been taken off the market because of possible side effects.
SB had an option to acquire and market renzapride which was being developed by the
British firm Alizyme Therapeutics plc. Because the merger would eliminate one of the
few efforts underway to develop a drug for the treatment of irritable bowel syndrome, the
order required SB to assign all of its intellectual property rights and relinquish all options to regain control over renzapride to Alizyme.

In Pfizer Inc. and Warner-Lambert Company, Docket No. C-3957 (consent order issued July 27, 2000), the complaint alleged that Pfizer’s acquisition of Warner-Lambert Company would lessen competition in four pharmaceutical markets, and the consent order therefore included provisions intended to prevent that alleged lessening of competition with respect to the following drugs:

1) antidepressant drugs called selective serotonin reuptake inhibitors (SSRIs) and selective norepinephrine reuptake inhibitors (SNRIs), in which Pfizer manufactured Zoloft, the second largest selling SSRI, and Warner and Forest Laboratories co-promoted Celexa, the fastest-growing SSRI. The order required Warner to end its co-promotion agreement with Forest, return all confidential information regarding Celexa to Forest, maintain the confidentiality of all Celexa marketing information, and prohibited former Warner sales employees involved in marketing Celexa from selling Zoloft until March 2001;

2) pediculicides or treatments for head lice infestation, in which Pfizer and Warner were the two largest manufacturers and accounted for approximately 60 percent of the market. The order required Pfizer to divest its brand RID to Bayer Corporation;

3) drugs for treating Alzheimer’s disease, in which Pfizer’s Aricept and Warner’s Cognex were the only two drugs sold in the U.S. for the treatment of Alzheimer’s disease. The order required the divestiture of Cognex to First Horizon; and

4) EGFr-tk inhibitors, which are drugs used to treat solid tumor cancers, in which Pfizer and Warner were the two most advanced among four companies developing EGFr-tk inhibitors. The order required Pfizer to return its EGFr-tk inhibitor, CP-358,774, along with its technology and know-how assets to its development partner OSI, to grant OSI an irrevocable worldwide license to its rights and patents jointly owned with Pfizer, to provide OSI with a manufacturing and supply agreement for the continued supply of CP-358,774 until the transfer of the manufacturing technology to a new manufacturer, and to pay OSI’s costs for completing clinical trials on the drug. The order also provided for the appointment of an interim trustee to ensure that the development of CP-358,774 is maintained in the future.

In Zeneca Group plc, Docket No. C-3880 (consent order issued June 7, 1999), the complaint and consent order concerned long-acting local anesthetics, which are pharmaceutical products used to relieve pain during the course of surgical or other medical procedures, without the use of general anesthesia. For certain procedures, long-acting local anesthetics are the only viable anesthetic. The complaint alleged that Zeneca entered into an agreement with Chiroscience Group plc to market and assist in the development of levobupivacaine, a new long-acting local anesthetic being developed by Chiroscience. The complaint further alleged that Zeneca proposed to acquire Astra, the leading supplier of long-acting local anesthetics, and one of only two companies approved by the FDA for the manufacture and sale of these kinds of drugs in the United States. The complaint further alleged that while Zeneca did not currently participate in the market for long-acting local anesthetics, it was a potential competitor — by
virtue of its agreement with Chiroscience — and that the acquisition therefore would eliminate a significant source of new competition. The consent order required Zeneca to transfer and surrender all of its rights and assets relating to levobupivacaine to Chiroscience,\(^6\) and to divest its approximately 3 percent investment interest in Chiroscience.

In Merck/Medco, Docket No. C-3853 (consent order issued February 18, 1999), the Commission issued a consent order against Merck and Co., Inc. (Merck), a leading pharmaceutical manufacturer, and its subsidiary, Merck-Medco Managed Care, LLC (Medco) to resolve antitrust concerns resulting from Merck’s acquisition of Medco. The complaint alleged that Merck’s ownership of Medco, the largest pharmacy benefits manager ("PBM") in the United States, would allow Merck to favor its own drugs on Medco’s formularies, leading to higher prices and reduced quality. PBMs serve as middlemen in the provision of prescription drugs to managed care plans. A PBM’s formulary often affects drug choice and reimbursement under certain health plans. The order requires Merck/Medco to maintain an open formulary, whereby drugs are selected according to objective criteria by an independent panel of physicians, pharmacists, and others, known as a Pharmacy and Therapeutics Committee.

In Tyco International, Ltd./Mallinckrodt, Inc., Docket No. C-3985 (consent order issued December 1, 2000), the consent order addressed antitrust concerns stemming from the $4.2 billion acquisition of Mallinckrodt, Inc. by Tyco International, Ltd. The complaint alleged that both Tyco and Mallinckrodt were leading suppliers of disposable medical supplies, and were head to head competitors in the $47 million market for endotracheal tubes, which are the principal means by which anesthesia and oxygen are administered to patients in operating and emergency room settings. The consent order, while permitting the acquisition, required Tyco to divest its endotracheal tube business to Hudson RCI, a California-based company.

In Hoechst AG/Rhone-Poulenc S.A., Docket No. C-3919 (consent order issued January 18, 2000) the consent order settled allegations in an accompanying administrative complaint that the merger of Hoechst AG and Rhone-Poulenc S.A. to create Aventis S.A. would violate federal law by restraining competition in the markets for thrombin inhibitors (drugs used in the treatment of blood clotting diseases), new anticlotting drugs, and cellulose acetate, a widely used thermoplastic. In particular, the complaint alleged that Hoechst sold Refludan, the only direct thrombin inhibitor currently sold in the U.S. market; that Rhone-Poulenc was in the final stages of developing its own direct thrombin inhibitor, Revasc; and that the merger consequently would both eliminate direct competition between Hoechst and Rhone-Poulenc and reduce potential competition and innovation competition among researchers and developers of direct thrombin inhibitors. The consent order consequently required Aventis to transfer all of Rhone-Poulenc’s rights for Revasc to Novartis or some other third party, and to enter into a short term service agreement with the acquirer of Revasc in order to ensure the continued performance of development work on Revasc. The consent order also required Aventis to divest its interest in Rhodia, its specialty chemicals subsidiary (which produced cellulose acetate) to a level of five percent or less — and to sequester that interest pending its divestiture — thereby preserving competition in the manufacture, marketing and sale of cellulose acetate thermoplastics.

In FTC v. The Hearst Trust, et al., Civ. Action No. 1-01CV00734 (D.D.C. filed March 5, 2001), the Commission filed a complaint in U.S. District Court alleging that Hearst and its wholly owned subsidiary, First DataBank Inc., illegally acquired a monopoly over key types of
drug information databases used by pharmacists, other health care professionals, hospitals, and health plans. According to the complaint, the 1998 acquisition of Medi-Span, Inc. allowed First DataBank to institute substantial price increases to its customers who rely on the databases for clinical, pricing and other information on prescription and non-prescription drugs. The complaint also alleges that Hearst illegally withheld several high-level corporate documents prepared to evaluate the competitive impact of the Medi-Span acquisition, and that Hearst was required to provide those documents to the antitrust agencies prior to the merger to help them determine whether a full pre-merger antitrust review of the acquisition was needed. The complaint asks the Court to order Hearst to create and divest a new competitor to replace Medi-Span -- and to forfeit the illegally gained profits from the allegedly anticompetitive price increases -- and the litigation continues.

In Medtronic, Inc./Avecor Cardiovascular, Inc., Docket No. C-3879, (consent order issued on June 3, 1999), Medtronic, Inc. agreed to divest AVECOR's non-occlusive arterial pump assets to settle Commission charges that Medtronic's $106 million acquisition of its competitor would lessen competition for the research, development, manufacture and sale of non-occlusive arterial pumps in the United States. The complaint alleged that entry into the market would not be timely, likely or sufficient to prevent adverse competitive effects, and that there are no competitive substitutes for non-occlusive arterial pumps, which are perfusion devices used in heart/lung machines. The consent order therefore required the divestiture of certain assets to Baxter Healthcare Corporation.

In Sorin Biomedica S.p.A./COBE Cardiovascular, Inc. et al., File No. 9910095, Docket No. C-3889 (consent order issued on July 28, 1999) the complaint alleged that the proposed acquisition of COBE Cardiovascular, Inc., COBE Laboratories Inc., and other assets and liabilities from Gambro AB, by Sorin Biomedica S.p.A., would eliminate substantial competition between SNIA and Gambro in the market for research, development, manufacture and sale of heart-lung machines. Such machines are the durable equipment portion of an extracorporeal bypass system that replaces the function of the heart and lungs by circulating and supplying oxygen to a patient's blood during open heart surgery. The consent order, while permitting the acquisition, required SNIA to divest all of COBE's heart-lung machine business to Baxter Healthcare Corporation within ten days after the FTC accepted the consent agreement for public comment.

Allegedly Anticompetitive Agreements
One of the core areas of antitrust enforcement addresses allegedly anticompetitive agreements; that is, agreements among the providers of a good or a service which allegedly increase prices, reduce product quality, or in some other way artificially reduce the level of competition between the providers. Such agreements among pharmaceutical manufacturers or among health care providers may deprive older Americans of the ability to obtain prescription drugs or treatment at competitive price and quality levels. The Commission therefore addressed a number of allegedly anticompetitive agreements among pharmaceutical manufacturers and among health care providers in 1999 and 2000.

As an example, the Commission filed a complaint in U.S. District Court against four pharmaceutical companies in FTC v. Mylan Laboratories et al., 62 F. Supp. 2d 25 (D.D.C.).
32 State Attorneys General filed parallel federal court actions. One of the defendants, Mylan, is the nation's second largest manufacturer of generic drugs, and it produces, among other drugs, the generic drugs lorazepam and clorazepate, which are widely prescribed to treat anxiety and hypertension. The complaint alleged that the defendants used licensing arrangements and other practices to restrain trade, monopolize, attempt to monopolize, and conspire to monopolize the markets for lorazepam and clorazepate, in violation of Section 5(a) of the FTC Act. In particular, the complaint alleged that Mylan entered into exclusive licensing agreements with the principal manufacturers of the active ingredients used in those drugs, with the effect of foreclosing substantially the supply of those ingredients to its competitors.

The complaint further alleged that in January 1998 Mylan raised the wholesale price of 7.5 mg clorazepate tablets from $11.36 to approximately $377.00 per 500-tablet bottle, and that in March 1998 it raised the wholesale price of 1 mg lorazepam tablets from $7.30 to $191.00 per 500-tablet bottle. The complaint alleged that as a result of these price increases, many purchasers -- including pharmacies, hospitals, insurers, managed care organizations, wholesalers, and government agencies -- paid substantially higher prices, and that some patients may have stopped taking lorazepam and clorazepate tablets altogether, or may have been forced to reduce the quantity they take, because they could not afford them. The complaint sought a permanent injunction against conduct violating Section 5(a); rescission of the unlawful licensing arrangements; and other equitable relief, including disgorgement and restitution in an amount exceeding $120 million plus interest.

On November 29, 2000, the Commission approved a proposed settlement under which Mylan agreed to pay $100 million for distribution to injured consumers and state agencies, and to an injunction preventing them and the other defendants from engaging in similar conduct in the future. The States also approved the agreement, and on February 9, 2001, the U.S. District Court entered the Stipulated Permanent Injunction agreed to by the parties. On April 27, 2001, the District Court preliminarily approved a distribution plan for the $100 million, requiring Mylan to place the funds in an escrow account for distribution to purchasers of lorazepam and/or clorazepate during the time period covered by the settlement.

In addition to the litigated case in Mylan, the Commission secured 14 consent orders during the January 1999-August 2001 period, pursuant to which pharmaceutical manufacturers and health care providers agreed to cease using a variety of allegedly anticompetitive practices. In FMC Corporation/Asahi Chemical, File No. 9810237 (announced on December 20, 2000), for example, the complaint alleged the existence of a conspiracy to monopolize a binder used in nearly all pharmaceutical tablets sold in the United States. In particular, the complaint alleged that for more than a decade, FMC Corporation ("FMC") -- based in Chicago, Illinois and the largest manufacturer and seller of microcrystalline cellulose ("MCC") in the world -- attempted to neutralize or eliminate competing MCC sellers and to secure monopoly power within the market. To accomplish this, the complaint alleged, in or around 1984, FMC entered into a conspiracy with Asahi Chemical, based in Tokyo, to divide the MCC market into two territories; that is, FMC allegedly agreed not to sell any MCC product to customers in Japan or East Asia without Asahi Chemical's consent, and Asahi Chemical allegedly agreed not to sell such products to customers in North America or Europe without the consent of FMC. According to the complaint, FMC also sought agreements with three smaller MCC manufacturers to maintain its
monopoly position. Under the terms of the proposed consent order, FMC and Asahi Chemical would be prohibited from: (I) agreeing with competitors to divide or allocate markets, customers, contracts or geographic territories in connection with the sale of MCC, and (2) agreeing with competitors to refrain in whole or in part from producing, selling or marketing MCC. Both companies would also be barred from inviting or soliciting other companies to enter into agreements not to compete in this market. In addition, the proposed order would prohibit FMC for 10 years from acting as the U.S. distributor for any competing manufacturer of MCC (including Asahi Chemical), and for five years would prohibit FMC from distributing in the United States any other product manufactured by Asahi Chemical. The proposed order contains several limited exemptions to these prohibitions which would allow FMC and Asahi to engage in certain lawful and procompetitive activities. For example, each company would be able to enter into exclusive trademark license agreements, enforce its intellectual property rights, and abide by reasonable restraints in conjunction with a lawful joint venture agreement.

The Commission has also become concerned about potential abuse of the regulatory framework governing the entry of generic drug products that compete with branded pharmaceuticals. Under the Drug Price Competition and Patent Term Restoration Act of 1984, commonly known as the Hatch-Waxman Act, a company can seek approval from the Food and Drug Administration to market a generic drug before the expiration of a patent relating to the brand-name drug upon which the generic is based. In these cases, the generic drug manufacturer certifies in its Abbreviated New Drug Application (ANDA) that the branded product’s patent(s) are invalid or will not be infringed by the generic drug for which the ANDA applicant seeks approval. The Act then provides a 45-day window during which the patent holder may file a patent infringement suit against the applicant. If such a suit is filed, the Act forbids the FDA from approving the ANDA for 30 months or until the litigation is completed, whichever comes sooner (“30-month stay”). The provision is generally thought to protect branded companies against patent infringement. To encourage generic competition, the first company to file an ANDA with the FDA is given the exclusive right to market the generic drug for 180 days. No other generic can gain FDA approval until this 180-day period expires (“180-day marketing exclusivity”).

The Commission is now conducting a study to determine whether the 30-month stay and 180-day marketing exclusivity provisions of the Hatch-Waxman Act have encouraged generic competition or facilitated the use of anticompetitive strategies. In addition, in light of the FTC’s investigations of several cases in which the manufacturers of brand name drug products and generic competitors have allegedly entered into anticompetitive agreements to delay generic entry, the study is also examining the use of agreements between pharmaceutical companies, and any other strategies, which may delay generic drug competition.

The Commission has also initiated a number of law enforcement actions addressing allegedly anticompetitive arrangements between brand-name and generic drug manufacturers. Thus, for example, in Schering-Plough Corporation, et. al., Docket No. 9297 (complaint issued March 30, 2001), the Commission issued a complaint alleging that three drug manufacturers -- Schering-Plough Corporation (Schering), Upsher-Smith Laboratories (Upsher-Smith), and American Home Products Corporation -- entered into anticompetitive agreements aimed at keeping low-cost generic drugs off the market. The FTC’s administrative complaint alleges that
Schering, the maker of K-Dur 20 -- a widely prescribed potassium chloride supplement used to treat patients with low blood potassium levels (a condition that most commonly occurs in people taking certain drugs to treat high blood pressure and that can lead to dangerous cardiac problems) -- made illegal payments to Upsher-Smith and American Home Products to induce them to delay launching their generic versions of the drug beyond the date they might have agreed to without such payments. The complaint further alleges that the agreements have cost consumers more than $100 million.

The complaint includes more detailed allegations as to the chronology of events. In particular, it alleges that Schering sued Upsher, a generic drug manufacturer, for patent infringement after Upsher sought FDA approval to manufacture and distribute Klor Con M20, a generic version of K-Dur 20. The complaint alleges that Schering and Upsher reached an agreement in 1997 to settle the patent infringement lawsuit, whereby Schering paid Upsher $60 million dollars not to market any generic version of K-Dur 20 until September, 2001. The complaint further alleges that while, under the agreement, Schering received licenses to market five of Upsher's products, the value of the licenses had little relation to the $60 million dollar payment, and the effect of the agreement was to ensure that no other company's generic K-Dur 20 could obtain FDA approval and enter the market during the term of the agreement.

The complaint further alleges that Schering agreed to pay ESI Lederle, Inc. -- a division of American Home Products -- up to $30 million to delay marketing its generic version of K-Dur 20. The complaint alleges that Schering sued ESI for patent infringement after ESI sought FDA approval to manufacture and distribute its generic version of K-Dur 20. As part of a subsequent patent infringement litigation settlement, the complaint alleges that ESI agreed, in exchange for the payments, not to market any generic version of K-Dur 20 until January 2004, and to market only one generic version between January 2004 and September 2006 when Schering's patent expired. According to the complaint, ESI also agreed not to prepare, or to help any other firm prepare, bioequivalence studies necessary for FDA approval of an application for a generic version of K-Dur 20 until September 2006. As part of the agreement, the complaint alleges that ESI also granted Schering a license to two of its generic products, but further alleges that the payment was designed to delay the entry of a generic version of K-Dur 20, and was not based on the value of the licenses to the two generic products. Counsel supporting the complaint are seeking an order that would prohibit the respondents from entering into: (1) a settlement of patent infringement litigation which involves restraints on the research, development, manufacture, marketing, or sale of a "non-infringing" drug product; (2) any agreement in which one party agrees to refrain from conducting or assisting a bioequivalence study of a product to the NDA holder's drug product; and (3) any agreement in which the NDA holder provides anything of value to the alleged infringer in return for the alleged infringer not selling a drug product for any period of time. Counsel for the complaint are also seeking an order provision that would require Schering to immediately license its '743 patent (the formulation patent for K-Dur 20 and K-Dur 10) to Upsher and ESI, and would require Upsher to relinquish its right to the 180-day exclusivity period for Klor Con M20, its generic version of K-Dur 20.

In Hoechst Marion Roussel, Inc., Cardem Capital L.P., and Andrx Corp., Docket No. 9293 (consent order issued on May 8, 2001), the Commission issued a complaint alleging that Hoechst and Andrx entered into an agreement in which Andrx was paid millions of dollars to
delay bringing to market a competitive generic alternative to Cardizem CD. Andrx, a generic drug manufacturer, was the first to file for FDA approval to market its generic version Cardizem CD, Hoechst's brand name hypertension and angina drug, but was then sued by Hoechst for patent infringement. Because certain provisions of the Hatch-Waxman Act grant the initial generic manufacturer a 180-day market exclusivity period, the complaint alleged that the effect of the agreement was to ensure that no other company's generic drug could obtain FDA approval and enter the market during the term of the agreement. Under the agreement, according to the complaint, Andrx agreed not to market its product when it received FDA approval, not to give up or relinquish its 180-day exclusivity right, and not to market a non-infringing generic version of Cardizem CD during the ongoing patent litigation. The consent order subsequently issued to settle the complaint allegations prohibits the respondents from entering into agreements in which the first generic company to file an ANDA agrees that it: (1) will not relinquish its rights to the 180-day exclusivity period; and (2) will not develop or market a non-infringing generic drug product. The consent order also requires Hoechst and Andrx to notify the Commission, and obtain court approval, before entering into any agreements involving payments to a generic company in which the generic company temporarily refrains from bringing a generic drug to market.

In Abbott Laboratories and Geneva Pharmaceuticals, Inc. Docket Nos. C-3945, C-3946 (consent orders issued on May 22, 2000), the complaint alleged that Abbott paid Geneva $4.5 million per month to delay bringing to market a generic alternative to Abbott's brand-name hypertension and prostate drug, Hytrin. Geneva, a generic drug manufacturer, sought and received FDA approval to market its generic capsule version. After Geneva received FDA approval, Abbott and Geneva reached an agreement under which Geneva would not bring a generic version of Hytrin to market during the ongoing patent litigation on Geneva's tablet version of Hytrin, in exchange for the $4.5 million monthly payment, an amount which exceeded the amount Abbott estimated Geneva would have earned if it had actually marketed the generic drug. Because of the provisions of the Hatch-Waxman Act noted above, which grant the initial generic manufacturer a 180-day market exclusivity period, the complaint alleged that the effect of the agreement was to ensure that no other company's generic Hytrin could obtain FDA approval and enter the market during the term of the agreement. The consent orders prohibit Abbott and Geneva from entering into agreements in which a generic company agrees with the brand drug manufacturer that it: (1) will give up or transfer its Hatch-Waxman Act 180-day exclusivity rights, and (2) will not enter the market with a non-infringing product. In addition, the orders require that agreements involving payments to a generic company to stay off the market during the pendency of patent litigation be approved by the court with notice to the Commission. Geneva was also required to waive its right to a 180-day exclusivity period for its generic tablet, so other generic tablets could immediately enter the market. In a statement accompanying the consent orders, the Commission stated that in the future it will consider its entire range of remedies in enforcement actions against similar arrangements, including seeking disgorgement of illegally obtained profits.

Investigations initiated by Commission staff have also revealed allegedly anticompetitive agreements among health care providers. For example, in Alaska Healthcare Network, Inc., Docket No. C-4007 (consent order issued on April 25, 2001), the complaint alleged that the
Alaska Healthcare Network, Inc. (AHN) — an association of 86 physicians practicing in the Fairbanks, Alaska area — restrained competition among physicians and blocked or delayed the entry of health care plans into the Fairbanks area. AHN included approximately 63 percent of all physicians in full-time, year-round private practice in Fairbanks. The complaint further alleged that — acting as the de facto collective bargaining agent for its members — AHN fixed prices and other terms when contracting with HMOs and other healthcare payers, refused to deal with payers except on collectively agreed-upon terms, and encouraged its members not to deal with any health plan in any manner except through AHN. The consent order prohibits AHN from: (1) negotiating or refusing to deal with health plans; (2) determining the terms upon which physicians deal with health plans; and (3) restricting the ability of physicians to deal with any health plan, whether on an individual basis or through any other arrangement. The order also imposes a structural remedy for a period of five years, which requires that if AHN operates a qualified risk-sharing or clinically-integrated joint arrangement, AHN-participating physicians can constitute no more than 30 percent of Fairbanks physicians in five medical specialties. Also, when offering the services of its physicians through any other arrangement permitted by the order, AHN’s participating physicians may constitute no more than 50 percent of Fairbanks physicians in those specialties.

In Texas Surgeons, P.A., Docket No. C-3944 (consent order issued on May 18, 2000), the complaint alleged that Texas Surgeons, P.A., an independent physician association, restrained competition among general surgeons in the Austin, Texas area, resulting in more than $1,000,000 in increased costs for surgical services in 1998 and 1999. According to the complaint, the IPA collectively refused to deal with two health plans, terminated contracts with Blue Cross of Texas, and threatened to terminate contracts with United HealthCare of Texas if the payer did not comply with the association’s demand for rate increases. Both plans increased their rates in response to the IPA’s demands. The order prohibits the IPA from: (1) negotiating on behalf of any physician with health plans; (2) refusing to deal or threatening to refuse to deal with health plans; (3) determining the terms on which its members deal with health plans; and (4) restricting the ability of any physicians to deal with any payer or provider individually or through any other arrangement. The order also prohibits the respondent from exchanging information among Austin-area physicians concerning negotiations with any health plan regarding reimbursement terms, or any physician’s intent to refuse to deal with any health plan. The order does allow the IPA to operate any “qualified risk-sharing joint arrangement” or any “qualified clinically integrated joint arrangement” as reflected in the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care.63

In Colegio de Cirujanos Dentistas de Puerto Rico, Docket No. C-3953 (consent order issued on June 12, 2000), the complaint alleged that an association of approximately 1800 dentists, acting as the collective bargaining agent for its members, fixed prices, boycotted payers to obtain higher reimbursement rates, and restrained truthful advertising by its members. The association, comprising almost all dentists practicing in Puerto Rico, negotiated with numerous payers about fees and set the terms its members would accept from the payers. The complaint also alleged that the association used its Code of Ethics to ban truthful advertising by dentists who advertised their willingness to accept patients from neighboring areas where dentists were conducting a boycott of the Reform, a government program to provide medical services to the
indigent. The order prohibits the association from negotiating on behalf of any dentists with payers or providers, refusing to deal with or boycotting payers, determining the terms upon which dentists will deal with providers, and restricting or interfering with truthful advertising or solicitation concerning dental services.

In Wisconsin Chiropractic Association, Docket No. C-3943 (consent order issued on May 18, 2000), the complaint alleged that the Wisconsin Chiropractic Association and its executive director conspired to boycott third-party payers to obtain higher reimbursement rates, thereby increasing prices for chiropractic services. The Wisconsin Chiropractic Association has 900 members, and represents about 90 percent of the chiropractors licensed in the state. According to the complaint, the association, in response to the introduction of new billing codes by private insurers and the federal government, advised its members to collectively raise their prices to specific levels, circulated fee schedules to coordinate pricing among its members, advised members to discuss contract offers to improve their bargaining position with payers, and assisted in boycotts of two payers to obtain higher reimbursement rates. The order prohibits the association from fixing prices or encouraging others to fix prices for chiropractic services, boycotting any payer, or negotiating on behalf of any chiropractor or group of chiropractors. The order also prohibits the association from initiating, conducting, or distributing any fee surveys for healthcare goods or services prior to December 31, 2001. In addition, for five years thereafter, the WCA may conduct or distribute fee surveys only if the surveys conform to the safe harbor provisions regarding fee surveys contained in the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care.

In Michael T. Berkley, D.C. and Mark A. Cassellius, D.C., Docket No. C-3936, (consent order issued on April 11, 2000), the Commission filed a complaint alleging that two chiropractors conspired to fix prices for chiropractic services in the La Crosse, Wisconsin area, and boycotted the Gundersen Lutheran Health Plan to obtain higher reimbursement for chiropractic services. As a result of the boycott, Gundersen increased its reimbursement rates by 20 percent. The consent order is similar to the Wisconsin Chiropractic Association order (discussed above), and prohibits Drs. Berkley and Cassellius from fixing prices for chiropractic services, engaging in collective negotiations on behalf of other chiropractors, and orchestrating concerted refusals to deal. The order does allow the chiropractors to engage in conduct — including collectively determining reimbursement and other terms of contracts with payers — that is reasonably necessary to operate a "qualified risk-sharing joint arrangement," or a "qualified clinically integrated joint arrangement," as reflected in the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care.

In North Lake Tahoe Medical Group, Inc., Docket No. C-3885 (consent order issued on July 21, 1999), the complaint alleged that North Lake Tahoe Medical Group, Inc. (Tahoe IPA), an independent physician association, restrained competition among physicians and delayed the entry of managed care into the Lake Tahoe Basin in California. Tahoe IPA, based in Truckee, California, is composed of ninety-one physicians comprising 70 percent of the physicians practicing in the Lake Tahoe area. The complaint further alleged that the IPA conspired to fix prices, engaged in collective negotiations over prices with payers, and refused to deal with Blue Shield of California and other third party payers when they did not comply with the Tahoe IPA’s plans. The order prohibits the IPA from: (1) engaging in collective negotiations on behalf of its
members; (2) orchestrating concerted refusals to deal; (3) fixing prices, or other terms, on which its members deal; and (4) restricting the ability of any physician to deal with any payer or provider individually or through any arrangement outside of Tahoe IPA. The order also requires Tahoe IPA to terminate the membership of physicians who refused to deal (or gave notice of their intent to refuse to deal) with Blue Shield, unless the physicians make a good faith effort to reparticipate and continue to participate in Blue Shield for a period of six months. The order does allow the IPA to operate any “qualified risk-sharing joint arrangement,” or, upon prior notice to the Commission, any “qualified clinically integrated joint arrangement,” as reflected in the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care.

In *Mesa County Physicians Independent Practice Association, Inc., Docket No. 9284* (consent order issued on May 4, 1999), the Commission issued a revised complaint and final order against the Mesa County Physicians Independent Practice Association, Inc., an organization whose members comprise 85 percent of all physicians and 90 percent of the primary care physicians in Mesa County, Colorado. According to the complaint, the IPA acted to restrain trade by combining to fix prices and other competitively significant terms of dealing with payers, and collectively refused to deal with third party payers, thereby hindering the development of alternative health care financing and delivery systems in Mesa County. The complaint alleged that the IPA, through its alliance with the Rocky Mountain Health Maintenance Organization, created a substantial obstacle to the ability of other payers to contract with a physician panel in Mesa County. The complaint also alleged that the IPA’s Contract Review Committee negotiated collectively on behalf of the IPA’s members with several third party payers, using an IPA Board-approved set of guidelines and fee schedule, and that a similar organization formed after the consent order was issued in 1998 engaged in the same conduct. The order prohibits the Mesa County IPA from: (1) engaging in collective negotiations on behalf of its members; (2) collectively refusing to contract with third party payers; (3) acting as the exclusive bargaining agent for its members; (4) restricting its members from dealing with third party payers through an entity other than the IPA; (5) coordinating the terms of contracts with third-party payers with other physician groups in Mesa County or in any county contiguous to Mesa County; (6) exchanging information among physicians about the terms upon which physicians are willing to deal with third-party payers; and (7) encouraging other physicians to engage in activities prohibited by the order. The order also requires the Mesa IPA to abolish its Contract Review Committee, and prohibits the IPA from employing any person or participating physician who is conducting payer contract review. The order, however, allows the respondent to engage: (1) in any “qualified clinically integrated joint arrangement” (with prior notice to the Commission), and (2) in conduct that is reasonably necessary to operate any “qualified risk-sharing joint arrangement” as set forth in the 1996 DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care.

In *Asociacion de Farmacias Region de Arecibo, Docket No. C-3855* (consent order issued on March 2, 1999), the complaint alleged that an association, composed of approximately 125 pharmacies in northern Puerto Rico, fixed the terms and conditions, including fixing prices, of dealing with third party payers, and threatened to withhold services from a government program to provide health care services for indigent patients. The association was formed in 1994 as a vehicle to negotiate with health plans. According to the complaint, in January 1995, the
association refused to contract with Triple-S -- the payer for the reform program in northern Puerto Rico -- until Triple-S raised the fees paid to the association's members. Furthermore, in March 1996, the association threatened to withhold its members' services unless Triple-S rescinded a new fee schedule calling for lower reimbursement fees for the pharmacies. Triple-S acceded to the association's demands and increased fees by 22 percent. The order prohibits the association from negotiating on behalf of any pharmacies with any payer or provider, jointly boycotting or refusing to deal with third party payers, restricting the ability of pharmacies to deal with payers individually, or determining the terms or conditions for dealing with third party payers. The order does allow the association to operate any "qualified risk-sharing joint arrangement" or, upon prior notice to the Commission, any "qualified clinically integrated joint arrangement," as reflected in the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care.

In Ernesto L. Ramirez Torres, D.M.D., et al., Docket No. C-3851 (consent order issued on February 5, 1999), the complaint alleged that a group of dentists -- comprising a majority of the dentists in Juan Diaz, Coamo, and Santa Isabel, Puerto Rico -- fixed prices and engaged in an illegal boycott of a government program to provide dental care for indigent patients. According to the complaint, the dentists threatened a boycott of the reform program if they were not reimbursed at certain prices, and then boycotted the program. After several months, the dentists' price demands were met and they agreed to participate in the program. The order prohibits the dentists from jointly boycotting or refusing to deal with third party payers, or collectively determining any terms or conditions for dealing with third party payers. The order does allow the dentists to operate any "qualified risk-sharing joint arrangement" or, upon notice to the Commission, any "qualified clinically integrated joint arrangement," as reflected in the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care.

Hospital Mergers

Changes in the structure of the health care system, including the growth of HMOs, have created increased pressure for cost containment. These pressures have been felt throughout the health care system, which has responded with efforts to reduce costs and to improve efficiency. Hospital mergers have been one tool for reducing costs. While such mergers are often beneficial to consumers, they can be especially harmful to seniors if they lead to an anticompetitive outcome or lack of availability for hospital services in a particular area. As in other industries, the Commission approaches those mergers in a cautious and considered way. The Commission has found that the vast majority of hospital mergers pose no competitive problems and only a relative handful of them are investigated. The agency challenges only those specific mergers which it has reason to believe may substantially lessen competition or tend to create a monopoly, and it seeks a remedy that is carefully tailored to eliminate only the anticompetitive part of the transaction while allowing the remainder to proceed. The level of hospital merger activity has generally tended to decline since its peak in the mid 1990s.
Energy Sector

Older Americans with low and moderate incomes are greatly affected by increases in refined petroleum product prices, as well as by increases in electricity and natural gas prices. The Commission continues to pursue an active law enforcement program in the energy sector.

Petroleum Industry Mergers

During the January 1999-August 2001 period, a substantial level of merger and acquisition activity occurred among several of the world's largest petroleum companies, and the Commission conducted extensive investigations of these transactions. For example, in Exxon Corporation/Mobil Corporation, Docket No. C-3907 (consent order issued on January 26, 2001), the Commission investigated the merger of two of the world's largest petroleum companies, and issued a consent order settling allegations in an accompanying complaint that the merger would substantially lessen competition or tend to create a monopoly in certain markets for refining and marketing gasoline in the United States. Exxon's operations included, \textit{inter alia}, the operation of petroleum refineries -- including four in the United States -- which made various grades of gasoline, lubricant base stock, and other petroleum products, and sold these products to intermediaries, retailers and consumers; the operation of more than 2,000 gasoline stations in the United States (through ownership or leasing arrangements); and the sale of gasoline to distributors or dealers operating another 6,475 retail outlets throughout the United States. Mobil's operations included, \textit{inter alia}, the operation of petroleum refineries -- also including four in the United States -- which made gasoline, lubricant base stock, and other petroleum products, and sold those products throughout the United States; and the operation of about 7,400 retail outlets selling Mobil-branded gasoline throughout the United States. In December 1998, Exxon and Mobil entered into an agreement to merge the two corporations into a corporation to be known as ExxonMobil Corporation.

The Commission conducted an extensive investigation of the proposed merger, and the resultant complaint alleged that consummation of the merger would violate Section 7 of the Clayton Act and Section 5 of the FTC Act by lessening competition in each of the following markets: (1) the marketing of gasoline in the Northeastern and Mid-Atlantic United States (including the States of Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, and New York (collectively "the Northeast"), and the States of New Jersey, Pennsylvania, Delaware, Maryland, Virginia, and the District of Columbia (collectively the "Mid-Atlantic"), and smaller areas contained therein); (2) the marketing of gasoline in five metropolitan areas in the State of Texas; (3) the marketing of gasoline in Arizona; (4) the refining and marketing of "CARB" gasoline (specially formulated gasoline required in California) in the State of California; (5) the bidding for and refining of jet fuel for the U.S. Navy on the West Coast; (6) the terminaling of light petroleum products in the Boston, Massachusetts, and Washington, D.C., metropolitan areas; (7) the terminaling of light petroleum products in the Norfolk, Virginia, metropolitan area; (8) the transportation of refined light petroleum products to the inland portions of the States of Mississippi, Alabama, Georgia, South Carolina, North Carolina, Virginia, and Tennessee (i.e., the portions more than 50 miles from ports such as Savannah, Charleston, Wilmington and Norfolk) ("inland Southeast"); (9) the transportation of
crude oil from the north slope of the State of Alaska via the Trans Alaska Pipeline System ("TAPS"); (10) the importation, terminaling and marketing of gasoline and diesel fuel in the Territory of Guam; (11) the refining and marketing of paraffinic lubricant base oils in the United States and Canada; and (12) the worldwide manufacture and sale of jet turbine lubricants. The Commission also examined competition and the likely effects of the merger in a number of other markets, including the worldwide markets for exploration, development and production of crude oil; markets for crude oil exploration and production in the United States and in parts of the United States; markets for natural gas in the United States; markets for a variety of petrochemical products; and markets for pipeline transportation, terminaling or marketing of gasoline or other fuels in sections of the country other than those alleged in the Complaint. The Commission did not, however, find a reason to believe that the merger would produce likely anticompetitive effects in markets other than the markets alleged in the complaint.

The Commission consent order permitted the merger to proceed but — in order to remedy the allegedly anticompetitive effects of the merger described in the complaint — imposed a number of divestiture obligations on the merging parties. In particular, the consent order required the largest retail divestiture in Commission history — the sale or assignment of 2,431 Exxon and Mobil gas stations in the Northeast and Mid-Atlantic (1,740), California (360), Texas (319) and Guam (12). More particularly, the consent order required ExxonMobil to divest or otherwise surrender control of: (1) all of Mobil's gasoline marketing in the Mid-Atlantic (New Jersey, Pennsylvania, Delaware, Maryland, Virginia, and the District of Columbia), and all of Exxon's gasoline marketing in the Northeast (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, and New York); (2) Mobil's gasoline marketing in the Austin, Bryan/College Station, Dallas, Houston and San Antonio, Texas, metropolitan areas; (3) Exxon's option to repurchase retail gasoline stores from Tosco Corp. in Arizona; (4) Exxon's refinery located in Benicia, California ("Exxon Benicia Refinery"), and all of Exxon's gasoline marketing in California; (5) the terminal operations of Mobil in Boston and in the Washington, D.C. area, and the ability to exclude a terminal competitor from using Mobil's wharf in Norfolk; (6) either Mobil's interest in the Colonial pipeline or Exxon's interest in the Plantation pipeline; (7) Mobil's interest in TAPS; (8) the terminal and retail operations of Exxon on Guam; (9) a quantity of paraffinic lubricant base oil equivalent to the amount of paraffinic lubricant base oil refined in North America that is controlled by Mobil; and (10) Exxon's jet turbine oil business.

The Commission conducted its investigation of the merger in coordination with the Attorneys General of the States of Alaska, California, Connecticut, Maryland, Massachusetts, New Jersey, New York, Oregon, Pennsylvania, Texas, Vermont, Virginia and Washington. As a result of that joint effort, ExxonMobil also entered into agreements with the States of Alaska, California, Delaware, Maryland, Massachusetts, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Texas, Vermont, Virginia and Washington, and the District of Columbia, settling allegations developed by the States that the merger would violate both state and federal antitrust laws.

In BP Amoco p.Lc./Atlantic Richfield Company, File No. 9910192, Docket No. C-3938 (consent order issued on August 25, 2000), the Commission investigated the merger of two other large petroleum companies, and issued a consent order settling allegations in an accompanying complaint that the merger would substantially lessen competition or tend to create a monopoly in
certain petroleum markets in the United States. BP Amoco — a United Kingdom corporation and the world’s third largest oil company — was engaged in exploration, development, and production of crude oil on the Alaskan North Slope (“ANS crude oil”), which it sold to refineries on the West Coast of the United States, Hawaii, and Alaska, and in markets abroad. It also owned capacity on the Trans-Alaska Pipeline System (“TAPS”) and leasehold interests in Jones Act tankers. These specialized tankers are used by BP Amoco to transport ANS crude oil from the North Slope production fields to its refinery customers. ARCO, a Delaware corporation, was also engaged in the exploration, development, and production of ANS crude. ARCO also owned capacity on TAPS, and it owned its own Jones Act tankers, which it used to transport ANS crude oil to the West Coast. In addition, ARCO owned and operated two refineries on the West Coast that refine ANS crude oil. Together, BP Amoco and ARCO produced approximately 74 percent of all ANS crude oil. In March 1999, BP Amoco and ARCO entered into an agreement to merge their companies.

The Commission complaint alleged that the proposed merger would violate Section 7 of the Clayton Act and Section 5 of the FTC Act by lessening competition in the markets for: (1) the production, sale and delivery of ANS crude oil; (2) the production, sale and delivery of crude oil used by targeted West Coast refiners; (3) the production, sale and delivery of all crude oil used on the West Coast; (4) the purchase of exploration rights on the Alaskan North Slope; (5) the sale of crude oil transportation on the Trans-Alaska Pipeline System (TAPS); (6) the development for commercial sale of natural gas on the Alaskan North Slope; and (7) the supply of crude oil pipeline transportation to, and crude oil storage in, Cushing, Oklahoma. To remedy these alleged anticompetitive effects, the consent order required BP Amoco to divest certain of ARCO’s complete, free-standing businesses, including oil and gas interests, tankers, pipeline interests, real estate exploration data and selected long-term supply agreements. In particular, the consent order required BP Amoco to divest: (1) all of ARCO’s assets and interests related to and primarily used with or in connection with ARCO’s Alaska businesses; and (2) all of ARCO’s assets related to its Cushing, Oklahoma crude oil business.

In *British Petroleum Company p.l.c/Amoco Corporation, Docket No. C-3868* (consent order issued on April 19, 1999), the complaint outlining the charges alleged that the merger of BP and Amoco would lessen competition in: (1) the wholesale sale of gasoline in 30 cities or metropolitan areas in the eastern United States; and (2) the terminaling of gasoline and other light petroleum products in nine specified geographic markets. With respect to wholesale gasoline sales, the complaint alleged that BP and Amoco sold both branded and unbranded gasoline at terminals serving 30 markets — and consequently set the wholesale prices of their respective gasolines — and that, as a result of the merger, these markets would become significantly more concentrated. In order to resolve these antitrust concerns, the consent order required the divestiture of 134 gas stations in eight markets in which the companies’ ownership overlapped, including all the Amoco retail gas stations in Tallahassee, Florida and Pittsburgh, Pennsylvania, and all the BP stations in Charleston, South Carolina; Charlotte, North Carolina; Columbia, South Carolina; Jackson, Tennessee; Memphis, Tennessee; and Savannah, Georgia. In addition, in all 30 markets — including markets in which neither BP nor Amoco owned gas stations — the order required BP Amoco to give the BP and Amoco wholesale customers (both jobbers and open dealers) the option of canceling their franchise and supply agreements with Amoco and BP,
freeing them to switch their gas stations to other brands. The consent order also provided that unless retail gasoline sellers representing a specified volume of sales in Toledo and Youngstown, Ohio, agreed to switch to other brands, BP Amoco would have to divest retail gasoline stations with an equivalent volume of sales to an acquirer acceptable to the Commission.

As noted above, the complaint also alleged that in nine metropolitan areas, the terminaling of gasoline and other light petroleum products would become significantly more concentrated as a result of the merger, and that entry into those markets would be difficult. The consent order required BP Amoco to divest the nine terminals to Williams Energy Ventures, Inc., ("Williams") -- a major energy company with substantial experience in operating terminals -- or to another acquirer approved by the Commission.

In *Duke Energy Corporation/Phillips Petroleum Company, File No. 0010080* (consent order issued on May 5, 2000), the Commission issued a consent order resolving allegations in an accompanying complaint which arose in December 1999, when Phillips and Duke agreed to transfer their natural gas gathering and processing businesses to DEFS, and Duke agreed to acquire Conoco and Mitchell's jointly held Oklahoma gas gathering and processing assets. Gas gathering involves the pipeline transportation of natural gas from a wellhead or central delivery point to a gas transmission pipeline or processing plant. Following an investigation of the proposed transactions, the FTC determined that both the merger and the acquisition could lead to competitive concerns in several counties in Kansas, Oklahoma and Texas. The complaint alleged that there were seven relevant markets in which gas producers were limited in their choice of gas gathering services and could only turn to Phillips or Duke (or, at most, one other gatherer). To remedy these concerns, the consent order required Duke to divest a total of 2,787 miles of its pipeline systems in these markets, including 2,250 miles of pipeline which were to be divested to its joint venture partners. In February 2001, Duke divested its interest in 1,450 miles of pipe in the Austin Chalk area of Texas to Mitchell, a co-owner of Ferguson-Burleson County Gas Gathering System. The remaining 537 miles of pipeline will be sold to other Commission-approved buyers under the terms of the order.

In *El Paso Energy Corporation/Sonat, Inc., File No. 9910178* (consent order issued on January 6, 2000), the Commission issued a consent order resolving allegations in an accompanying complaint that the proposed merger would result in highly concentrated markets in several geographic areas, and would substantially reduce competition or tend to create a monopoly in the transportation of natural gas by eliminating both actual and potential competition between El Paso and Sonat. In addition, the complaint alleged that -- due to the cost of developing and placing natural gas pipelines -- entry into the marketplace by additional competitors would not be timely or sufficient to prevent the anticipated anticompetitive effects of the merger. To address complaint allegations regarding the potential for reduced competition offshore, the consent order required El Paso to divest Sea Robin -- a wholly-owned subsidiary of Sonat -- and to divest Sonat's one-third ownership interest in Destin (a large natural gas pipeline off the Louisiana coast). To address complaint allegations concerning Southeastern onshore consuming areas, the order required El Paso to divest ETNG, the El Paso pipeline system that
serves customers in eastern Tennessee and northern Georgia. In addition, the order contains ancillary provisions related to both the onshore and offshore markets. In particular, customers on the ETNG system have transportation and/or storage contracts with ETNG and Tennessee Gas Pipeline Co. — another El Paso subsidiary — and many of these contracts have renewal election deadlines which will run in the midst of the ETNG divestiture process. The consent order therefore extended the renewal deadline for these contracts until 60 days after the divestiture of ETNG, so that customers will know the identity of the acquirer of ETNG before they commit to new contracts for natural gas transportation and storage. In addition, the order contains ancillary provisions which would apply to El Paso’s operation of VKGC in the event that Sonat’s Destin interest is sold to a natural gas producer.

In El Paso Energy Corporation/Coastal Corporation, File No. 0010086 (consent order issued on March 19, 2001), the Commission issued a consent order which allowed the $16 billion merger of El Paso Energy Corporation (“El Paso”) and the Coastal Corporation (“Coastal”), while addressing the competitive concerns identified regarding the transaction as originally proposed. The consent order required El Paso and Coastal to divest their interests in 11 natural gas pipeline systems totaling more than 2,500 miles of pipe, and also provided for the divestiture of the proposed Gulfstream pipeline in Florida to a new purchaser, in order to restore competition to pre-merger levels and ensure future competition for natural gas transportation into the state. The consent order also required the divestiture of El Paso and Coastal interests in existing natural gas pipelines serving customers in New York State and the Midwest. In addition, to address the complaint allegations of injury to competition in the Gulf of Mexico, the consent order required the divestiture of seven pipelines and established a development fund for the purchaser of El Paso’s Green Canyon and Tarpon pipelines to cover the costs of extending these pipelines to specified areas in the Gulf where El Paso and Coastal pipelines are significant competitors.

In El Paso Energy Corporation/Pacific Gas & Electric, File No. 0010121 (consent order issued on January 30, 2001), the complaint alleged that the proposed acquisition would lessen competition in each of the following markets: (1) the transportation of natural gas out of the Permian Basin (the large gas supply area located in western Texas and southeastern New Mexico); (2) the transportation of natural gas into Central Texas; and (3) the transportation of natural gas out of the Matagorda Island offshore production area (located in waters off of the Texas coast near Galveston). The complaint also alleged that the acquisition, if consummated, would result in highly concentrated markets and would allow El Paso to raise prices unilaterally. In addition, the complaint alleged that entry into any of the three markets would not be timely, likely or sufficient to prevent a price increase. To remedy these alleged anticompetitive effects, the consent order required the respondents to divest all of El Paso’s share of Oasis Pipe Line Company to third party acquirers — including Aquila Gas Pipeline Corporation, Dow Hydrocarbons and Resources, Inc. and the Oasis Pipe Line Company — and to divest the Teoco Pipeline to Duke Energy Field Services, LLC. The consent order also required the respondents to divest all of PG&E’s pipeline assets in Matagorda to Panther Pipeline.

In Dominion Resources, Inc./Consolidated Natural Gas Company, Docket No. C-3901 (consent order issued on December 9, 1999), the Commission’s complaint alleged that the proposed merger would combine the dominant provider of electric power in Virginia (Dominion)
with the primary distributor of natural gas in southeastern Virginia, Virginia Natural Resources (VNG), a subsidiary of Consolidated (CNG). The complaint further alleged that entry into the electric power generation market in southeastern Virginia by companies unaffiliated with Dominion might be deterred or disadvantaged, because Dominion -- with the control of VNG which it would secure -- would as a result be able to exercise unilateral market power to raise the cost of entry and production or otherwise gain a competitive advantage. The complaint alleged that, for these and other reasons, the merger would increase the likelihood that consumers would have to pay higher prices for electricity. The consent order consequently required Dominion to divest VNG, in accordance with the stipulation entered into among Dominion, CNG, and the staff of the Virginia State Corporation Commission, and with any proposed acquirer to be subject to Commission approval. The consent order further provided that if Dominion could not find a suitable purchaser, it would have to spin off VNG to its shareholders, with the proviso that no Dominion shareholder could receive more than five percent of the voting shares of VNG.

In Koch Industries, Inc./Entergy Corporation, Docket No. C-3998 (consent order issued on January 31, 2001), the Commission issued a consent order against Entergy Corporation ("Entergy") and Entergy-Koch, LP ("EKLP") -- a limited partnership owned equally by Entergy and Koch Industries, Inc. -- which allowed EKLP to acquire 50 percent of the Gulf South Pipeline Company, LP ("Gulf South," formerly the Koch Gateway Pipeline Company) from Koch. The consent order resolves allegations in an accompanying complaint that the transaction would substantially lessen competition or tend to create a monopoly -- in the retail sale of electricity to consumers (in certain Louisiana and Mississippi markets) and the distribution of natural gas to consumers (in certain Louisiana markets) -- in violation of Section 7 of the Clayton Act and Section 5 of the FTC Act. It requires Entergy, inter alia, to implement an open, transparent process -- for buying natural gas and natural gas transportation -- which will assist state regulators in determining whether Entergy, in any given instance, purchases gas supplies from EKLP at inflated prices.

In Michigan Consolidated Gas Company/The Detroit Edison Company, Docket No. C-4008 (consent order issued on May 15, 2001), the complaint alleged that the proposed merger, if consummated, would violate the law, with respect to the distribution of electricity and natural gas: (1) by eliminating competition between DTE and MCN in the distribution of electricity and the distribution of natural gas in the City of Detroit and certain Michigan counties in which both DTE distributes electricity and MCN distributes natural gas (the "Overlap Area"); (2) by consequently increasing the likelihood that market power would be exercised in the Overlap Area in connection with the distribution of electricity and the distribution of natural gas; and (3) by consequently increasing the likelihood of anticompetitively higher prices and reduced competition for the distribution of electricity and the distribution of natural gas in the relevant market. The consent order the Commission issued permitted the merger to proceed, but required DTE/MCN to divest certain assets to Exelon no later than five days after it was consummated. Exelon is one of the largest suppliers of electricity and natural gas in the nation, and it currently markets natural gas to buyers in Michigan (as well as in other states) and has an affiliate that is engaged in the distribution of microturbines and distributed generation equipment.

In CMS Energy Corporation/Duke Energy Company, Docket No. C-3877 (consent order issued on June 2, 1999), the complaint alleged that the proposed acquisition of the Panhandle and
Trunkline pipelines would give CMS/Consumers Energy ("CMS") -- the owner of the only Michigan intra-state natural gas transmission system through which consumers can buy natural gas from other suppliers -- an incentive to restrict other pipelines' access to the Consumer Energy system, with the effect of permitting price increases on the Trunkline and Panhandle pipelines. The complaint alleged that these effects could in turn increase the price of natural gas and electricity for consumers and industrial users in all or portions of 54 Michigan counties. The Commission consent order prohibits CMS from restricting or eliminating interconnection capacity available to the pipelines that compete with Panhandle and Trunkline. It also requires CMS to give shippers the choice of two options if the interconnection capacity with competing pipelines falls below historical levels. First, if CMS cannot accept a shipment at the regular interconnect point -- but the shipper can provide its shipment at another point at no additional cost to the shipper -- the order requires CMS to accept the gas at the other pipeline interconnect point. If, by contrast, the shipper would incur additional cost -- or if no other interconnection point is available -- the order would require CMS to provide gas from its own supply (essentially loaning the gas) until the shipper can access the interconnect point and replace that gas. The consent order also requires CMS to post information about the capacity, shipments and throughput of the system on an electronic bulletin board.

_Allegedly Anticompetitive Agreements_

Horizontal agreements on pricing or output or other collusive conduct can lead to higher fuel prices for consumers than would result from competitive markets, and the Commission therefore carefully monitors competitive conditions in the petroleum sector, and as appropriate provides assistance to other law enforcement agencies. Thus, for example, in 2000 a number of State Attorneys General in the Northeast opened an investigation of heating oil and diesel fuel price increases in their jurisdictions, and the Commission provided substantial assistance and consultation to the Attorneys General and their staffs with respect to that investigation.

More recently, the Commission completed two investigations relating to the pricing of gasoline. The first was an extensive and intensive investigation into the causes of the gasoline price spikes which occurred in a number of local markets in the Midwest during the spring and summer of 2000. The Commission staff secured a great deal of evidentiary material in the course of the investigation, but ultimately the Commission did not find any credible evidence of collusion or other anticompetitive conduct by the oil industry, and therefore closed the investigation. In its final report on the investigation, the Commission identified the major cause of the price increases as a supply shortage which, in turn, arose from a number of different factors, including, in particular, refinery production problems, pipeline disruptions, and low inventory levels.

Second, the Commission conducted an intensive and extensive investigation of various marketing and distribution practices employed by the major oil refiners in Arizona, California, Nevada, Oregon, and Washington State. The Commission did not, however, find any evidence of conduct by the refiners which violated the federal antitrust laws, and therefore closed the investigation. In particular, the investigation addressed the practice of "zone pricing," pursuant to which refiners "set uniform wholesale prices and supply branded gasoline directly to their company-operated and leased stations and to some independent open dealer stations within a
small but distinct geographic area called a price zone. The investigation did not find any evidence of collusion between oil companies in furtherance of this practice. The investigation also addressed the practice of “redlining,” pursuant to which refiners prevent independent gasoline distributors (“jobbers”) “from competing with them to supply branded gasoline to independent dealers in metropolitan areas.” The investigation “revealed no evidence of conspiracy or coordination” with respect to this practice.

The Commission will continue to monitor carefully competitive conditions in the petroleum industry, given its importance to the United States economy and, more specifically, to consumers such as older Americans who are particularly vulnerable to increases in petroleum product prices. To that end, on August 2, 2001, the Commission held an initial public conference to examine factors that affect prices of refined petroleum products in the United States. The public conference was the first step in soliciting information from interested parties that will assist the Commission in structuring hearings later this year to focus in a comprehensive manner on the most relevant and important issues regarding petroleum prices. Participants in the initial conference focused on domestic and international aspects of the following areas: (1) the supply of crude oil, including crude oil exploration, production, importation, and transportation; (2) the refining of fuel products and the importation of refined products; (3) the transportation of refined petroleum products; and (4) the marketing and distribution of refined petroleum products.

**Electric Utilities**

The cost of electricity can be especially burdensome to older consumers because those on fixed incomes face greater relative economic burdens in meeting electricity costs. Moreover, retired individuals -- who tend to spend more time at home than working individuals -- may have less of an opportunity to lower their electricity requirements during the day. Furthermore, senior citizens -- because they are more susceptible to heat stress -- are often vulnerable to summertime temperatures in their homes which younger persons can tolerate, and often require uninterrupted air conditioning to maintain their health.

On September 13 and 14, 1999, as part of its Retail Electricity Competition Study, the Commission held a public workshop examining the competition and consumer protection issues involved with deregulating and restructuring the U.S. electricity industry. The purpose of the workshop was to allow idea-sharing on two topics which bear directly on the FTC's expertise: (1) market power (e.g., evaluating and addressing horizontal market power concerns in electricity generation); and (2) consumer protection (e.g., disclosures by electric service providers of the environmental attributes of the power they sell). The workshop provided a forum for discussing experiences under policies which have been implemented at the state level, rather than attempting to provide all of the answers to a complex set of issues that vary by region and locale. The Commission expects this type of robust exchange of views and ideas among those working on the issues to prove useful as the regulatory reform process moves forward, at both the state and the federal level.

Based in part on the September workshop, in July 2000, the Commission released a staff report entitled "Competition and Consumer Protection Perspectives on Electric Power Regulatory Reform." The report highlights how electric power restructuring is enabling consumers to select their own electricity supplier. The report concludes that consumers in electric power markets are
likely to be better able to promote their interests when they can readily switch among suppliers offering a variety of products and services and when they can readily compare prices and terms of competing offers.

**Retail Sector**

Many older Americans, especially those on fixed incomes, may be particularly vulnerable to excessively high food prices. The Commission's antitrust enforcement activities during the January 1999-August 2001 period in this sector included law enforcement actions addressing a number of supermarket mergers and acquisitions.

**Supermarket Mergers**

In *Kroger Co./The John C. Groub Company, Inc., Docket No. C-3905* (consent order issued on Nov. 8, 1999), the consent order resolved allegations in an accompanying complaint that Kroger's proposed acquisition of The John C. Groub Company, Inc. would violate the law by substantially lessening supermarket competition in two markets in Indiana. In particular, the complaint alleged that two Kroger supermarkets directly competed with four Groub stores in Columbus, Indiana, and Madison, Indiana; that in those markets the proposed acquisition would therefore increase concentration and consequently reduce competition; and that the proposed acquisitions therefore could produce price increases and reductions in the quality and selection of food, groceries, or services. The consent order permitted the proposed acquisition, but required Kroger, *inter alia*, to divest three supermarkets in the two markets -- one Groub "Jay C" store and one Groub "Foods Plus" store in Columbus, Indiana, and one "Kroger" store in Madison, Indiana -- to Roundy's. In addition, the consent order for ten years requires Kroger to provide notice to the Commission before acquiring any supermarket assets in Bartholomew or Jefferson Counties, Indiana.

In *Etablissements Delhaize Freres et Cie "Le Lion" S.A./Hannaford Bros. Co., Docket No. C-3962* (consent order issued on May 30, 2001), the complaint alleged that the merger of Delhaize and Hannaford would violate the law by eliminating direct competition between supermarkets owned or controlled by Delhaize and those owned by Hannaford in certain geographic markets; by increasing the likelihood that Delhaize would exercise unilateral market power and raise prices for consumers within those markets; and by increasing the possibility of coordinated interaction between the remaining supermarket firms in the Southeast. The consent order required Delhaize to divest 37 supermarkets in Virginia and North Carolina to three FTC-approved buyers -- including Kroger Co. (20 stores in Virginia), Lowe's Food Stores, Inc. (12 stores in North Carolina), and the Sylvester Group (five stores in North Carolina) -- and to divest one unbuilt supermarket site in North Carolina.

In *Winn-Dixie Stores, Inc./Jitney-Jungle Stores of America, Inc., File No. 0110022* (consent order issued on February 14, 2001), the complaint alleged that Winn-Dixie's proposed acquisition of various supermarket assets of Jitney-Jungle would violate Section 5 of the FTC Act and Section 7 of the Clayton Act by eliminating direct competition between supermarkets currently owned or operated by Jitney-Jungle and those owned or operated by Winn-Dixie in several geographic markets in Florida and Mississippi; by increasing the likelihood that Winn-Dixie would unilaterally exercise market power within those markets; and by increasing the
likelihood of collusion or coordinated interaction among the remaining supermarket firms in these markets. The complaint further alleged that each of these effects would increase the likelihood that prices for food, groceries or services would increase -- and that the selection of these items would decrease -- in the relevant geographic markets. The consent order settling these allegations, *inter alia*, for ten years prohibits Winn-Dixie from acquiring any interest in four specified Jitney-Jungle supermarkets without obtaining prior FTC approval, and for ten years requires Winn-Dixie to provide written notice to the Commission before acquiring any interest in a supermarket owner or operator, or any facility that has operated as a supermarket within the previous six months in the relevant geographic markets.

In *Koninklijke Ahold nv/Giant Food, Inc., Docket No. C-3861* (consent order issued on April 5, 1999), the complaint alleged that Ahold's proposed acquisition of Giant would violate the law by eliminating direct competition between Ahold and Giant in four Maryland markets and three Pennsylvania markets; by eliminating actual potential competition in another Pennsylvania market; by increasing the likelihood that Ahold would unilaterally exercise market power; and by increasing the likelihood of collusion among the remaining supermarket firms. The complaint alleged that each of these effects would increase the likelihood that the prices of food, groceries or services would increase -- and that the quality and selection of food, groceries or services would decline -- in these markets. The consent order permitted the proposed acquisition, but required Ahold, *inter alia*, to divest ten supermarkets in eight separate geographic markets, and to provide the Commission with prior notice of plans to acquire additional supermarkets within those markets.

In *Kroger Co./Fred Meyer Stores, File No. 9910024* (consent order issued on January 10, 2000), the complaint alleged that Kroger's proposed acquisition of Fred Meyer would increase concentration and as a result reduce competition in seven western U.S. markets -- in Arizona, Wyoming, and Utah -- with consequent price increases and reductions in the quality and selection of food, groceries or services in those markets. The consent order permitted the proposed acquisition, but required Kroger to divest eight specific supermarkets in the seven markets; the required divestitures included either all of the Kroger stores or all of the Fred Meyer supermarkets in each market. The consent order also requires Kroger to provide the Commission with prior notice of plans to acquire additional supermarkets in six of the markets.

In *Albertson's Inc./American Stores Company, File No. 9810339* (consent order issued on December 6, 2000), the complaint alleged that Albertson's proposed acquisition of American Stores by Albertson's raised competitive issues in 57 markets in California, Nevada and New Mexico. These 57 markets contained a large percentage of stores owned by Albertson's and American Stores. Over half of the parties' supermarkets in California, New Mexico and Nevada were direct competitors. The complaint alleged that each of the local markets at issue would have been highly concentrated after this merger, as defined by the Commission's Merger Guidelines. The FTC's complaint alleged that by eliminating direct competition and actual potential competition in the relevant markets, Albertson's proposed acquisition of American Stores could result in price increases and reductions in the quality and selection of food, groceries or services. The complaint outlining the charges alleges that entry in these markets is difficult and would not be timely, likely, or sufficient to prevent anticompetitive effects. The consent order was designed to remedy the Commission's concerns by requiring the divestiture of 144
supermarkets and five supermarket sites in the relevant markets to five different buyers. The companies were required to divest 104 Albertson's supermarkets and three Albertson's sites, and 40 American Stores' supermarkets and two American Stores' sites. The 104 Albertson's supermarkets consist of 96 stores that operate under the "Albertson's" trade name and eight stores that operate under the "Max Grocery Warehouse" trade name. The 40 American Stores supermarkets consist of 36 stores that operate under the "Lucky" trade name, three stores that operate under the "SuperSaver" trade name, and one store that operates under the "Lucky Sav-On" trade name.

In Shaw's Supermarkets, Inc./Star Markets, Inc., File No. 9910075 (consent order issued on April 5, 2000), the complaint alleged that the effect of this acquisition, if consummated, would be to substantially lessen competition in the relevant markets by eliminating direct competition between Shaw's and Star Markets and increase the likelihood of or facilitate collusion or coordinated action, with the effects of increasing prices and reducing the quality and selection of food, groceries or services. The consent order resolved these antitrust concerns by requiring the divestiture of 10 designated Shaw's or Star Markets supermarkets in eight communities. The remaining three stores, Star's Saugus, Stowe, and Sudbury stores, were to be divested within three months after the date the consent agreement was signed.

Funeral Homes and Cemeteries Sector

Funeral services, which often cost $10,000 or more, come at emotionally difficult times and may be among the most expensive of consumer purchases and are of considerable importance to older Americans and their families. The Commission is active on the antitrust side of its jurisdiction in ensuring that competition is maintained in funeral services and cemetery services. Where mergers take place between two chains providing such services, we examine them for overlaps in particular local markets, in order to ensure that every local market retains enough providers to give consumers a competitive range of alternatives.

In Service Corporation International/La Grone Funeral Home, Docket No. C-3959 (consent order issued on June 29, 2000), Service Corporation International ("SCI") owned the Ballard Funeral Home -- a full-service funeral home in Roswell, New Mexico -- and in May 1994 acquired the LaGrone Funeral home, the only remaining full-service funeral home in Roswell. The complaint alleged that the acquisition gave SCI a monopoly in the provision of funeral services in Roswell, and that after the acquisition there had been no new entry into the provision of funeral services in Roswell and prices for funeral services had increased. Accordingly, the consent order required SCI to divest the Ballard Funeral Home to a Commission-approved buyer, and for a 10-year period to provide the Commission with prior notice of any proposed acquisition of a funeral home serving the Roswell area.

In Service Corporation International/Equity Corporation International, Docket No. C-3869 (consent order issued on April 22, 1999), the consent order settled allegations in an accompanying administrative complaint that SCI's proposed acquisition of Equity Corporation International (ECI) -- the fourth largest funeral home and cemetery company in the United States -- would substantially lessen competition among funeral home or cemetery establishments in 14 local markets. The complaint alleged in particular that the proposed acquisition -- which would combine SCI's approximately 3,200 funeral homes and 400 cemeteries in 41 states, Canada,
Australia and Great Britain with ECI's 354 funeral homes and cemeteries in 33 states -- would have eliminated substantial existing competition between SCI and ECI, and would have led to higher prices or reduced services to consumers. The consent order permitted SCI to acquire ECI, but required the respondent to divest sufficient funeral service and cemetery properties to Carriage Services, Inc. in each of the 14 relevant markets to remedy the allegedly anticompetitive effects of the acquisition.

CONCLUSION

This report summarizes Commission programs from January 1999 through August 2001 which may be of particular interest or usefulness to older Americans. Through its law enforcement and consumer and business education efforts, the Commission strives to provide a fair and competitive marketplace where older consumers, and their younger counterparts, can make decisions and choose their purchases from a competitive range of options and on the basis of complete and truthful information.
1. The FTC has limited or no jurisdiction over some specified types of entities and activities that are regulated by other parts of the government. These include banks, savings associations, and federal credit unions; regulated common carriers; air carriers; non-retail sales of livestock and meat products under the Packers and Stockyards Act; certain activities of nonprofit corporations; and the business of insurance. See, e.g., 15 U.S.C. §§ 44-46 (FTC Act); 15 U.S.C. § 21 (Clayton Act); 7 U.S.C. § 227 (Packers and Stockyards Act); 15 U.S.C. § 1011-1015 (McCarran-Ferguson Act).

2. 15 U.S.C. § 45(a). The Commission also has responsibilities under 46 additional statutes, including, for example, the Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq., which establishes important privacy protections for consumers' sensitive financial information; the Truth in Lending Act, 15 U.S.C. §§ 1601 et seq., which mandates disclosures of credit terms; and the Fair Credit Billing Act, 15 U.S.C. §§ 1666 et seq., which provides for the correction of billing errors on credit accounts. The Commission also enforces more than 35 Rules governing specific industries and practices, including, for example, the Used Car Rule, 16 C.F.R. Part 455, which requires used car dealers to disclose warranty terms via a window sticker; the Franchise Rule, 16 C.F.R. Part 436, which requires the provision of information to prospective franchisees; and the Telemarketing Sales Rule, 16 C.F.R. Part 310, which defines and prohibits deceptive telemarketing practices and other abusive telemarketing practices.

3. In addition, pursuant to its liaison agreement with the FTC, the FDA exercises primary jurisdiction over the advertising and labeling of prescription drugs.

4. Lane Labs manufactured and distributed these products, while Cartilage Consultants, Inc. supplied consumers with information on how to use the products, purportedly to treat cancer.

5. The complaint also alleged that the defendants collected consumers' medical and financial data with allegedly false assurances as to the security and encryption used to protect consumers' information, and in addition sent "spam" to 11,000 customers informing them that their credit cards would be billed $50 for "Y2K Remediation." Consequently, the consent decree also prohibits the defendants from "selling, renting, leasing, transferring or disclosing the personal information that was collected from their customers without express authorization from the customer;" requires them to post a privacy policy that discloses the types of personal identifying information they are collecting, either actively or passively; and requires them to establish and maintain reasonable procedures to protect the confidentiality, security, and integrity of personal information collected from consumers.

6. Subprime lending refers to the extension of high-rate, high-fee loans to persons who are considered to be higher-risk borrowers.

7. The Commission's ECOA and FDCPA claims are discussed more fully below, in the sections describing those statutes.

9. Manufacturers must derive this information from standardized tests which the EPCA directs the Department of Energy ("DOE") to develop. See 42 U.S.C. § 6293. The Commission's Rule must require disclosure on labels of energy use information derived from the DOE test procedures. See 42 U.S.C. § 6294(c)(1)(A).

10. The survey also indicated that consumers aged 50 and older accounted for about 36 percent of prize/sweepstakes fraud.

11. See www.consumer.gov/sentinel. This system is an expansion of the earlier NAAG-FTC Telemarketing Complaint System.

12. For instance, Consumer Sentinel allows members to submit an "Auto Query" search on scams or possible targets, which allows them to get an e-mail notice whenever responsive new complaints are entered in the database.

13. These agencies include the FBI, the Offices of the United States Attorneys, and other parts of the Department of Justice; the United States Postal Inspection Service; the Secret Service; the Securities and Exchange Commission; the Commodity Futures Trading Commission; and the Internal Revenue Service. They also include the offices of all fifty State Attorneys General; local district attorneys and sheriffs; and Canadian authorities such as the Royal Canadian Mounted Police, the Competition Bureau, Industry Canada, and a number of Provincial and city police departments.

14. Consumer Sentinel also gives members the ability to search the National Tape Library—a clearinghouse of undercover tape recordings of telemarketing sales calls—and to make a tape request online; in addition, it provides an Internet resource bookmark list, a library of telemarketing pleadings, newsletters, and other information useful to law enforcers.


16. The CRC now receives more than 12,000 inquiries and complaints per week. They cover a broad spectrum, including everything from complaints about get-rich-quick telemarketing scams and online auction fraud to questions about consumer rights under various credit statutes and requests for educational materials. Counselors record complaint data, provide information to assist consumers in resolving their complaints, and answer their inquiries.

17. In 1998, the Interagency Resources Management Conference Award recognized Consumer Sentinel as an exceptional initiative to improve government service.

18. The FTC and 12 partners from other countries launched econsumer.gov at the last meeting of the International Marketing Supervision Network (IMSN) on April 24, 2001. The IMSN is a membership organization consisting of the consumer protection authorities of 29 countries, and representatives from the European Commission and the Organisation for Economic Cooperation and Development (OECD). Most IMSN member countries are OECD members. The main objective of the IMSN is to facilitate practical action to prevent and redress deceptive marketing practices with an international component. The IMSN fosters cooperative efforts to tackle consumer problems connected with cross-border.
transactions in both goods and services. It facilitates the exchange of information among the participants for mutual benefit and understanding.

The other participating IMSN countries are Australia (Australian Competition and Consumer Protection Commission), Canada (Competition Bureau, Industry Canada), Denmark (Danish Consumer Ombudsman), Finland (Finnish Consumer Ombudsman), Hungary (Hungarian General Inspectorate for Consumer Protection), Korea (Korea Consumer Protection Board), Mexico (Procuraduria Federal del Consumidor), New Zealand (New Zealand Ministry for Consumer Affairs), Norway (Norwegian Consumer Ombudsman), Sweden (Swedish Consumer Ombudsman), Switzerland (State Secretariat for Economic Affairs of Switzerland), and the United Kingdom (Office of Fair Trading).

19. The online complaint form accommodates international address information and foreign currencies.


22. Although the Commission actively pursues every avenue to collect as much of the judgments it secures as possible, for a variety of reasons — including in particular the insolvency of the defendants involved — it is not always possible to do so.


24. Commission records indicate that some consumers have lost as much as tens of thousands of dollars to prize promotion telemarketers.

25. As part of Project Prize Fighter, the FTC filed 3 actions, the U.S. Postal Service filed 10 actions, Attorneys General from Ohio, North Carolina, Florida, Missouri and Utah initiated 5 actions, and 2 additional actions were taken by the County of Orange Boiler Room Apprehension (COBRA) Task Force and the Los Angeles County Sheriff's Department.


27. The Commission had conducted two previous sweeps of similar cases in 1996 and 1997.

28. In the three other cases, the complaints similarly alleged that the defendants provided consumers who paid fees ranging from $28 to $159 nothing more than information on how to improve their credit ratings; lists of banks that marketed secured credit cards; bundles of worthless coupons; basically worthless “100 percent guarantee” certificates; and/or groups of credit card applications. See FTC v. 1263523 Ontario, Inc., doing business as Consumer Credit Services, Donald M. Davies, et al.; FTC v. Modern Credit Financial Services, Inc., et al.; and FTC v. Credit National, Inc. and Mark Wolf, doing business as Credit America.

29. In the other cases, the complaints similarly alleged that the defendants provided consumers who paid fees ranging from $45 to $89 nothing more than materials on credit management; a basically worthless “100 percent guarantee” certificate; and/or information about banks that were supposed to issue the promised credit cards. See, e.g., FTC v. First Credit Alliance, Inc.; FTC v. Navestar DM, Inc.

31. The Commission filed a similar set of complaints filed against credit card protection fraud artists in 1999.

32. Similarly, in FTC v. Liberty Direct, Civ. Action No. CV-99-1637-PHX-RCB (D. Ariz. Announced May 7, 2001), the Commission filed a Section 13(b) complaint alleging that Liberty Direct sold credit card loss "protection" services through third-party telemarketers from January 1998 until February 1999. During this time, the company used telemarketing scripts to promote its service, typically priced at $199, by falsely representing to consumers that the defendants were affiliated with the consumers' credit card issuer; that consumers would be held liable for all unauthorized charges made against their accounts; and that consumers owed money to the defendants. The final order bans the defendants from participating in or benefitting from a business that sells credit card loss protection services; required them to post a $1 million bond before engaging in telemarketing; and prohibited a number of misrepresentations, including.

The FTC has also filed several cases against fraudulent enterprises operating in Canada, each involving credit card loss protection scams. These matters are also ongoing. See, e.g., FTC v. 1306506 Ontario Ltd, note 26 above.

33. A large percentage of these cross-border complaints are contributed to Consumer Sentinel by Canada's Project Phonebusters.

34. Dollars paid are equated with dollar loss, given that consumers receive products or services of either no or minimal value from the types of schemes involved.


37. 3.5 U.S.C. § 6105(b).


39. 16 C.F.R. § 310.3(b) (2001).

40. The British Columbia Attorney General has filed a parallel action in the Canada Prepaid matter, and the FTC, the Department of Justice's Office of Foreign Litigation, and the receiver in the FTC's case have jointly filed a civil common law fraud action in British Columbia against the defendants seeking the return of assets to the U.S. on behalf of defrauded U.S. consumers. At about the same time, the U.S. Attorney's Office in Los Angeles obtained an indictment against the central figure behind the telemarketing network. That person was arrested in Vancouver and now faces extradition to the United
States.

41. Pew Internet and American Life Project, *More Online, Doing More* (reported at http://www.pewinternet.org/reports/toc.asp?Report=30) (comparison of tracking survey data in May and June with data from Thanksgiving and Christmas indicates that the number of American adults with Internet access grew from about 88 million to more than 104 million in the second half of 2000).

42. Reported at www.census.gov/mrts/www/current.html.

43. Id.


45. The Commission initiated Consumer Sentinel in 1997, and the fact that the system both made consumers more aware that they could register their complaints with the Commission and made it easier for them to do so probably provides a partial explanation for the increase in Internet fraud complaints described in the text.

46. To date the Commission has collected more than $55 million in redress for victims of Internet fraud and deception.

47. These figures are based on estimated annual fraudulent sales by defendants in the twelve months prior to filing the complaint. Fraudulent sales figures are based on, among other things, financial statements, company records, receiver reports, and deposition testimony of company officials.

48. The other federal agencies included the Commodity Futures Trading Commission, the Department of Justice, the Securities and Exchange Commission, and the United States Postal Inspection Service.

49. Governmental participants included consumer protection agencies from Australia, Canada, Finland, Germany, Ireland, New Zealand, Norway, the United Kingdom and the United States.

50. The Attorneys General of Arizona, Colorado, Florida, Illinois, Iowa, Indiana, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Jersey, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, Texas, and Washington all filed one or more lawsuits. Consumer protection offices in West Virginia and Wisconsin also took action, as did the Louisiana Department of Justice, the Oklahoma Department of Securities, and the Washington State Securities Division.

51. Telephone/Pay-Per-Call Solicitation Frauds are schemes that exploit the telephone billing and collection system to charge consumers for telephone-based entertainment programs ("audiotext" in industry parlance) or other so-called "enhanced services" that are not telecommunications transmission but are often billed on consumers' telephone bills. Modern dialers and videotext schemes, like the operation attacked in *FTC v. Verity International*, No.00 Civ. 7422(LAK) (S.D.N.Y. 2000), described *infra*, are ones that, unbeknownst to a consumer, cause his or her computer modem to disconnect from his or her usual Internet service provider, dial an expensive international telephone number, and reconnect to the Internet at a remote location overseas, charging the consumer as much as $5.00 or more.
per minute for as long as the consumer remains online.

52. Pyramid operators typically promise enormous earnings or investment returns, based not on commissions for retail sales to consumers, but rather on commissions for recruiting new pyramid members. Recruitment commissions, of course, are premised on an endless supply of new members. Inevitably, when no more new recruits can be found, these schemes collapse and a vast majority of participants lose the money they invested.

53. To date, the Commission has collected about $42.6 million in these cases.


55. Identity theft is use by a thief, unbeknownst to his victim, of the victim’s name, social security number or other personal identifying information, to open accounts and rack up huge debts for goods and services. Identity theft certainly predates the Internet, and although identity thieves are finding ways to exploit this new tool, often this pernicious practice utilizes low technology means, such as intercepting a victim’s mail, or scavenging personal information from a victim’s trash.

56. The Commission has been working closely with other agencies to establish a coordinated effort to enhance law enforcement efforts and to help consumers resolve identity theft problems. Thus, in April 1999, Commission representatives met with representatives of approximately a dozen other federal agencies and the National Association of Attorneys General to discuss the implementation of the consumer assistance provisions of the Identity Theft Act. As a part of the resultant cooperative efforts, the FTC staff work with the Identity Theft Subcommittee of the Attorney General’s Council on White Collar Crime to coordinate law enforcement strategies and initiatives. FTC staff also incorporate into the clearinghouse database Social Security number misuse complaints — a leading source of identity theft problems — received by the fraud hotline of the Social Security Administration’s Inspector General’s Office.


59. The FTC has coordinated or co-sponsored the following Surf Days, listed by the dates of their announcements, since the beginning of 1999: Jewelry Guides Surf (January 1999), Pyramid Surf Day II (March 1999), Green Guide Surf (April 1999), Coupon Fraud II Surf Day (June 1999), Jewelry Guides Surf II (January 2000), Scholarship Services Surf (January 2000), GetRichQuick.com Surf (March 2000), False or Unsubstantiated Lice Treatment Claims Surf (April 2000), Credit Repair Surf II (August 2000), Children’s Online Privacy Protection Act Compliance Surf (August 2000), False Claims of Authenticity
for American Indian Arts and Crafts Surf Day (October 2000), TooLate.Com [Surf of Online Retailers' Compliance with the Mail or Telephone Order Merchandise Rule] (November 2000), and Operation Detect Pretext [Surf of more than 1,000 web sites (coupled with a review of more than 500 advertisements in the print media) for firms offering to conduct financial searches, in order to identify potential violators of the Gramm-Leach-Bliley Act, which specifically prohibits obtaining, or attempting to obtain, another person's financial information by making false, fictitious or fraudulent statements to financial institutions].


61. The original consumer.gov team received an Executive Branch award for federal employees who have made significant contributions to reinventing government.

62. The assets to be transferred to Chiroscience consisted principally of intellectual property and know-how, and included all of the applicable patents, trademarks, copyrights, technical information, and market research relating to levobupivacaine.

63. In 1999 the Texas legislature enacted a statute that permits the Texas Attorney General to approve, under certain conditions, joint negotiations between health plans and groups of competing physicians. Because it is unclear whether the IPA's conduct in this matter would be approved by the Texas Attorney General, the order allows the IPA to engage in future conduct that is approved and supervised by the State of Texas, if that conduct is protected from liability under the federal antitrust laws under the "state action" doctrine.

64. The Alaska North Slope is a major oil-producing region of the United States. ANS crude oil is used to supply refineries in Alaska, Hawaii, the West Coast of the United States, and Asia.

65. Petroleum terminals provide temporary storage of gasoline and other petroleum products received from a pipeline or marine vessel, and the redelivery of such products from the terminal's storage tanks into tank trucks for ultimate delivery to retail gasoline stations or other buyers. There are no substitutes for petroleum terminals for providing terminaling services.

66. The Divestiture Agreement consists of two separate agreements: (1) an "Easement Agreement" entered into between MichCon and Exelon and (2) an "Auditor Agreement" entered into between MichCon, Exelon, and a third party that serves an oversight function with respect to the Easement Agreement between MichCon and Exelon.


68. Id.

69. Id.

70. Id.
Throughout Fiscal Year 2001, the Commission’s Regional Offices—in conjunction with other law enforcement agencies, AARP, Better Business Bureaus, social service agencies, media, and business and consumer groups—have conducted a comprehensive initiative to help educate and empower senior citizens to protect themselves from fraudulent operators. In furtherance of this initiative, the Regional Offices hosted or participated in the following media events and outreach programs, conferences, and educational forums from October 2000 through August 2001:

1. Better Business Bureau “Scam Jam” (Decatur, AL)
   Office: Southeast Region
   Topic: Identity Theft, Door to Door Sales, Credit Fraud
   Date: October 13, 2000

2. Bay Area Senior Services
   Office: Western Region - San Francisco
   Topic: Telemarketing Fraud/Funeral Rule
   Date: October 13, 2000

3. North of Market Senior Services
   Office: Western Region - San Francisco
   Topic: Telemarketing Fraud/Slave Redress
   Date: October 21, 2000

4. Better Business Bureau “Scam Jam” (Florence, AL)
   Office: Southeast Region
   Topic: Identity Theft, Door to Door Sales, Credit Fraud
   Date: October 27, 2000

5. Fort Worth Senior Fraud Conference
   Office: Southwest Region
   Topic: Internet Fraud and Telemarketing Fraud
   Date: October 28, 2000

6. Institute for Puerto Rican and Hispanic Elderly at Manhattan Community College
   Office: Northeast Region
   Topic: Financial fraud
   Date: October 2000
7. Massachusetts Health Data Consortium Conference (Boston, MA)  
Office: Northeast Region  
Topic: Competition and consumer issues relating to the cost of prescription drugs  
Date: October 2000

8. Middle Tennessee Better Business Bureau "Scam Jam" (Fayetteville, TN and Nashville, TN)  
Office: Southeast Region  
Topic: Internet Fraud, Telemarketing Fraud, and Identity Theft  
Date: November 1-3, 2000

9. Consumer University (Atlanta, GA)  
Office: Southeast Region  
Topic: Internet Fraud and Telemarketing Fraud  
Date: November 2, 2000

10. On Lok Senior Health Center  
Office: Western Region - San Francisco  
Topic: Funeral Rule/Door to Door Sales  
Date: November 3, 2000

11. Senior University - Senior Citizens' Services (Macon, GA)  
Office: Southeast Region  
Topic: Internet Fraud and Telemarketing Fraud  
Date: November 8, 2000

12. On Lok Senior Health Center  
Office: Western Region - San Francisco  
Topic: Telemarketing Fraud/Funeral Rule  
Date: November 9, 2000

13. New Hope Missionary Church Seniors Group  
Office: Western Region - San Francisco  
Topic: Slave Redress/Funeral Rule  
Date: November 11, 2000

14. AARP Metropolitan Dallas Legislative Council (Dallas, TX)  
Office: Southwest Region  
Topic: Fraud against the Elderly  
Date: November 11, 2000

15. Harlem Consumer University with AARP (New York, NY)  
Office: Northeast Region
16. On Lok Senior Health Center
   Office: Western Region - San Francisco
   Topic: Consumer Protection Issues
   Date: November 20, 2000

17. Mt. Zion Greater Baptist Church Seniors Group
   Office: Western Region - San Francisco
   Topic: Slave Redress/Funeral Rule/Telemarketing
   Date: November 26, 2000

18. On Lok Senior Health Center
   Office: Western Region - San Francisco
   Topic: Funeral Rule/Telemarketing
   Date: December 1, 2000

19. Bay View Hunter’s Point Senior Citizens
   Office: Western Region - San Francisco
   Topic: Slave Redress/Internet Shopping
   Date: December 2, 2000

20. On Lok Senior Health Center
    Office: Western Region - San Francisco
    Topic: Internet Fraud
    Date: December 6, 2000

21. Jerusalem Church of God In Christ Senior Group
    Office: Western Region - San Francisco
    Topic: Telemarketing/Slave Redress
    Date: December 12, 2000

22. WHDH--Channel 7 (NBC Affiliate--Boston, MA)
    Office: Northeast Region
    Topic: Advance Fee Loan Scams/Foreign Lottery Tickets
    Date: January 8, 2001 (aired in February 2001)

23. Third Baptist Church Seniors Group
    Office: Western Region - San Francisco
    Topic: Slave Redress
    Date: January 10, 2001
24. Allen Temple Baptist Church  
   Office: Western Region - San Francisco  
   Topic: Slave Redress/Funeral Rule  
   Date: February 4, 2001

25. National Consumer Week Consumer Protection Fair (Chicago, IL)  
   Office: Midwest Region  
   Topic: Consumer Protection Issues - Abusive Lending Practices  
   Date: February 6, 2001

26. AARP Conference on Abusive Lending Practices (New York, NY)  
   Office: Northeast Region  
   Topic: Training Conference on Abusive Lending Practices for AARP Staff and Volunteers  
   Date: February 7, 2001

27. On Lok Senior Health Center  
   Office: Western Region - San Francisco  
   Topic: How not to be victim  
   Date: February 17, 2001

28. National Consumer Week -- Consumer Information Fair  
   Office: Western Region - LA  
   Topic: Consumer Protection Issues  
   Date: February 2001

29. Mt. Zion Greater Baptist Church Seniors Group  
   Office: Western Region - San Francisco  
   Topic: Consumer Protection Issues  
   Date: March 14, 2001

30. Jerusalem Church of God In Christ Seniors Group  
   Office: Western Region - San Francisco  
   Topic: Slave Redress/Telemarketing Fraud  
   Date: March 18, 2001

31. AARP Nassau County President’s Council (Long Island, NY)  
   Office: Northeast Region  
   Topic: FTC’s Missions & Policies  
   Date: March 23, 2001
32. Senior consumer meeting sponsored by credit union (Seattle, WA)
   Office: Northwest Region (with WA AG Office)
   Topic: ID Theft/Internet fraud
   Date: March 2001

33. Abusive Lending Practices Forum with AARP (New York, NY)
   Office: Northeast Region
   Topic: Abusive Lending Practices
   Date: April 3, 2001

34. California Association of Retired Teachers
   Office: Western Region - San Francisco
   Topic: Consumer Protection Issues
   Date: April 6, 2001

35. Third Baptist Church Seniors Group
   Office: Western Region - San Francisco
   Topic: Funeral Rule/Door to Door Sales
   Date: April 11, 2001

36. The Flim-Flam Show - Series of Town Hall Meetings sponsored by SAF-T
   (Seniors Against Fraud Texas) (Tyler, TX)
   Office: Southwest Region
   Topic: Telemarketing Fraud Prevention
   Date: April 17-18, 2001

37. "Operation No Profit-No Return" Reverse Boiler Room
   Office: Southwest Region
   Topic: Investment Fraud Prevention
   Date: April 17-18, 2001

38. Macedonia Baptist Church
   Office: Western Region - San Francisco
   Topic: Slave Redress/Funeral Rule
   Date: April 22, 2001

39. Abusive Lending Practices Forum with AARP (Rochester, NY)
   Office: Northeast Region
   Topic: Abusive Lending Practices
   Date: April 2001
40. East Bay Forum on Fraud  
Office: Western Region - San Francisco  
Topic: Telemarketing/ID Theft/Funeral Rule  
Date: May 4, 2001

41. Better Business Bureau “Scam Jam” (San Diego)  
Office: Western Region - Los Angeles  
Topic: Telemarketing/ID Theft/Shopping By Mail & Phone  
Date: May 5, 2001

42. Senior Action Fair - Martin Luther King, Jr./Drew Medical Center (LA)  
Office: Western Region - Los Angeles  
Topic: Telemarketing Fraud  
Date: May 7, 2001

42A. Senior consumer meeting sponsored by credit union (Yakima, WA)  
Office: Northwest Region (with WA AG Office)  
Topic: ID Theft/Internet fraud  
Date: May 2001

42. Georgia Elderly Legal Assistance Program Conference (Atlanta, GA)  
Office: Southeast Region  
Topic: FTC’s Funeral Rule  
Date: May 9, 2001

43. Better Business Bureau “Scam Jam II” (Huntsville, AL)  
Office: Southeast Region  
Topic: Identity Theft, Door to Door Sales, Credit Fraud  
Date: May 10-11, 2001

44. Better Business Bureau “Scam Jam” (Seattle, WA)  
Office: Northwest Region  
Topic: Consumer Fraud  
Date: May 10-11, 2001

45. Better Business Bureau Senior Citizen’s Fair (Chicago, IL)  
Office: Midwest Region  
Topic: Consumer Fraud  
Date: May 14, 2001
46. Chicago Dept. on Aging Senior Citizen’s Community Conferences (Chicago, IL)
   Office: Midwest Region
   Topic: Consumer Fraud
   Date: May 15, 23 & 25, 2001

47. 28th Annual Meeting of Elder Services of Cape Cod and the Islands (Falmouth, MA)
   Office: Northeast Region
   Topic: Telemarketing Fraud, Identity Theft and Other Marketing Scams
   Date: May 21, 2001

48. Consumer University (Savannah, GA)
   Office: Southeast Region
   Topic: Internet Fraud, Telemarketing Fraud, Identity Theft
   Date: May 22, 2001

49. Better Business Bureau "Scam Jam II" (Cullman, AL)
   Office: Southeast Region
   Topic: Identity Theft, Door to Door Sales, Credit Fraud
   Date: May 23-24, 2001

50. Elder Fraud Conference (Phoenix, AZ)
   Office: Western Region - LA
   Topic: Identity Theft, Internet and Telemarketing Fraud
   Date: May 23-24, 2001

51. Vermont AG/National White Collar Crime Center (Rutland, VT)
   Office: Northeast Region
   Topic: Reverse Boilerroom Project
   Date: May 24, 2001

52. Abusive Lending Practices Forum with AARP (Schenectady, NY)
   Office: Northeast Region
   Topic: Abusive Lending Practices
   Date: May 31, 2001

53. Consumer University -- Senior Class (Cleveland, OH)
   Office: East Central Region
   Topic: Identity Theft, Scams, Cons & Fraud, Abusive Lending Practices
   Date: June 15 -16, 2001
54. Senior Action Fair - White Memorial Medical Center (Los Angeles)
   Office: Western Region - Los Angeles
   Topic: Telemarketing Fraud
   Date: June 28, 2001

55. Abusive Lending Practices Forum with AARP (Buffalo, NY)
   Office: Northeast Region
   Topic: Abusive Lending Practices
   Date: June 2001

56. The Flim-Flam Show - Phase II (Tyler, TX)
   Office: Southwest Region
   Topic: Telemarketing Fraud Prevention
   Date: Television Rebroadcast June 2001

57. Senior Citizens Awareness Day (SCAD) (Tacoma, WA)
   Office: Northwest Region
   Topic: Consumer fraud exhibit booth
   Date: August 2001

The following additional events have been planned for September and October 2001:

58. Consumer University (Gainesville, GA)
   Office: Southeast Region
   Topic: Internet Fraud and Telemarketing Fraud
   Date: September 28, 2001

59. Georgia Gerontology Society Annual Meeting (Columbus, GA)
   Office: Southeast Region
   Topic: Internet Fraud, Telemarketing Fraud, Identity Theft
   Date: October 1, 2001
In addition, the Regional Offices participate in the following ongoing Working Groups, Task Forces, and Projects:

<table>
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<tr>
<th>Region</th>
<th>Projects</th>
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<tr>
<td>Midwest Region:</td>
<td>Canadian Cross-Border Strategic Partnership</td>
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<td>Northeast Region:</td>
<td>NYCitywide Foreclosure Prevention Task Force</td>
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<td>Northwest Region:</td>
<td>Oregon Dept. of Aging Consumer Education Project</td>
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<td>Canadian lottery “reverse mail” project, to educate intended recipients of</td>
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<td>Canadian lottery mailings seized by US Customs.</td>
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<td>Southeast Region:</td>
<td>AARP/Georgia Consumer Fraud Task Force</td>
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<tr>
<td>Western Region - LA</td>
<td>Telemarketing Victim Call Center – Reverse Boilerroom Project</td>
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<td>Phoenix, Arizona Elder Abuse Task Force</td>
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<tr>
<td>All Regions:</td>
<td>Funeral Rule Enforcement Project</td>
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APPENDIX II
COMMISSION TESTIMONY BEFORE CONGRESS
JANUARY 1999-AUGUST 2001


Prepared Statement of the Federal Trade Commission on Agency Lockout on the Off-Label Use of EDTA Chelation Therapy Before the Committee on Government Reform, United States House of Representatives (March 10, 1999)


Prepared Statement of the Federal Trade Commission Concerning H.R. 1304 - the Quality Health-Care Coalition Act of 1999 Before the Committee on the Judiciary, United States House of Representatives (June 22, 1999)


Prepared Statement of the Federal Trade Commission on Slotting Allowances and the Antitrust Laws Before the Committee on the Judiciary, United States House of Representatives (October 20, 1999)

Prepared Statement of the Federal Trade Commission on Web Site Cramming Before the Committee on Small Business, United States Senate (October 25, 1999)


Prepared Statement of the Federal Trade Commission Before the Subcommittee on Antitrust, Business Rights, and Competition of the Committee on the Judiciary, United States Senate, Concerning Commission Antitrust Enforcement Activities (March 22, 2000)

Prepared Statement of the Federal Trade Commission On Office Supply Fraud Before the Committee on Small Business, United States Senate (March 28, 2000)

Prepared Statement of the Federal Trade Commission Before the Committee On the Judiciary, United States House of Representatives, Concerning Solutions to Competitive Problems in the Oil Industry (March 29, 2000)

Prepared Statement of the Federal Trade Commission Before the Special Committee On Aging, United States Senate, Concerning Commission Law Enforcement Activities Regarding the Funeral Industry (April 11, 2000)


Prepared Statement of the Federal Trade Commission On "Proposed Legislation: The 'Telemarketing Victims Protection Act' (HR 3180) and the 'Know Your Caller Act' (HR 3100), Before the Subcommittee on Telecommunications, Trade and Consumer Protection of the Committee On Commerce, United States House of Representatives (June 13, 2000)

Prepared Statement of the Federal Trade Commission Concerning Midwest Gasoline Prices, Before the Committee on Government Reform, United States House of Representatives (June 28, 2000)

Prepared Statement of the Federal Trade Commission Concerning Midwest Gasoline Prices, Before the Committee on the Judiciary, United States House of Representatives (June 28, 2000)

Prepared Statement of the Federal Trade Commission Concerning Midwest Gasoline Prices, Before the Committee On Commerce, United States House of Representatives (June 28, 2000)

Prepared Statement of the Federal Trade Commission On Living Trust Scams, Before the Special Committee On Aging, United States Senate (July 11, 2000)

Prepared Statement of the Federal Trade Commission On Identity Theft Before the Subcommittee on Technology, Terrorism and Government Information of the Committee on the Judiciary, United States Senate (July 12, 2000)

Prepared Statement of the Federal Trade Commission On "Fraud Against Seniors" Before the Special Committee on Aging, United States Senate (August 10, 2000)


Prepared Statement of the Federal Trade Commission On Identity Theft, Before the Committee On Banking and Financial Services, United States House of Representatives (September 13, 2000)


Prepared Statement of the Federal Trade Commission On “Internet Fraud,” Before the Committee On Finance, United States Senate (April 5, 2001)


Prepared Statement of the Federal Trade Commission On The Electronic Signatures In Global and National Commerce Act, Before the Committee On Financial Services, United States House of Representatives (June 28, 2001)


Prepared Statement of the Federal Trade Commission On Rent-To-Own Transactions, Before the Financial Institutions and Consumer Credit Subcommittee of the Financial Services Committee, United States House of Representatives (July 12, 2001)

APPENDIX III
COMMISSION PUBLIC HEARINGS, WORKSHOPS, AND CONFERENCES
JANUARY 1999-AUGUST 2001
(Organized Chronologically, By the News Releases Announcing Them)


Federal Register Notice Soliciting Public Comment and Announcing Possible July 20, 1999 Workshop Concerning the Children's Online Privacy Protection Rule (April 20, 1999)

Federal Register Notice Announcing Public Workshop on Proposed Regulations Implementing the Children's Online Privacy Protection Act (June 23, 1999)

Announcement of Public Workshop on Online Profiling: The National Telecommunications and Information Administration of the United States Department of Commerce and the Federal Trade Commission have determined to hold a public workshop on "online profiling," the practice of aggregating information about consumers' preferences and interests, gathered primarily by tracking their movements online, and using the resulting consumer profiles to create targeted advertising on Web sites. (September 15, 1999)

Announcement of Joint Public Forum on the Advertising and Marketing of Dial-Around and Other Long-Distance Telecommunications Services (September 23, 1999)

Announcement of Date of Public Workshop Conference Concerning Regulatory Review of the Trade Regulation Rule on Funeral Industry Practices (October 15, 1999)


Telemarketing Sales Rule: Rule Review, Request for Public Comments, and Announcement of Public Forums (February 23, 2000)

Alternative Dispute Resolution for Consumer Transactions in the Borderless Online Marketplace: Notice Announcing Dates and Location of Public Workshop and Extending Deadline for Public Comments (April 6, 2000)


Warranty Protection for High-Tech Products and Services: Announcement of Dates, Times, and Location of Public Forum (September 29, 2000)


Announcement of Public Workshop Concerning the Mobile Wireless Web, Data Services and Beyond: Emerging Technologies and Consumer Issues (December 11, 2000)


The Information Marketplace: Merging and Exchanging Consumer Data: Announcement of Public Workshop (February 2, 2001)

Federal Trade Commission and Department of Commerce, National Telecommunications and Information Administration: Electronic Signatures In Global And National Commerce Act: Request for Public Comment and Academic Papers and Announcement of Public Workshop (February 7, 2001)

Public Conference: Factors That Affect Prices of Refined Petroleum Products: Notice Announcing Public Conference and Opportunity for Public Comment (July 12, 2001)
ITEM 21—GENERAL ACCOUNTING OFFICE

CALENDAR YEARS 1999 AND 2000 REPORTS AND CORRESPONDENCE ON ISSUES AFFECTING OLDER AMERICANS

During calendar years 1999 and 2000, GAO issued 120 reports on issues affecting older Americans. Of these, 72 were on health issues, 33 were on income security issues, 10 were on veterans and Department of Defense (DOD) issues and 5 were on multiple issues.

HEALTH ISSUES


About 2.7 billion prescriptions were filled in the United States in 1998. Although prescription drugs have great clinical benefits, serious adverse drug events can lead to hospitalization, disability, and even death. Adverse drug events are caused by harmful drug reactions or by medication errors committed by health care professionals and patients. Two factors that can increase the risk of a patient suffering from an adverse drug event are illness severity and intensity of treatment, including taking several drugs simultaneously. Although it is clear that a wide range of commonly used drugs cause adverse drug events with potentially serious consequences for patients, relatively little is known about their frequency. Data routinely collected on adverse drug events during clinical trials or after drugs are marketed are intended to identify the adverse drug events that are associated with particular drugs and do not focus on their frequency. Information on the overall incidence of adverse drug events from all drugs has been limited to a few research studies that typically examined the experience of patients in one of two specific institutions—generally hospitals or sometimes nursing homes—leaving the overall incidence of adverse drug events in outpatient care largely unexplored. Greater understanding of certain factors that affect the likelihood of adverse drug events has led researchers and patient safety advocates to suggest a range of measures to decrease their number and severity. These proposals range from better communication between doctors and patients about the risks and benefits of medications to accelerating research on the safety of marketed drugs. Suggestions for reducing medication errors include developing computerized prescribing and dispensing systems to detect possible errors, increasing the role of pharmacists as advisers to physicians and as monitors of drug ther-
apy, and improving health care providers’ pharmaceutical education.


Assisted living facilities provide a growing number of elderly Americans with an alternative to nursing homes. To make informed choices from among various facilities, consumers need clear and complete information on services, costs, and policies. A GAO review of assisted living facilities in four states—California, Florida, Ohio, and Oregon—found that the facilities did not always give consumers enough information to determine whether a particular facility could meet their needs, for how long, and under what circumstances. Marketing materials, contracts, and other written materials provided by facilities are often incomplete and sometimes vague or misleading. Only about half of the facilities GAO surveyed reported that they provide prospective residents with such key written information as the amount of assistance residents can expect to receive with medications, the circumstances under which the cost of services might change, or when residents might be required to leave if their health deteriorates. Consumers also need assurance that facilities provide high-quality care and protect consumers’ interests. All four states license assisted living facilities, conduct periodic inspections, and investigate complaints. Yet GAO found that more than one-fourth of the facilities it reviewed had been cited by state licensing, ombudsman, or other agencies for five or more quality-of-care or consumer protection deficiencies or violations during 1996 and 1997. Eleven percent of the facilities had been cited for 10 or more deficiencies or violations during the same period. Frequently identified problems included facilities (1) providing poor care to residents, such as inadequate medical attention following an accident; (2) having insufficient, unqualified, and untrained staff; (3) not providing residents with appropriate medications and not storing medications properly; and (4) not following admission and discharge policies required by state regulation.


Pursuant to a congressional request, GAO provided information on the availability of blood to meet the nation’s requirements, focusing on: (1) recent trends in blood donation and the demand for blood transfusions; (2) the expected effect of a ban on blood from donors who have traveled to the United Kingdom; and (3) the potential effect of policy changes to allow units of blood collected from individuals with hemochromatosis to be distributed.

GAO noted that: (1) GAO found that, while there is cause for concern about shortages of certain blood types or in certain regions, the blood supply as a whole is not in crisis; (2) GAO believes that the National Blood Data Resource Center (NBDRC) study overstates the decline in the blood supply; (3) most of the decline found by NBDRC was in donations targeted for specific individuals, not in the community supply of blood available to anyone in need; (4) further, the projection relies on data from only 2 years, the most recent of which is now 2 years old; (5) the United Kingdom donor
exclusion policy has been estimated to reduce the blood supply by approximately 2.2 percent; (6) blood banks fear that the actual loss due to this exclusion will be greater, but it is not possible to assess the accuracy of these estimates; (7) while the estimates of the potential increase in the blood supply from donations by individuals with hemochromatosis vary widely, most of these increases could not occur until regulations are changed; and (8) therefore, such donations will not affect the available blood supply for some time.

Comments on HCFA Medicare Integrity Program Operating Plans. (B-282777. Sept. 2, 1999).

GAO commented on the Health Care Financing Administration's (HCFA) plans for operating the Medicare Integrity Program (MIP), focusing on whether: (1) the law authorizing the MIP permits HCFA to assign responsibility for local Medicare coverage policy to the payment safeguard contractors (PSC) who will run the MIP under contract to HCFA; and (2) HCFA's proposed MIP regulations would provide an adequate legal basis for HCFA to conduct local policy-making through PSCs. GAO noted that HCFA reasonably interpreted the law to mean that its PSCs could set local Medicare coverage policy. GAO also noted that the proposed MIP regulations provide an adequate basis for HCFA's action.


The Health Care Financing Administration (HCFA) provided GAO with copies of 96 agreements in which HCFA negotiated settlements for Medicare overpayments exceeding $100,000. In 93 of the 96 matters, which were negotiated between 1991 and 1999, GAO found nothing improper. In settling the three largest overpayments, however, HCFA acted inappropriately. These three largest matters represented 66 percent of all Medicare overpayment settlements since 1991 for which HCFA provided records. In the settlements, HCFA agreed to accept $120 million for debts exceeding $332 million (or about 36 cents on the dollar). GAO found that (1) former HCFA Administrator Bruce Vladek's participation in the largest settlement raised conflict-of-interest concerns, (2) HCFA chose not to obtain the Department of Justice's approval of the settlements and ignored its own regulations and internal guidance requiring them to do so, (3) HCFA appears to have disregarded permissible settlement criteria established by regulations, (4) the settlement agreements contained questionable provisions, and (5) HCFA executed settlements without the benefit of legal counsel.


Pursuant to a congressional request, GAO provided information on the proliferation of Medicare, Medicaid, and private health insurance fraud on the part of criminals and organized criminal groups, focusing on: (1) the makeup and prior activities of such groups; (2) how organized criminal groups created medical entities or used legitimate medical entities or individuals to defraud Medi-
care, Medicaid, and private insurers; (3) schemes used by such groups to commit health care fraud; and (4) the impact that illegal activity by such groups has on consumers and legitimate health care providers.

GAO noted that: (1) while the full extent of the problem remains unknown, GAO determined that career criminal and organized criminal groups are involved in Medicare, Medicaid, and private insurance health care fraud or alleged fraud throughout the country; (2) in the cases GAO reviewed, criminal groups varied in size from 2 or 3 participants to more than 20 participants and generally had one leader; (3) many group members had prior criminal histories for criminal activity unrelated to health care fraud, indicating that they moved from one field of criminal activity to another; (4) the primary subjects in these cases had little or no known medical or health care education, training, or experience; (5) at least two groups learned or were suspected of having learned how to commit health care fraud from others already engaged in such fraud; (6) in some of the cases GAO reviewed, criminal-group members had relatives or associates in foreign countries who helped them transfer their ill-gotten health care proceeds; (7) these groups created as many as 160 sham medical entities—such as medical clinics, physician groups, diagnostic laboratories, and durable medical equipment companies, often using fictitious names or the names of others on paperwork—or used the names of uninvolved legitimate providers to bill for services and equipment not provided or not medically necessary; (8) for the most part, these entities existed only on paper; (9) once the structure was in place, subjects used a variety of schemes to submit claims to Medicare, Medicaid, or private insurance companies; (10) one scheme used is sometimes referred to as “patient brokering” or “rent-a-patient;” (11) under this scheme, the subjects used recruiters to organize and recruit beneficiaries (patients) who visited clinics owned or operated by such subjects for unnecessary diagnostic testing or medical services; (12) recruiters received a fee for each beneficiary brought in; (13) the above-described activities affect consumers, beneficiaries, health care providers, and law enforcement officials; (14) consumers pay increased health care costs in the form of taxes, because taxpayer contributions support Medicare and Medicaid; (15) in the case of private insurance, insured individuals pay increased premiums; and (16) because of the multiplicity of schemes and the ease with which subjects move their operations from location to location, law enforcement officials find it difficult to keep up with this growing and widespread form of fraud and are often unable to seize or recoup fraudulent proceeds that are quickly moved out of their reach.

*Influenza Pandemic: Plan Needed for Federal and State Response.*


Although vaccines are considered the first line of defense to prevent or reduce influenza-related illness and death, GAO found that they may be unavailable, in short supply, or ineffective for some portions of the population during the first wave of an influenza pandemic. Antiviral drugs and other secondary interventions, such as pneumonia vaccines are also expected to be in short supply if a pandemic occurs. Federal and state influenza pandemic plans are
in various stages of completion and do not completely or consistently address key issues surrounding the purchase, distribution, and administration of vaccines and antiviral drugs. Inconsistencies in state and federal policies could contribute to public confusion and weaken the effectiveness of the public health response.


The unique qualities of the Internet pose new challenges for enforcing state pharmacy and medical practice laws because they allow pharmacies and physicians to reach consumers across state and international borders and remain anonymous. Public officials are concerned about unlicensed Internet pharmacies, particularly those that are affiliated with physicians that prescribe on the basis of an online questionnaire and those that dispense drugs without a prescription. Dispensing prescription drugs without adequate physician supervision increases the risk of consumers’ suffering adverse events, including side effects from inappropriately prescribed medications and misbranded or contaminated drugs. State efforts to stop Internet pharmacies have encountered difficulty in identifying responsible parties and enforcing laws across state boundaries. Federal efforts to stem the flow of prescription drugs from foreign-based Internet pharmacies have also faced difficulties. Enactment of federal legislation requiring Internet pharmacies to disclose minimum information would aid consumers and state and federal regulators.


Twenty-two of the 25 large grant programs rely partly on decennial census data to apportion federal funding among state and local governments. In fiscal year 1998, $167 billion was obligated for them. By comparing statistical sampling results to the actual 1990 census count, the Census Bureau estimated that it had undercounted the U.S. population by 4 million persons. GAO recalculated current funding amounts for 15 of the 22 programs, assuming the same proportional net undercount. These 15 represented $147 billion, or 79 percent, of population-based programs. Using the adjusted population counts would have reallocated $449 million among the 50 states and the District of Columbia. California, Arizona, New Mexico, and Texas the four states bordering Mexico—accounted for more than one-third of the adjusted populations and would have received nearly 75 percent of the total reallocated, or $336 million. California accounted for about 20 percent and would have received $223 million. Pennsylvania would have received the largest dollar reduction ($110 million); Rhode Island the largest percentage reduction (1.8 percent). Medicaid accounted for 90 percent of all reallocated funds. Funding would have generally shifted from northeastern and midwestern states to southern and western states. The Bureau proposes to use statistical sampling techniques to estimate the population for the 2000 census. Although the Supreme Court has ruled that the Census Act prohibits using sampling techniques for reapportioning seats in the House of Rep-
resentatives, the ruling did not address the use of adjusted counts for apportioning federal grant funding.


In 1995, premiums, deductibles, and coinsurance cost single persons at the federal poverty level 10 percent of income, and married couples, 15 percent. State Medicaid programs helped them bear their costs through the congressionally enacted Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, and the Qualifying Individuals program. In 1996, about 43 percent of the potentially eligible Medicare beneficiaries who are white, widowed or married, or have Medicare coverage because of age rather than disability. Many potential recipients do not enroll because they do not know the programs exist, fear that the state will try to recover payments made to them from a surviving spouse or children, or are unwilling to accept what they think of as welfare. Moreover, the application process will be burdensome and complex, and the states’ cost-sharing obligations limit their incentives to notify and enroll eligible individuals. Efforts to increase enrollment include a Social Security Administration demonstration project, state outreach and enrollment efforts through their State Children’s Health Insurance Programs, and efforts by the Health Care Financing Administration under the Government Performance and Results Act.


This publication is part of GAO’s performance and accountability series which provides a comprehensive assessment of government management, particularly the management challenges and program risks confronting federal agencies. Using a “performance-based management” approach, this landmark set of reports focuses on the results of government programs—how they affect the American taxpayer—rather than on the processes of government. This approach integrates thinking about organization, product and service delivery, use of technology, and human capital practices into every decision about the results that the government hopes to achieve. The series includes an overview volume discussing government wide management issues and 20 individual reports on the challenges facing specific cabinet departments and independent agencies. The reports take advantage of the wealth of new information made possible by management reform legislation, including audited financial statements for major federal agencies, mandated by the Chief Financial Officers Act, and strategic and performance plans required by the Government Performance and Results Act. In a companion volume to this series, GAO also updates its high-risk list of government operations and programs that are particularly vulnerable to waste, fraud, abuse, and mismanagement.
This volume deals with the major management challenges at the Department of Health and Human Services. Among the challenges are

• the solvency of Medicare's Hospital Insurance Trust Fund, which funds Medicare Part A;
• the need for reliable and comprehensive data and data systems to manage programs and assess results; and
• the integrity of the Medicare program.


Before the Balanced Budget Act of 1997, Medicare's payment rates for home oxygen exceeded those of the Department of Veterans Affairs by almost 38 percent. The act reduced Medicare's rates by 25 percent effective January 1, 1998, and GAO evaluated changes in Medicare's patients' access to home oxygen since the payment reduction. Preliminary indications are that access remained substantially unchanged. The number of Medicare beneficiaries using home oxygen equipment increased, and the proportion of those using the more costly stationary liquid oxygen systems decreased. Even Medicare beneficiaries who were expensive or difficult to serve were able to get the appropriate systems for their needs, and suppliers accepted the Medicare allowance as full payment for more than 99 percent of claims. Most suppliers increased operating efficiencies to mitigate the effect of the payment reduction. However, subtle access issues may not be readily apparent, and problems could emerge as more and better information becomes available. Beyond contracting with a peer review organization for an evaluation of access to and the quality of home oxygen equipment, the Health Care Financing Administration (HCFA) has not established an ongoing method to monitor the use of this benefit and gather the information essential to assessing the payment system. It has also not developed service standards for home oxygen suppliers, as required by the act, to allow them to decide themselves what services they will provide.

Medicare: Contractors Screen Employees but Extent of Screening Varies. (GAO/HEHS-00-135R, June 30, 2000).

Pursuant to a congressional request, GAO provided information on the use of employee screening measures by Medicare claims administration and program safeguard contractors, focusing on the: (1) requirements the Health Care Financing Administration (HCFA) has placed on Medicare contractors to conduct employee background checks; (2) steps Medicare contractors are taking to ensure that employees are trustworthy in handling Medicare funds and sensitive information; and (3) costs to Medicare contractors of conducting background checks or using other employee screening measures.

GAO noted that: (1) HCFA expects its contractors to exercise sound business judgment when they make hiring decisions; (2) as a result, HCFA does not specifically require its Medicare claims administration and program safeguard contractors to conduct background checks or undertake other employee screening measures; (3) however, HCFA does advise its claims administration contractors
to adopt personnel selection safeguards, specifically employment verification and applicant certifications; (4) HCFA also requires its claims administration contractors to obtain fidelity bonds for certain employees; (5) in addition, both Medicare claims administration and program safeguard contractors are required to collect and submit to HCFA conflict of interest information; (6) the Medicare claims administration and program safeguard contractors GAO surveyed screen their employees as common business practice without specific requirements from HCFA to do so; (7) nearly all the contractors in GAO's sample said that they perform typical screening measures, such as employment and education verification, reference checking, and credential validation; (8) most of the claims administration contractors GAO spoke to also reported that they perform more extensive screening measures, such as criminal background checks and drug tests; (9) in contrast, the two program safeguard contractors GAO surveyed indicated that they do not conduct criminal background checks or require drug testing unless such requirements are included in their contracts; (10) both claims administration and program safeguard contractors reported that they rarely use less traditional screening measures, such as credit checks and government debarment and exclusion database reviews; (11) the costs associated with employee screening vary by the complexity and urgency associated with each screening measure; (12) however, the Medicare contractors GAO surveyed could not calculate the total cost of their employee screening measures; and (13) the fact that employee screening efforts are conducted and continue to be recognized as a common business practice within the Medicare contractor community suggests that such measures are considered worthwhile.


In general, a compliance program consists of a Medicare provider organization's internal policies, processes, and procedures that help it prevent and detect violations of Medicare law. According to recent surveys, most hospitals either had or planned to soon implement a compliance program, but no readily available data exist on program prevalence. Direct program costs appear to account for less than one percent of total patient revenues; indirect costs may be larger. Lacking compliance budgets, hospitals cannot always distinguish between compliance program and normal operations costs. Comprehensive baseline data with which to measure programs' effectiveness are lacking. The costs associated with gathering baseline data on the amount of improper payments made to providers— or comparison data for providers without compliance programs— have precluded the use of this effectiveness measure. Although hospital officials reported that program benefits outweigh costs, Medicare contractors reported receiving refunds of provider overpayments with more frequency, and formal provider self-disclosures have increased in recent years. This preliminary evidence, however, does not demonstrate that compliance programs have reduced improper Medicare payments. According to hospitals, the major intangible indicator of effectiveness is an increased corporate awareness of compliance as shown by frequent calls to compliance staff
or hotlines for guidance. Some hospitals plan to measure improved employee knowledge of compliance issues, risk areas, and procedures in conjunction with compliance training.


Pursuant to a congressional request, GAO provided information on efforts to recover Medicare's overpayments, focusing on: (1) how the Health Care Financing Administration (HCFA) and its contractors identify potential overpayments, and whether techniques used by recovery auditors would improve overpayment identification; (2) how well HCFA and its contractors collect overpayments once they are identified, and whether the services of recovery auditors would improve HCFA collection efforts; and (3) what challenges HCFA would face if it were required to hire recovery auditors to augment its overpayment identification and collection activities. GAO noted that: (1) despite HCFA's efforts to pay claims correctly in its $167 billion fee-for-service Medicare program, several billions of dollars in Medicare overpayments occur each year; (2) it is therefore critical that HCFA undertake effective postpayment activities to identify overpayments expeditiously; (3) HCFA's claims administration contractors use several postpayment techniques to identify overpayments; (4) these include medical review to ensure reports for providers that are paid on the basis of their costs, and reviews to determine if another entity besides Medicare has primary payment responsibility; (5) the contractors identify and collect billions of dollars through these activities, but how well each contractor performs them is not clear because HCFA lacks the information it needs to measure the effectiveness of contractors' overpayment identification activities; (6) while recovery auditors may also save money for clients, such as state Medicaid agencies, by identifying overpayments, the identification techniques they use are generally similar to those already used by HCFA and its contractors; (7) this does not mean that HCFA could not benefit from a stronger focus on specific postpayment activities; (8) however, doing so may require additional program safeguard funding so as not to shift funds away from HCFA's other efforts, such as prepayment review to prevent overpayments; (9) Congress has given HCFA assured funding for program safeguard activities; (10) however, the funding level is about one-third less than it was in 1989 and, although it will increase until 2003, it will only keep pace with expected growth in Medicare expenditures; (11) for fiscal year 1999, based on HCFA estimates, the Medicare Integrity Program saved the Medicare program more than $17 for each dollar spent about 55 percent from prepayment activities and the rest from postpayment activities; (12) because these activities can bring a positive return, GAO suggests that Congress consider increasing HCFA's funding to bolster its postpayment review program; (13) HCFA plans to expand its pilot projects from some to all of its claims administration contractors; and (14) however, it has established minimum thresholds for referrals for collection that are higher than the Department of the Treasury and debt collection center will accept because HCFA says that it does not have the resources needed to pursue collection on the large volume of debt below its thresholds.

Pursuant to a congressional request, GAO provided information on the Health Care Financing Administration's (HCFA) approval and oversight of private Medicare accreditation organizations, focusing on: (1) HCFA's criteria for approving accreditation organizations; (2) HCFA's ongoing oversight of accreditation organizations that have been granted deemed status; and (3) recent evaluations of accreditation organizations' performance.

GAO noted that: (1) HCFA is required to consider several factors when evaluating a private accreditation organization for deemed status; (2) HCFA must assess an organization’s standards to ensure that the providers they accredit will meet or exceed Medicare requirements; (3) HCFA is required to evaluate an accreditation organization's ability to monitor and enforce provider compliance with its standards; (4) HCFA monitors the performance of accreditation organizations and ensures continued equivalence of its standards to those of Medicare by requiring accreditation organizations to provide survey findings and to submit proposed changes to its standards for HCFA's review; (5) HCFA requires each accreditation organization to document its policies and procedures regarding employee professional or financial affiliation with facilities being accredited; (6) HCFA has not, however, developed specific criteria to prohibit conflicts of interest between these organizations and the providers they accredit, even though accreditation organizations are typically governed by a board of directors that includes industry representatives; (7) a recent evaluation of accreditation organization performance by the Department of Health and Human Services' Office of Inspector General found that the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) collegial approach to hospital accreditation relies heavily on education and performance improvement, with less emphasis on regulatory approaches, which include unannounced surveys, responding to complaints, and collecting standard performance measures; (8) in another report HCFA recommended against relying on JCAHO for deeming of nursing homes, citing concerns that JCAHO requirements for nursing home accreditation were not sufficient to ensure that Medicare conditions and requirements would be met and questioning whether JCAHO surveyors would identify serious care deficiencies in nursing homes.


One of the first defenses against improper Medicare billings is the screening of applications from providers seeking to participate in the program. The Health Care Financing Administration (HCFA) operates and manages the Medicare program and, with help from insurance companies, reviews provider applications to determine whether providers meet Medicare requirements and if there is a reason to suspect that providers' future Medicare billings would be improper. GAO found that HCFA's current provider enrollment process does not completely ensure that dishonest and unqualified providers are prevented from obtaining Medicare billing
privileges. GAO suggests consolidating provider enrollment tasks with fewer contractors to strengthen HCFA’s ability to oversee these contractors and enhance the efficiency of the enrollment process. HCFA is implementing several changes to its provider enrollment processes that may make it more difficult for dishonest providers to enroll in Medicare; however, delays in implementing these initiatives will also postpone their benefits.


Pursuant to a congressional request, GAO reviewed the operations of Behavioral Medical Systems, Inc.

GAO noted that: (1) while BMS represented itself to the Medicare Program as a provider, in fact it functioned as a broker and a third-party biller; (2) GAO found a consistent pattern by which BMS caused improper Medicare claims to be submitted for services not provided by six psychiatrists; (3) of the Medicare claims filed by BMS during a 20-month period, 87% were for provider services that reportedly were not rendered; (4) these Medicare claims totaled $1.3 million, of which BMS received over $362,000; (5) GAO referred the matter to the Office of the Inspector General, Department of Health and Human Services, for its consideration; and (6) in functioning as a broker and a third-party biller, BMS violated 42 U.S.C. 1395u(b)(6), which establishes the general principle that Medicare program payments should be made directly to the beneficiary or, under an assignment, to the physician who provides the medical service.


In its fiscal year 1999 accountability report to Congress, the Health Care Financing Administration (HCFA) reported clerical errors in the accounting for the Medicare trust funds, which caused the Hospital Insurance (HI) Trust Fund to be over invested by about $14 billion and the Supplementary Medical Insurance (SMI) Trust Fund to be under invested by about $18 billion. Because of these errors, the HI Trust Fund earned excess interest and the SMI Trust Fund lost interest. GAO found that these errors occurred over a six month period and were not detected because of internal control weaknesses. Inadequate training and supervision and ineffective reconciliations were key factors that allowed the errors to go undetected. HCFA, in coordination with Treasury, took corrective action once the errors were discovered.


Pursuant to a legislative requirement, GAO reviewed the Health Care Fraud and Abuse Control (HCFAC) Program financial reports for fiscal years (FY) 1998 and 1999 as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

GAO noted that: (1) the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) joint HCFAC re-
ports for fiscal years 1998 and 1999 reported that $107.4 million and $114.4 million, respectively, were deposited into the trust fund pursuant to HIPAA; (2) the sources of these deposits, as shown in the joint reports, were primarily penalties and damages ($103 million in FY1998 and $73.6 million in FY1999) resulting from health care fraud audits, evaluations, investigations, and litigation; (3) the joint reports also stated that $119.6 million in FY1998 and $137.2 million in FY1999 were appropriated from the trust fund for the HCF AC program; (4) of those amounts, HHS and DOJ allocated $85.7 million in FY1998 and $98.2 million in FY1999 to the HHS/Office of Inspector General (OIG) to continue its Medicare and Medicaid fraud enforcement activities; (5) the remaining $33.9 million in FY1998 funds and $39 million in FY1999 funds were allocated to: (a) DOJ, which received $28.5 million in FY1998 and $30.7 million in FY1999 primarily to continue its litigative efforts and to provide health care fraud training; and (b) other HHS organizations, which received $5.5 million in FY1998 and $8.2 million in FY1999 for a variety of activities, including the development of a new adverse action databank; (6) based on GAO's review of selected deposit, allocation, and expenditure transactions, GAO found that these transactions were related to HIPAA deposits, allocations, and expenditures as reported by HHS and DOJ in their joint reports; (7) GAO found no material weakness in HHS' and DOJ's processes for accumulating HCFAC deposit, allocation, and expenditure information; (8) GAO could not identify expenditures from the trust fund for HCFAC activities not related to Medicare because neither the HHS/OIG nor DOJ separately account for or monitor those expenditures; (9) GAO also could not determine the magnitude of savings to the trust fund, or other savings, resulting from the HCFAC trust fund expenditures during fiscal years 1998 and 1999; (10) however, the HHS/OIG reported $10.8 billion and $11.8 billion for fiscal years 1998 and 1999, respectively, in cost savings of health care funds as a result of its recommendations or other initiatives; (11) the Healthcare Integrity and Protection Data Bank (HIPDB) opened for reporting on November 22, 1999, and for querying on March 6, 2000; and (12) however, implementation of HIPDB was postponed primarily as a result of the delayed issuance of final governing regulations.


Pursuant to a congressional request, GAO described how the Health Care Financing Administration (HCFA) and its contractors monitor third-party billing companies' involvement in the submission of claims to Medicare. GAO noted that: (1) providers are ultimately responsible for the claims that they submit or that are submitted on their behalf; (2) despite this, HCFA has an interest in tracking claims submitted by third-party billers as one way of targeting its program safeguard resources and determining the source of inappropriate or fraudulent claims; (3) GAO found that HCFA cannot identify when third-party billers were involved in the more than 700 million electronic claims in fiscal year 1998, because its systems identify only one of the many possible entities involved in preparing a claim; (4) further, paper claims—146 million in 1998—
do not have any identifying information that would indicate whether third-party billers submitted them; (5) GAO also found weaknesses in HCFA’s efforts to obtain information about third-party billers; (6) HCFA issued a new enrollment form for providers first enrolling in Medicare after May 1996; (7) this form obtains the identity of third-party billers that the enrolling providers use; (8) however, since 96 percent of Medicare’s providers enrolled in Medicare before 1996, HCFA has no information on billing arrangements for most providers; (9) HCFA is proceeding with plans to develop a national system to capture this information on the enrollment form, even though the system would initially contain data for only a fraction of all Medicare providers; and (10) although HCFA’s plans for implementing this system are not final, HCFA officials told GAO they plan to complete it after addressing computer systems work needed to prepare for year 2000.


Criminal and/or civil actions have been taken against at least six Medicare contractors since 1993. Three of the contractors or their employees—BCBS of Illinois, Blue Shield of California, and Pennsylvania Blue Shield—pled guilty to criminal charges and agreed to pay fines and penalties. Investigations of three other contractors—BCBS of Massachusetts, BCBS of Michigan, and BCBS of Florida—resulted in civil settlements only. More than $261 million was assessed against these six contractors. Contractors improperly screened, processed, and paid claims, resulting in additional costs to Medicare; improperly destroyed or deleted claims; failed to recoup overpayments to Medicare providers within the prescribed time and to collect required interest payments; falsified documentation and reports to the Health Care Financing Administration (HCFA) about their performance; and altered or hid files that involved claims that had been incorrectly processed or paid and altered contractor audits of Medicare providers before HCFA’s reviews. The persons GAO spoke with said that these deceptions and improprieties became a way of doing business and went undetected for long periods because HCFA reviews of Medicare contractors relied on information supplied by the contractors. HCFA also gave contractors advanced notice of the files it intended to review, giving contractors ample time to “correct,” delete, or hide claim-related documents or redo provider audits and related workpapers before HCFA’s review. This system also resulted in contractors deviating from their normal operating procedures during HCFA evaluations in order to deceive HCFA about their accuracy and efficiency in claims processing and customer service. As a result, criminal and other improper activities were discovered only after whistleblowers filed complaints under the False Claims Act.


The Health Care Financing Administration (HCFA) collects and maintains personally identifiable health information on its 39 million Medicare beneficiaries for paying claims, determining eligibility, reviewing care, and performing research that helps improve
Medicare. Under the Privacy Act of 1974, HCFA may disclose this information to other agencies, but confidentiality is compromised by HCFA’s and its contractors’ management of electronic information and its inability to prevent unauthorized disclosures or uses and to correct them in a timely way. HCFA also cannot readily provide beneficiaries with an accounting of the disclosures it makes and does not always clearly inform them of its purpose in disclosing information as required by the Privacy Act. It does not adequately provide oversight agencies such as the Office of Management and Budget with complete information on its Privacy Act activities. Also, HCFA’s policy of allowing the states to withhold sensitive health information could adversely affect its ability to set rates, monitor quality, and conduct or support health-related research. GAO recommends ways HCFA can improve its protection of confidential information.


Medicare has undergone many changes as Congress has expanded and modernized the program. The Health Care Financing Administration’s (HCFA) implementation of these changes has sometimes created program vulnerabilities. As a result, dishonest or unknowing providers have submitted claims for inappropriate service, unknowledgeable contractors have processed these claims, and HCFA has sometimes paid more than it should have. The Balanced Budget Act of 1997 set in motion additional changes that were intended to modernize the Medicare program, expand benefits, and extend the life of the Medicare trust fund. HCFA faces the challenge of implementing the act’s provisions in a way that ensures beneficiaries’ access to covered services without compromising the program’s fiscal integrity. This report compares (1) HCFA’s implementation of the expansion of the partial hospitalization benefit and (2) HCFA’s implementation of the more recent changes under the act to determine whether HCFA is acting upon lessons learned from the partial hospitalization program.

Medicare: Methodology to Identify and Measure Improper Payments in the Medicare Program Does Not Include All Fraud. (GAO/AIMD–00–69R, Feb. 4, 2000).

Pursuant to a congressional request, GAO provided information on the methodology used to estimate the $12.6 billion in Medicare improper payments, as reported by the Department of Health and Human Services’ (HHS) Office of Inspector General (OIG) for fiscal year (FY) 1998, focusing on whether the methodology included tests to detect improper payments resulting from fraudulent and abusive schemes in the Medicare program. GAO noted that: (1) the HHS OIG developed an overall methodology to estimate the level of improper payments within the Medicare Fee-for-Service program; (2) the OIG developed and tested the methodology during its audit of the FY1996 financial statements of the Health Care Financing Administration (HCFA); (3) previously, no overall methodology existed to estimate Medicare improper payments; (4) the methodology was a significant step toward quantifying Medicare improper payments; (5) its primary pur-
pose was to provide users of HCFA's financial statements with an estimate of Medicare fee-for-service claims that were paid in error; (6) it was not designed to identify or measure the full extent of levels of fraud and abuse in the Medicare program; (7) the HHS OIG testified that the estimate of improper payments did not take into consideration numerous kinds of outright fraud such as "phony records" or kickback schemes; (8) the methodology assumes that all medical records received for review represent actual services provided; (9) in response to the increased focus resulting from HHS OIG's efforts in this area, HCFA is developing plans to enhance its efforts to identify or measure Medicare improper payments; and (10) GAO is reviewing these plans and will report to Congress separately on them.

Medicare: More Beneficiaries Use Hospice but for Fewer Days of Care. (GAO/HEHS-00-182, Sept. 18, 2000).

Pursuant to a congressional request, GAO provided information on the Medicare hospice benefit, focusing on: (1) the patterns and trends in hospice use by Medicare beneficiaries; (2) factors that affect the use of the hospice benefit; and (3) the availability of hospice providers to serve the needs of Medicare beneficiaries.

GAO noted that: (1) the number of Medicare beneficiaries choosing hospice services has increased substantially; (2) in 1998, nearly 360,000 Medicare beneficiaries enrolled in a hospice program, more than twice the number who elected hospice in 1992; (3) of Medicare beneficiaries who died in 1998, about one in five used the hospice benefit, but use varies considerably across the states; (4) although cancer patients account for more than half of Medicare hospice patients, growth in use has been particularly strong among individuals with other common diagnoses such as heart disease, lung disease, stroke, and Alzheimer's disease; (5) although more beneficiaries are choosing hospice, many are doing so closer to the time of death; (6) the average period of hospice use declined from 74 days in 1992 to 59 days in 1998; (7) half of Medicare hospice users now receive care for 19 or fewer days, and care for 1 week or less is common; (8) many factors influence the use of the Medicare hospice benefit; (9) decisions about whether and when to use hospice depend on physician preferences and practices, patient choice and circumstances, and public and professional awareness of the benefit; (10) along with these factors, increases in federal scrutiny of compliance with program eligibility requirements may have contributed to a decline in the average number of days of hospice care that beneficiaries use; (11) the growth in the number of Medicare hospice providers in both urban and rural areas and in almost every state suggests that hospice services are more widely available to program beneficiaries than in the past; (12) between 1992 and 1999, the number of hospices participating in Medicare increased 82 percent, with large providers and those in the for-profit sector accounting for a greater proportion of the services delivered; (13) at the same time, hospice industry officials report cost pressures from declining patient enrollment periods and increased use of more expensive forms of palliative care; (14) because reliable data on provider costs are not available, however, the effect of these reported cost pressures on the overall financial condition of
hospice providers is uncertain; and (15) as required by the Balanced Budget Act of 1997, the Health Care Financing Administration began collecting information in 1999 from hospice providers about their costs to allow a reevaluation of the Medicare hospice payment rate.


Pursuant to a congressional request, GAO provided information on the: (1) rationale for imposing per-beneficiary limits on Medicare's coverage of rehabilitation therapy services; and (2) effect of the therapy caps on Medicare beneficiaries' access to needed care.

GAO noted that: (1) the per-beneficiary caps on coverage of outpatient rehabilitation therapy services are part of a larger effort by Congress to curb Medicare spending for post-acute care services; (2) in particular, Medicare spending for outpatient rehabilitation therapy services, between 1990 and 1996, grew at nearly double the rate of Medicare spending overall; (3) at the same time, inadequate program controls failed to ensure that this spending growth was warranted; (4) under the fee schedule and coverage caps imposed by the Balanced Budget Act of 1997 (BBA), Medicare can moderate the price and utilization of these services; (5) the beneficiary caps are unlikely to affect the vast majority of Medicare's outpatient therapy users; (6) only a small share of beneficiaries uses outpatient therapy extensively; (7) furthermore, most of the users with greater needs will likely have access to hospital outpatient departments, which are not subject to the $1,500 caps; (8) in addition, owing to Health Care Financing Administration's (HCFA) partial approach to enforcing the caps while year 2000 adjustments are made to Medicare's automated systems, noninstitutionalized beneficiaries can avoid having the caps curtail service coverage by switching providers; (9) however, the caps may restrict coverage for some nursing facility residents; (10) studies are under way or planned to better assess the effect of the caps and evaluate alternative utilization controls; (11) BBA required HCFA to recommend a need-based payment system by 2001, which could help target payments to beneficiaries who genuinely require more services than are covered under the current dollar limits; and (12) such a system would raise the dollar limits for therapy users with extensive needs and lower them for users with modest needs.


GAO responded to congressional questions related to financial and information technology management of the Medicare Program. Among the topics discussed were claims processing, management of statistical data, and computer viruses. For example, in reference to claims processing, GAO noted that, as of December 2000, Medicare carriers and fiscal intermediaries use six standard claims processing systems to process Medicare part A and B claims. Each contractor relies on one of these standard systems to process its claims, and adds its own front-end and back-end processing sys-
tems. These claims processing systems date back as far as 1982. In reference to the management of statistical data, GAO noted that the Health Care Financing Administration's (HCFA) common working file provides individual beneficiary claims data to HCFA's National Claims History File, which is used as the source of statistical information on Medicare and medical data. HCFA officials were not aware of any system outside HCFA where this type of data could be obtained. Finally, regarding computer viruses, a HCFA information technology security official informed GAO that the "ILOVEYOU" virus did not contaminate its systems. The official said the virus had no adverse effects on any of the workstations, because the electronic mail application used at HCFA was not capable of executing the Visual Basic Script file, which is how the "ILOVEYOU" virus was executed. The official also said that the Melissa virus was detected and there were no incidents.


In 1992, Medicare began using a fee schedule to pay doctors for more than 7,000 procedures, from routine office visits to brain surgery. The intent of the new payment system was to base physicians' payments on the relative resources used to provide a procedure rather than on the physicians' charges. To develop the fee schedule, each medical procedure is ranked on a scale according to the amounts of three categories of resources used to perform the procedure — physician work, practice expenses, and malpractice expenses. A fee schedule amount for each procedure is computed by multiplying the sum of the procedure's three rankings, known as relative value units, by a conversion factor that translates the units into dollars. This report discusses the Health Care Financing Administration's (HCFA) ongoing efforts to develop resource-based practice expense relative value units. GAO's review focuses on (1) whether the new methodology is an acceptable approach for revising Medicare's fee schedule; (2) questions raised about the data, assumptions, and adjustments underlying the new methodology that need to be addressed during the three-year phase-in period; and (3) the need for future updates to the practice expense relative value units to reflect changes in health care delivery and for ongoing assessments of the fee schedule's effect on Medicare beneficiaries' access to physicians' care.


Health Care Financing Administration (HCFA) contractors perform five main types of program safeguard activity under the Medicare Integrity Program, which was established in 1996 to protect Medicare from fraud, waste, and abuse. The program has dedicated, assured funding and HCFA's contractors are better able than before to plan and implement their safeguard strategy and efforts. HCFA is emphasizing prepayment claims reviews to promote correct claims payment and avoid the difficulty of seeking repayment from providers when claims are paid in error. HCFA has also recently hired program safeguard contractors which will initially
supplement, rather than take over, the safeguard activities of its claims processing contractors. HCFA has taken or plans to take corrective action to improve important areas identified by audit reports under the Chief Financial Officers Act. It is also taking seriously its responsibilities to improve program safeguard operations in response to recommendations from GAO and from the HHS Office of the Inspector General. HCFA will be better able to measure the program's effects with more time and better data.


Pursuant to a legislative requirement, GAO reviewed the Health Care Fraud and Abuse Control (HCFAC) program, focusing on: (1) the amounts deposited to the Federal Hospital Insurance Trust Fund pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the sources of such amounts; (2) the amounts appropriated from the trust fund for HCFAC program and the justification for the expenditures of such amounts; (3) expenditures from the trust fund for HCFAC activities not related to Medicare; (4) any savings to the trust fund, as well as other savings, resulting from expenditures from the trust fund for the HCFAC program; and (5) other aspects of the operation of the trust fund.

GAO noted that: (1) the Departments of Health and Human Services (HHS) and Justice (DOJ) together administer the HCFAC program and are required to issue a report to Congress on January 1 of each year concerning HCFAC program activities for the preceding fiscal year (FY); (2) they are required to report on: (a) amounts appropriated to the Federal Hospital Insurance Trust Fund pursuant to HIPAA and the source of those amounts; and (b) amounts appropriated from the trust fund for the HCFAC program and the justification for the expenditure of such amounts; (3) HHS and DOJ have issued two joint reports, covering fiscal years 1997 and 1998; (4) the next joint report, covering the FY1999 HCFAC program, is due on January 1, 2000; (5) the joint report covering FY1999 HCFAC program activity, which is not required to be issued until January 1, 2000, will contain information GAO needs to perform its review; (6) after receiving the joint report covering FY1999, GAO will need time to determine what, if any, additional information is needed as well as to obtain and review that information; and (7) therefore, GAO will be unable to meet its reporting deadline of January 1, 2000, and in all likelihood, its 2002 and 2004 commitments as well.


Pursuant to a congressional request, GAO reviewed Medicare and managed care plan hospital costs and payments, focusing on: (1) the relationship between Medicare and managed care plan payments and costs; (2) managed care plan payments and the relative importance of managed care business; and (3) Medicare and managed care plan payments and costs by hospital teaching status.
GAO noted that: (1) for the average hospital responding to GAO's survey, payments from both managed care plans and Medicare covered their respective costs for all types of cases, although there was considerable variation across hospitals in the relationship between payments and costs; (2) average managed care plan payments per case for inpatient services were lower than average Medicare payments for the types of cases GAO examined; (3) however, average managed care plan costs per case were also lower than Medicare's; (4) the relationship between managed care plan payments and costs appeared to be associated with the level of managed care enrollment in the responding hospital's market area and the hospital's relative share of inpatient revenues from this payer; (5) responding hospitals in areas with low managed care plan enrollment or responding hospitals with more managed care plan business were more likely to have higher plan payments, relative to their costs, than other responding hospitals; (6) the average hospital with a large teaching program reported losses from its managed care business, but Medicare payments were well above its costs; and (7) managed care plan payments were more generous than Medicare's to the average responding hospital with a smaller teaching program, although Medicare payments still on average covered its costs.


Pursuant to a congressional request, GAO reviewed states' initiatives to enroll dual eligibles (beneficiaries who qualify for both Medicare and Medicaid benefits) into one managed care plan, focusing on: (1) the status and key features of state initiatives to integrate care for dual-eligible beneficiaries; and (2) factors that have contributed to the length of the waiver negotiation process and implementation time frames.

GAO noted that: (1) Minnesota and Wisconsin are enrolling a small number of dual eligibles in limited geographic areas into integrated care programs, and two additional states plan to implement programs by 2001; (2) officials in these four states view their initial efforts as stepping stones and plan to make their programs more widely available; (3) since the 1995 approval of an integrated care program in Minnesota, the states of Wisconsin and New York also have received federal approval to integrate Medicaid and Medicare services for dual eligibles, and the Health Care Financing Administration and Massachusetts are working toward approval of that states' program; (4) states are emphasizing service delivery in beneficiaries' homes and targeting different segments of the dual-eligible population compared with the Program for All-Inclusive Care for the Elderly, which enrolls only frail individuals; (5) all health plans in states with approved programs are nonprofit, including the three participating health maintenance organizations in Minnesota; (6) important factors associated with states' decisions about pursuing integrated care programs for dual eligibles are the complexity of planning and implementing a demonstration and the extended time frames needed to do so; (7) states have criticized the length of the process required to gain federal approval for their ini-
tiatives; (8) in states with approved programs, the federal waiver review process ranged from over 1 year to over 3 years; (9) though some delays were associated with the Health Care Financing Administration's (HCFA) 1997 reorganization and the heavy new demands on the agency as a result of 1997 legislation, HCFA has taken action to try to speed up the review process; (10) difficulty in reaching agreement on an appropriate Medicare payment methodology for integrated care programs was an important factor that delayed the approval of state waiver applications; (11) the challenge has been to agree on payment rates that adequately compensate health plans for differences in frailty among dual eligibles while meeting the Office of Management and Budget's requirement that Medicare demonstrations not increase federal Medicare expenditures from what they would have been without the demonstration; (12) Medicare's move toward a new diagnosis-based risk-adjustment methodology raises concerns for state demonstrations because research has shown that the methodology tends to underestimate the costs of frail beneficiaries; and (13) this situation underscores the importance of learning from these four state demonstrations so that their experience may inform similar initiatives that other states may be considering.


The net effect of payment revisions under the Balanced Budget Act of 1997 has been to reduce, but not fully eliminate, excess payments to health plans. Some provisions, such as the reduced annual updates, have been implemented while others, such as the health-based risk adjustment system, are still to be phased in. Sweeping amendments to the act are not yet warranted for three reasons. First, the net effect of reforms on plans has been modest. Cuts in rate increases, for example, have held down per capita payment growth by only a little more than one percent. Second, at least some plans can provide the traditional Medicare package of benefits, offer some additional benefits, and make a profit even if they are paid less than they are today. For example, plans serving the Los Angeles area can provide the traditional Medicare package of benefits for about 79 percent of what they are currently paid. Third, the withdrawals GAO observed this year were not a reaction to the act's rate reductions alone. Market forces appear to have played a larger role. The acts health plan payment reforms will reduce aggregate excess payments and, as a result, some Medicare+Choice plans may reduce their supplemental benefits and rethink their participation in Medicare. The continuing challenge for Congress is to strike the appropriate balance between containing Medicare spending and fostering growth in Medicare+Choice.


GAO found that 16 managed care organizations participating in the Medicare+Choice program—Medicare's alternative to fee-for-
service—gave beneficiaries materials containing inaccurate or incomplete benefit information. For example, materials from five organizations said that annual screening mammograms required a physician’s referral, even though Medicare explicitly prohibits this. One organization provided an outpatient prescription drug benefit that was substantially less generous than that agreed to in its Medicare contract. GAO found no errors about ambulance services but written materials often omitted important information about that benefit. Some organizations provided complete information on benefits and restrictions only after a beneficiary had enrolled. Each organization used its own format and terms to describe its plan’s benefit package, making it difficult for beneficiaries to compare available options. Weaknesses in the processes the Health Care Financing Administration (HCFA) uses to review organizations’ member literature led some reviewers to rely on the organization to help verify its accuracy, created opportunities for inconsistent review practices, and led HCFA to fail to ensure that errors reviewers identified were corrected. Beneficiaries would be helped by (1) full implementation of HCFA’s new contract form describing the plans’ benefit coverage; (2) new standards for terminology, formats, and distribution of key member literature; (3) standard forms for routine administrative functions; (4) standard marketing procedures to review material; and (5) requiring organizations to provide beneficiaries with a single standard brochure like that distributed to members of the Federal Employees Health Benefits Program.


Humana, Inc., a large Medicare Choice Plan, provided a prescription drug benefit with a coverage limit that was below the amount listed in its 1998 Florida Medicare Choice contract. Ernst and Young, the contractor hired by the Health Care Financing Administration (HCFA) to review Humana’s contract submission, did not detect the discrepancies because it failed to follow HCFA’s review procedures. HCFA has revised its processes and procedures for monitoring the accuracy of the information in Medicare Choice plans’ contracts. The Humana case shows that the agency did not follow procedures that could have revealed the contract discrepancies that caused some beneficiaries to receive less coverage for brand name prescription drugs than the amount specified in their plan’s basic package. Unless HCFA adheres to its revised monitoring procedures, beneficiaries will have few guarantees that they will receive the prescription drug benefits for which the government contracted and paid.


Medicare+Choice has not yielded savings for Medicare because its plans attract a disproportionate selection of healthier and less-expensive beneficiaries relative to traditional fee-for-service (FFS) Medicare—a phenomenon known as favorable selection. The program spent about $3.2 billion, or 13.2 percent, more on health plan enrollees than if enrollees had received services through traditional
FFS Medicare. Although the Health Care Financing Administra-
tion (HCFA) introduced a new methodology to adjust payments for
beneficiary health status, it may ultimately remove less than half
of the excess payments caused by favorable selection. Spending
forecast errors built into plan payment rates and provisions in the
Balanced Budget Act caused an additional $2 billion, or eight per-
cent, in excess payments to plans. Although all of the 210 plans in
the study received excess payments, the percentage of estimated
excess payments varied substantially among plans. The largest es-
timated excess payment totaled $334 million, or 40 percent more
than Medicare would have paid in an FFS plan. Nine plans re-
ceived payments below their enrollees’ expected FFS costs. When
excess payments due to forecast error are included, only two of the
210 plans were paid less—$1.7 million and $175,000—than its en-
rollees’ expected FFS costs.

Medicare+Choice: Plan Withdrawals Indicate Difficulty of Provid-
ing Choice While Achieving Savings. (GAO/HEHS-00-183,
Sept. 7, 2000).

Pursuant to a congressional request, GAO reviewed health care
plans’ withdrawal from the Medicare+Choice program, focusing on
the: (1) geographic distribution and the distribution among plans of
enrollees affected by the recent plan withdrawals; (2) factors associ-
ated with plans that terminated or reduced their participation in
the program; and (3) likely role of payment rates in affecting plans’
decisions.

GAO noted that: (1) of 309 plans serving Medicare beneficiaries
at the end of 1999, 99 plans terminated their contracts or reduced
the number of counties they served for the 2000 contract year, and
118 have announced they will terminate their contracts or reduce
service areas for the 2001 contract year; (2) these withdrawals af-
acted about 328,000 enrollees in 2000 and will affect almost 1 mil-
lion enrollees in 2001; (3) the number of enrollees affected accounts
for about 5 percent of Medicare+Choice enrollees in 2000 and about
15 percent in 2001; (4) a disproportionate number of affected en-
rollees live outside of major urban areas; (5) a portion of the af-
fected enrollees, approximately 79,000 in 2000 and 159,000 in
2001, will have no other Medicare managed care option available
in their area and must either switch to a non-managed care option,
if one is available in their area, or return to traditional fee-for-serv-
ice (FFS) Medicare; (6) while a new private FFS plan has begun
to offer services in many of the affected areas as an alternative to
the traditional public FFS Health Care Financing Administration
(HCFA) manages, does not offer a prescription drug benefit; (7) in
January 2000, Medicare+Choice plans tended to withdraw from
more difficult to serve rural counties or large urban areas that they
had entered more recently or where they failed to attract sufficient
enrollment; (8) in 2001, the trend is essentially the same for the
service area reductions but somewhat different for the contract ter-
minations, which involve some older, more established plans; (9)
the pattern of Medicare+Choice withdrawals shares common ele-
ments with plan participation in the similarly choice-based health
insurance program for federal employees; (10) industry representa-
tives contend that the Balanced Budget Act’s (BBA) payment rate
changes were too severe and that low Medicare payment rates are largely responsible for the plan withdrawals; (11) however, since the BBA was enacted, Medicare+Choice payment rates have risen faster than per capita FFS spending; (12) in addition, many plans have attracted beneficiaries who have lower-than-average expected health care costs, while Medicare+Choice payments are largely based on the expected cost of beneficiaries with average health care needs; and (13) the extent to which Medicare+Choice payment rate increases would affect plans' participation decisions is unclear.

Medicare+Choice: Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments. (GAO/HEHS-99-144, June 18, 1999).

The Medicare+Choice program was created in 1997 to expand beneficiaries' health plan options, both by encouraging the wider availability of health maintenance organizations and by permitting other types of health plans, such as preferred provider organizations, to participate in Medicare. At the same time, the methodology used to determine plan payments was changed, in part because of concerns that (1) many health plans were overcompensated for the beneficiaries they served and (2) Medicare's managed care program had not, as originally expected, saved the program money. The new methodology is designed to both slow the growth of aggregate payments and more closely align per capita payments with the expected health care costs of plan members. Some health plan and industry representatives believe that these payment changes were too severe and will reduce beneficiaries' access to plans and additional benefits, such as outpatient prescription drug coverage, that are unavailable under fee-for-service plans. This report (1) reviews the extent to which health plans now provide additional benefits and whether they could continue to provide additional benefits if payments were reduced, (2) summarizes the evidence about managed care's effect on Medicare spending, and (3) assesses whether the provisions of the Balanced Budget Act will eliminate excess plan payments.


The Health Care Financing Administration's (HCFA) intermediary and carrier contractors improperly paid an estimated $12 billion in 1998 for Medicare fee-for-service claims from hospitals, physicians, and others. Yet HCFA does only limited reviews of these contractors' activities, generally accepting financial and workload information as presented, without systematically validating it and without verifying contractors' self-certifications that internal controls are working effectively. HCFA should (1) establish measurable contractor performance standards, particularly in the program safeguard area; (2) set program wide priorities for assessing all contractors on core performance standards; and (3) develop a standardized report format that will facilitate comparisons of contractors' performance and the use of trend data for longitudinal assessments of individual contractor performance. HCFA also needs an organizational structure that will ensure that regions are evaluated on, and
held accountable for, the quality of their oversight of contractors. It needs to regularly share best practices and ensure that regional oversight staff adopt them. HCFA contracts out claims administration to a shrinking pool of companies whose private interests are increasingly competing with their Medicare responsibilities. It is seeking legislative remedies, but it will need time, additional information, and experience to properly implement them. HCFA could benefit from a strategic plan for routinely conducting competitive procurements and managing claims administration contractors.

Medicare Contractors: Further Improvement Needed in Headquarters and Regional Office Oversight. (GAO/HEHS-00-46, Mar. 23, 2000).

HCFA is taking a number of steps to strengthen contractor oversight by its central office and 10 regional offices, but most of these actions are still in the planning or early implementation stages. Even if these efforts are successful, HCFA's central and regional offices are still likely to face difficulties in working together effectively to oversee Medicare contractors. Until very recently, HCFA regional overseers were not directly accountable to the central office group responsible for contractor oversight activities.

Other weaknesses in its oversight management have not yet been addressed. Specifically, HCFA (1) lacks adequate management information on regional office resources used or needed for evaluating contractors; (2) since 1995, has provided late annual instructions (or none at all) on what oversight must be conducted by regional office reviewers; and (3) does not effectively employ available management tools—such as routine feedback to regional offices—to ensure that adequate contractor oversight is performed. To enhance management of contractor oversight and improve accountability and communications, we made several recommendations in this report.


Although the Health Care Financing Administration (HCFA) is supposed to ensure that the billions of dollars spent on Medicare each year are managed in a fiscally responsible way, it has yet to establish adequate accountability and control over the program's financial operations. HCFA's financial management activities—from evaluation and follow-ups on audit findings to contractor monitoring and financial reporting—fall short in addressing weaknesses repeatedly cited in audits and other reviews. Unless these weaknesses are resolved, the government is at risk of substantial losses. Financial statement audits have long criticized claims contractors for internal control and financial reporting weaknesses, including failure to safeguard checks received from providers for overpayments and incorrectly recording billions of dollars owed to Medicare for such overpayments. However, HCFA's procedures for following up on audit findings and evaluating corrective actions remain insufficient. Poor monitoring of contractors' financial activities is another problem. Audit reports have also cited HCFA for inefficiencies in its internal financial reporting practices, including a lack of
documented policies and procedures. These deficiencies call into question the reliability of the data that Congress and HCFA use to track Medicare program costs and make decisions about future funding. HCFA officials have launched several initiatives to strengthen the agency's control and accountability, such as hiring outside consultants to evaluate the contractors' internal controls. However, the agency still lacks a comprehensive strategy to ensure successful implementation of these initiatives, direct financial management activities, and sustain improvements in the long term. Without such a strategy, billions of dollars will remain vulnerable to fraud and abuse and HCFA's financial management problems will likely persist.


Pursuant to a legislative requirement, GAO provided information on: (1) the Department of Justice's (DOJ) implementation of its False Claims Act guidance; and (2) DOJ's U.S. Attorneys' Offices' involvement in DOJ's national health care initiatives.

GAO noted that: (1) DOJ has begun taking steps to implement its False Claims Act guidance and has designated four national antifraud projects as national initiatives; (2) however, it is too early for GAO to reach a conclusion regarding DOJ's compliance with the guidance, in part, because its working groups are in various stages of preparing documentation to guide participating U.S. Attorneys' Offices; (3) in addition, while GAO surveyed all U.S. Attorneys' Offices concerning their involvement in national initiatives, GAO still needs to visit selected offices to evaluate their compliance with the guidance; (4) GAO's survey indicated that while most offices have matters pending related to at least one of these national initiatives, such matters represent a small part of their overall civil caseload; (5) the survey also indicated that since the guidance was issued, almost seven times as many national initiative matters were closed as were opened; and (6) about one-half of these closed matters involved settlements, while the remainder did not involve any adverse actions against providers.

**Medicare Fraud and Abuse: DOJ Has Made Progress in Implementing False Claims Act Guidance.** (GAO/HEHS–00–73, Mar. 31, 2000).

Health care fraud in the United States costs taxpayers billions of dollars each year. A key weapon against health care fraud is the False Claims Act, which allows the Justice Department to bring civil enforcement actions and seeks significant damages and penalties against providers who knowingly submit fraudulent bills to Medicare, Medicaid, and other federal health programs. The government collected more than $490 million from health care fraud settlements, judgments, and administrative actions in 1999. The Justice Department's use of the act, however, has been controversial. The hospital industry has alleged that a Justice Department investigation of hospitals nationwide has been unfair and overzealous. The Justice Department responded by issuing guidance to its staff on the appropriate use of the act in civil health care matters.
In a July 1999 report, GAO found that the Justice Department's process for assessing compliance at U.S. Attorney's Offices appeared superficial and that implementation of the guidance varied among the U.S. Attorney's Offices. GAO recommended that the Justice Department improve its oversight. This report discusses what has been done in response to GAO's earlier recommendations. This report also focuses on the most controversial of the four national initiatives—Laboratory Unbundling.


The Department of Justice (DOJ) uses four "national initiatives" to enforce the False Claims Act rather than seeking repayment for Medicare overpayments made because of error, fraud, medically unnecessary services, and other problems. After hospitals alleged that DOJ had targeted them unfairly and applied the act and the initiatives overzealously, and Congress expressed concern, DOJ issued guidance for the appropriate use of these enforcement tools. GAO found that DOJ's process for assessing the U.S. Attorneys' Offices' compliance with the guidance is superficial. DOJ's assessments involve little more than reviewers asking supervisors what they have done to ensure compliance. DOJ's plans for strengthening the process will not provide more substantive information. GAO also found varied implementation of the guidance among the U.S. Attorneys' Offices: Some actions were inconsistent with the guidance and some offices may not have promptly incorporated it into their investigations. GAO could not conduct a complete and independent review because DOJ officials restricted access to some types of information. Nevertheless, it appears that two of the four initiatives are being developed in accordance with the guidance. GAO's survey of state hospital associations found that half of those that had expressed concern before the guidance was issued now believe that it had fully addressed their concerns. GAO recommends that DOJ take additional steps to improve its oversight of national health care initiatives.


Pursuant to a congressional request, GAO modeled the impact of constraining, through various limits, home health agency (HHA) costs that are not directly related to patient care, focusing on the: (1) variation in total and non-patient-care costs across agencies; and (2) effect on Medicare payments if constraints were imposed on payments for non-patient-care costs.

GAO noted that: (1) per-visit costs varied widely both by visit type and across free-standing agencies; (2) home health aide visits were the least expensive, and medical social service visits were the most expensive; (3) across agencies, costs per visit for the most expensive agencies were 4 to 10 times those of the least expensive agencies, depending on the type of visit; (4) non-patient-care costs constituted a substantial portion of the cost for each home health visit, averaging around 44 percent for each visit type; (5) moreover, the portion of visit costs that were not directly related to patient
care was higher for more expensive visits; (6) in addition, for the sample of free-standing HHAs GAO analyzed, Medicare payments would have been approximately 4 to 13 percent less if payments for non-patient-care costs had been held to various limits based on the cost experience of a subset of HHAs; (7) for example, if Medicare payments for non-patient-care costs had been limited to the median costs of free-standing HHAs (the 50th percentile), total payments would have been reduced by 3.9 percent; (8) if payments for non-patient-care costs had been limited to the cost level of the least expensive 20 percent of HHAs (20th percentile), total spending would have been 12.6 percent lower; (9) the per-visit cost limits already indirectly constrain Medicare payments for non-patient care costs, although not as much as a limit applied directly to non-patient-care costs would; and (10) it is not known how the savings estimates would have differed if all HHAs, including the generally higher-cost hospital-based ones, had been included in the analysis.


Until 1998, home health care was one of Medicare's fastest growing benefits. In response to concerns about rising costs, fraud and abuse, and inadequate oversight, an interim payment system has been introduced that limits Medicare payments for home health care. Industry representatives claim that the cost limits are too stringent, causing some home health agencies to close. GAO found that prior to the widely publicized closures of agencies, both the number of agencies and the use of home health services had grown considerably. Although 14 percent of agencies closed between October 1997 and January 1999, beneficiaries are still served by more than 9,000 agencies—about the same number that were in business in 1996. Forty percent of the closures were concentrated in three states with considerable growth in the number of agencies and utilization rates (visits per user as well as users per thousand fee-for-service beneficiaries) well above the national average. In addition, most closures occurred in urban areas that still have a large number of agencies offering services. The pattern of agency closures suggests a response to the interim payment system. Attention has focused on the number of Medicare-certified home health agencies available to provide care, but GAO believes that the more important question is whether beneficiaries continue to have access to Medicare-covered home health services. Overall home health utilization in the first quarter of 1998 had declined since 1996, but it was about the same as a comparable period in 1994—the year that serves at the base for interim payment system limits. Moreover, the sizeable variation in utilization between counties with high and low use has narrowed. These changes are consistent with interim payment system incentives to control utilization. GAO interviews in 34 primarily rural counties with substantial closures indicate that beneficiaries continue to have access to services.
Medicare Home Health Agencies: Overpayments Are Hard to Identify and Even Harder to Collect. (GAO/HEHS/AIMD–00–132, April 28, 2000).

The Health Care Financing Administration (HCFA) has been slow to identify amounts that closed home health agencies (HHA) owe Medicare, and it collects little of the overpayments due from them after they close. HCFA is in the process of implementing the home health prospective payment system mandated by the Balanced Budget Act of 1997, which will involve predetermined payments for home health services. This system should reduce the potential for overpayments to HHAs because payment amounts would not be adjusted retrospectively to reflect allowable agency costs. GAO's estimate of the overpayments due from 15 closed HHAs in Texas that had the largest recorded overpayments among closed HAA's in that state differs significantly from an estimate HCFA reported. Using the same definitions of overpayment, GAO estimated that these agencies could owe $68 million, one-third of HCFA's initial $209 million estimate. HCFA's inability to accurately record and track overpayments has been a consistent weakness, documented in its financial statement audits from fiscal year 1996 through fiscal year 1999. The fiscal year 1998 audit, for example, found that HCFA lacked an integrated financial management system to track overpayments and their collection and that its procedures to help ensure that overpayments were valid and supported were inadequate. HCFA's contractors record and track overpayment activity for HHAs and other providers using fragmented and overlapping computer systems but do not always reconcile the data from these various systems. For example, contractor staff incorrectly keyed data from one of the contractor's systems into a HCFA system, erroneously reporting $77 million in overpayments for one Texas HHA in 1998. HCFA implemented several interim measures in 1999 to improve the reliability of its overpayment information and is planning additional improvements, but they could take years to implement.


In 1997, Congress required home health agencies (HHA) to begin posting $50,000 surety bonds that would allow the Health Care Financing Administration (HCFA) to recover delinquent overpayments made for any reason—not just in cases of fraud and abuse. However, net unrecovered overpayments were less than one percent of Medicare's home health care expenditures in 1996. HCFA requires larger HHAs to obtain bonds equal to 15 percent of their Medicare revenues and that they obtain separate bonds for Medicare and for Medicaid, which imposes a greater burden on them without a demonstrated commensurately greater benefit. GAO believes that requiring one $50,000 surety bond for both Medicare and Medicaid could effectively screen new HHAs to determine whether they are reasonably organized, follow sound business practices, and have financial stability. It would balance the benefit to Medicare of increased HHA scrutiny and recovery of overpayments.
with the burden on participating agencies to supply bond fees and collateral.

**Medicare Home Health Care: Prospective Payment System Could Reverse Recent Declines in Spending.** (GAO/HEHS-00-176, Sept. 8, 2000).

Pursuant to a congressional request, GAO provided information on Medicare home health care’s recent declines in spending, focusing on: (1) the declines in service use underlying the changes in spending; (2) the extent of the changes in use across beneficiaries, home health agencies (HHA), and locations; and (3) identify any implications these new patterns of home health use have for the impact of the prospective payment system (PPS).

GAO noted that: (1) the 48-percent reduction in Medicare home health care spending following the Balanced Budget Act (BBA) of 1997 was due to sharp declines in both the numbers of users and services used; (2) the number of Medicare beneficiaries receiving home health services fell by 22 percent; (3) during the same period, the average number of home health visits received by each user went down 44 percent; (4) changes in home health care varied across agencies and types of users as well; (5) in nearly all instances, declines were greatest for the types of agencies that had provided and the patients who had used the most services in 1996; (6) there was a similar pattern in the drop in usage across states; (7) declines in rural areas were larger than in urban areas; (8) states that had the highest levels of service use in 1996 had larger declines than states where beneficiaries historically received fewer services; (9) the recent changes in home health utilization occurred at least in part in response to changes in Medicare’s payment policies mandated by the BBA; (10) because the new PPS payment rates are based on the historically high utilization in 1998, even after adjusting for projected declines in utilization, they likely will be generous compared with current use patterns; (11) for this reason, home health agency responses to the PPS could result in overpayments relative to services provide while simultaneously raising Medicare spending; (12) under the PPS, Medicare will make a single payment for each 60-day episode of home health care; (13) the PPS will give agencies an incentive to increase the episodes of care they provide; and (14) this, in turn, could cause total Medicare home health spending to rise.

**Medicare Home Health Care: Prospective Payment System Will Need Refinement as Data Become Available.** (GAO/HEHS-00-9, Apr. 7, 2000).

Pursuant to a congressional mandate, GAO provided information on the design of a Medicare prospective payment system (PPS) for home health care, focusing on: (1) the objectives, findings, and costs of the Health Care Financing Administration’s (HCFA) research projects related to the design of a home health PPS, and (2) how these projects contributed to the proposed design of the PPS and which design decisions were based on incomplete information.

GAO noted that: (1) HCFA sponsored research and demonstration projects totaling almost $27 million; (2) yet key features of a PPS were not evaluated, thus limiting the ability to evaluate the
effects of certain payment policies on home health care service delivery and spending; (3) the research provided evidence that home health agencies (HHAs) would reduce their costs of providing visits when paid under a tightly controlled PPS that limited their profits and losses; (4) the research did not develop a system to adjust payments to reflect differences in resource use across groups of patients, but that ongoing research would continue to develop and refine this key component of a PPS; (5) quality measurement and monitoring are not well developed that will limit the ability to evaluate the effects of payment changes; (6) information gaps, coupled with the lack of standards for what constitute appropriate care mean that the PPS could cause unintended consequences for some beneficiaries, some HHAs, and Medicare spending; (7) the proposed unit of payment may be too long for many beneficiaries and could result in unnecessary expenditures; (8) a national average payment level will result in sharp revenue increases for some HHAs and large declines for others; (9) how patients are classified and how much the agencies are paid depend on therapy service provision that is directly controlled by HHAs, and (10) without adequate design features Medicare could overpay for unneeded services or under pay for required care, resulting in beneficiaries facing access problems or receiving poor quality of care.


Pursuant to a congressional request, GAO provided information on the scope and efficacy of Medicare’s existing rural hospital inpatient payment policies, focusing on the major special payment provisions available to rural hospitals under the prospective payment system (PPS) and the inpatient financial performance of these hospitals under PPS.

GAO noted that: (1) Medicare has implemented a variety of inpatient payment policies that have the effect of increasing payments under PPS to certain rural hospitals; (2) two-thirds of rural hospitals obtain some sort of special status to modify their Medicare PPS payments; (3) rural hospitals with special designations generally have fared better than other rural hospitals, although as a group they have still experienced consistently poorer financial performance under Medicare’s PPS than have urban hospitals; and (4) there is considerable variation in performance behind this average, and many rural hospitals operate at a loss in providing Medicare inpatient services.


Pursuant to a congressional request, GAO provided information on the structural problems that exist in the Medicare claims processing system, focusing on: (1) what Health Care Financing Administration (HCFA) proposals have been designed or initiated to measure Medicare improper payments; and (2) the status of these proposals and initiatives and how well they enhance HCFA’s ability to comprehensively measure improper Medicare payments and the
frequency of kickbacks, false claims, and other inappropriate provider practices.

GAO noted that: (1) since 1990, GAO has designated Medicare as a high-risk program, recognizing that the size of the program, its rapid growth, and its administrative structure continue to present vulnerabilities that challenge HCFA's ability to safeguard against improper payments, including those attributable to fraud and abuse; (2) due to the broad nature of health care fraud and abuse, a variety of detection methods and techniques—such as contacting beneficiaries and providers and performing medical records reviews, data analyses, and third party verification procedures—are being utilized to uncover suspected health care fraud and abuse; (3) efforts to measure the extent of improper payments, and ultimately to stem the flow of Medicare losses, depend upon the use of an effective combination of these techniques; (4) the Office of Inspector General's study to measure the extent of Medicare fee-for-service improper payments was a major undertaking and, as GAO reported, the development and implementation of the methodology it used as the basis for its estimates represent significant steps toward quantifying the magnitude of this problem; (5) it is important to note, however, that this methodology was not intended to and would not detect all potentially fraudulent schemes perpetrated against the Medicare program; (6) HCFA has initiated three projects designed to enhance its ability to measure the extent of Medicare fee-for-service improper payments; (7) two of these projects are designed to improve the precision of future improper payment estimates and help develop corrective actions to reduce losses—however, like the current methodology, they are not specifically designed to identify and measure the extent of improper payments attributable to potential fraud and abuse; (8) the third project, while still in the concept phase, will test the viability of using a variety of investigative techniques to develop a potential fraud and abuse rate; (9) determining the most appropriate combination of improper payment identification techniques to incorporate into measurement efforts requires careful evaluation; and (10) some techniques may be challenging to implement, such as contacting beneficiaries due to difficulties in locating them.

Medicare Managed Care: Greater Oversight Needed to Protect Beneficiary Rights. (GAO/HEHS-99–68, April 12, 1999).

Medicare requires managed care plans to notify a beneficiary in writing of the reasons for denying to provide or pay for a service and to state the beneficiary's appeal rights. The beneficiary can appeal a denial, in writing, first to the plan, then to the Center for Health Dispute Resolution, then to an administrative law judge, and finally to a U.S. District Court. Beneficiaries are entitled to expedited decisions on their appeals if the standard time for making decisions could endanger their health or life. Between January 1996 and May 1998, health maintenance organizations reported an average of nine appeals per 1,000 Medicare members (this number may be rising) and reversals of 75 percent of the original denials. However, the number of appeals may understate beneficiaries' dissatisfaction with the plans' initial decisions: (1) some beneficiaries switch out of their plans rather than appeal and (2) some receive
notices that fail to state reasons for a denial or to explain their appeal rights or they receive no notices at all. Furthermore, plans sometimes give beneficiaries little advance notice when they decide to discontinue paying for services. The Health Care Financing Administration (HCFA) does not determine whether beneficiaries who were denied services but did not appeal were informed of their appeal rights. HCFA does not monitor the provider groups to whom issuing denial notices and deciding whether to expedite initial decisions are delegated. HCFA also has not issued specific criteria for expedited cases. HCFA is implementing or planning initiatives to better protect beneficiaries’ rights.

Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues. (GAO/HEHS-99–91, April 27, 1999)

The Balanced Budget Act of 1997 created the Medicare+Choice program to expand beneficiaries’ managed care options, both by encouraging the wider availability of health maintenance organizations (HMO) and by allowing other types of health plans to participate in Medicare. The act also contained provisions to slow the growth in Medicare spending. Last fall, shortly before the start of the program, nearly 100 Medicare managed care plans announced that they would not renew their Medicare contracts or that they would reduce the geographic areas they served. Beneficiaries affected by these withdrawals either had to switch plans or return to traditional fee-for-service Medicare; a small number of beneficiaries were left with no alternative but fee-for-service. GAO found that although an unusually large number of managed care plans left Medicare recently, a number of new plans have applied to enter the program or expanded the areas in which they offer services. Plan withdrawals cannot be traced to a single cause; rather, various factors appear to be behind a plan’s decisions to participate. Payment level is one factor that influences where plans offer services, but withdrawals were not limited to counties with low payments. When a plan reduced its service area, however, GAO found that counties with low payment rates were more likely to experience a withdrawal than counties with higher payment rates. Also, a portion of the withdrawals may have been the result of plans’ deciding that they were unable to compete effectively in certain areas. Plan representatives also cited the administrative burden associated with Medicare+Choice as a significant factor. A broad comparison of plan benefit packages from 1997 and 1999 indicates modest reductions in the inclusion of certain benefits. In 1999, a slightly higher percentage of beneficiaries can join a plan offering prescription drug coverage, while a slightly smaller percentage of beneficiaries have access to a plan offering dental care, hearing exams, and foot care. Beneficiaries living in the lowest-payment areas saw greater decreases in access than the average beneficiaries. Also, those living in the lowest payment areas saw a decrease in access to plans offering prescription drug benefits, while beneficiaries in higher payment areas saw an increase in access to plans offering those benefits.

The oversight of end-stage renal disease (ESRD) facilities needs improvement. Increasing the number of federally funded inspections of ESRD facilities should help improve oversight, as would putting some teeth into the enforcement process. One way to give facilities more incentives to stay in compliance with Medicare reimbursement policies would be to have available the kinds of monetary penalties that can be used when nursing homes are found to have severe or repeated serious deficiencies. For example, the Health Care Financing Administration (HCFA) can fine nursing homes, and the fines are not forgiven when the facility corrects its problems. Another way to strengthen oversight would be for state agencies and ESRD’s networks to share information on complaints and known quality-of-care problems at specific facilities. This would help target inspection resources where they are most needed. HCFA’s efforts to use available outcome data for targeting its survey efforts might also eventually help in this regard, but more testing and evaluation are needed to help ensure that the data used are sufficient to predict noncompliance with Medicare’s quality standards.


Pursuant to a congressional request, GAO provided information on premiums for four of the ten Medicare supplemental insurance (Medigap) policies, including the three that provide outpatient prescription drug coverage, focusing on describing: (1) a description of the benefits under the four standard plans; and (2) the average premiums charged for the four plans.

Specifically: (1) GAO obtained Medigap premiums for four standard plans—F, H, I, and J—from insurance commissions in 38 states; (2) plans H and I provide drug coverage with a $250 deductible, 50 percent coinsurance, and an annual limit of $1,250; (3) plan J has the same drug benefit deductible and coinsurance and an annual limit of $3,000; (4) premiums for plan F, the most frequently purchased plan, are presented as a comparison because it does not cover prescription drugs; (5) the insurance companies report their premiums to state insurance commissions; (6) some companies list different premiums that are specific to a certain type of policy; (7) a company may have different premiums for policies that use different age-rating methodologies; (8) premiums may also differ by characteristics of the policyholder, such as gender or smoking status; (9) other companies may report a single sample premium for each age; (10) states may also have regulations that affect the standard premiums, such as not allowing premiums to vary based on age; (11) the average premiums should not be interpreted as the average prices that Medicare beneficiaries are paying for Medigap policies in a given state; and (12) although companies may offer policies at the published premiums, the number of Medicare beneficiaries who are actually paying the premiums was not available from the states, so GAO was not able to calculate the average premiums weighted by the number of policyholders.

The National Practitioner Data Bank is presently the nation's only central source of medical malpractice payment information. The data bank also maintains information on licensure actions imposed by states as well as certain clinical privilege restrictions imposed by hospitals and other health care providers. However, it is unclear whether all relevant data are being properly reported. GAO's review suggests that information in that data bank may not be as accurate, complete, or as timely as it should be. Inaccuracies in the way reported information was coded could confuse or mislead querying organizations about the severity of actions taken against practitioners. Also, duplicate reports overstate the amount of information that the databank has on a particular practitioner. The Health Resources and Services Administration (HRSA) has not established criteria for the information that states and other entities must report when notifying the data bank of the disciplinary actions taken. Moreover, HRSA lacks procedures for ensuring that reporters adhere to the criteria established for medical malpractice reports, including inappropriate references to patients' names. Furthermore, the practitioner notification and dispute resolution processes have not ensured that inaccurate and erroneously reported information is removed from the data bank and not released to entities seeking information on specific practitioners. Finally, without an examination of its financial operations, HRSA has little assurance that its data bank user fees are appropriate. An analysis of its cash balances and cash flows—user fee collections and disbursements—would be the best way for HRSA to determine the appropriateness of fees.

Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality. (GAO/HEHS–00–6, Nov. 4, 1999)

Pursuant to a congressional request, GAO provided information on the Health Care Financing Administration's (HCFA) oversight programs of state agencies' nursing home survey process, focusing on the: (1) effectiveness of HCFA's approaches to assessing state agency performance; (2) extent to which HCFA's regional offices vary in their application of these approaches; and (3) the corrective actions available to HCFA when it identifies poor state agency performance.

GAO noted that: (1) since last year, HCFA has undertaken a series of initiatives intended to address quality problems facing the nation's nursing home residents, including redesigning its program for overseeing state agencies that survey nursing homes to ensure quality care; (2) the objective of HCFA's oversight program is to evaluate the adequacy of each state agency's performance in ensuring quality care in nursing homes, but the mechanisms it has created to do so are limited in their scope and effectiveness; (3) HCFA's oversight mechanisms are not applied consistently across each of its 10 regional offices; (4) HCFA does not have sufficient, consistent, and reliable data to evaluate the effectiveness of state agency performance or the success of its recent initiatives to improve nursing home care; (5) given the wide range in the fre-
frequencies with which states identify serious deficiencies, HCFA cannot be certain whether some states are failing to identify serious deficiencies that harm nursing home residents; (6) HCFA does not have an adequate array of effective sanctions to encourage a state agency to correct serious or widespread problems with its survey process; (7) HCFA's primary mechanism to monitor state survey performance stems from its statutory requirement to survey annually at least 5 percent of the nation's 17,000 nursing homes that states have certified as eligible for Medicare or Medicaid funds; (8) but HCFA's approach to these federal monitoring surveys does not produce sufficient information to assess the adequacy of state agency performance; (9) to fulfill its 5 percent monitoring mandate, HCFA makes negligible use of its most effective technique—an independent survey done by HCFA surveyors following completion of a state's survey—for assessing state agencies' abilities to identify serious deficiencies in nursing homes; (10) a second HCFA oversight mechanism also has significant shortcomings; (11) about 3 years ago, HCFA implemented the State Agency Quality Improvement Program (SAQIP), a program under which the state agency does a self-assessment to inform HCFA, at least once a year, whether the state is in compliance with seven standard requirements; and (12) SAQIP is limited as an oversight program, however, because HCFA: (a) does not independently validate the information that the states provide, so it is uncertain whether all serious problems are identified or whether identified problems are being corrected; and (b) has no policy regarding consequences for states that do not comply.


Pursuant to a congressional request, GAO analyzed materials from the American Health Care Association (AHCA) to determine whether any cases reflected the actions of an overly aggressive regulatory process.

GAO noted that: (1) in each of the eight cases for which there was sufficient information for an objective assessment, GAO believes appropriate regulatory action was taken; (2) in these cases, either the surveyor's actions were justified or the Health Care Financing Administration (HCFA) or the state withdrew the initial actions after the nursing homes presented additional information; (3) in the remaining two cases, GAO was unable to obtain sufficient information to make a determination; (4) specifically, of the seven cases AHCA believes represent inappropriate citations, GAO found that in three of these cases a citation was justified; (5) in another two cases, the states withdrew the citations when the nursing homes supplied additional information not available to the surveyors, and for the final two, GAO was unable to obtain enough information to make a judgment; (6) in all three cases in which the homes were recommended for termination by a state agency, GAO believes the states and HFCA ultimately acted correctly in accordance with regulatory requirements; (7) furthermore, in only one of these cases did HFCA actually terminate the home from Medicare and Medicaid; (8) in the remaining two, HCFA rescinded the termi-
nation actions: in one case because deficiencies were corrected and in the other because of procedural errors by the state; (9) in GAO's analysis of the cases that AHCA selected as "symptomatic of a regulatory system run amok," GAO did not find evidence of inappropriate regulatory actions; (10) furthermore, in a recently released report in which GAO examined a random sample of 107 nursing home surveys containing 201 actual harm citations affecting one or a few residents, GAO found that 98 percent of the surveys documented that one or more residents had experienced actual harm; (11) moreover, two-thirds of these 107 nursing homes also were cited for actual harm or higher-level deficiencies in a prior or subsequent survey; (12) most of these repeat violators were cited for the same deficiency, and an additional 34 percent were cited for closely related deficiencies; and (13) GAO also found that most of the examples AHCA provided had deficiencies, in addition to those cited by AHCA, that caused harm to residents.


Despite reforms to ensure that nursing homes comply with federal quality standards, one-fourth of all homes nationwide continue to be cited for deficiencies that either caused actual harm to residents or carried the potential for serious injury or death. Although the reforms equipped federal and state regulators with many alternatives and tools to help sustain compliance with Medicare and Medicaid standards, the way in which the states and the Health Care Financing Administration (HCFA) have applied them appears to have resulted in little headway. Repeated noncompliance carries few consequences. HCFA's recent actions, such as broadening the definition of a poorly performing facility, are a step in the right direction. However, four key problems remain. First, if the backlog of civil monetary penalties is not reduced, much of their deterrent effect will be lost. Second, weaknesses remain in the deterrent effect of termination, including the lack of a tie to poorly performing facility status for reinstated homes and the limited reasonable assurance period for monitoring terminated homes before reinstating them. Third, the states are not required to refer for sanction all homes with deficiencies that contribute to resident deaths. Fourth, the changes do not address HCFA's need to improve its management information system. HCFA's ability to improve its oversight of nursing homes will depend heavily on whether it has the information to identify and monitor the homes that pose the greatest risk of harm.


Federal and state practices for investigating complaints about nursing home care are often not as effective as they should be. GAO found many problems in the 14 states it reviewed, including procedures or practices that may limit the filing of complaints, understatement of the seriousness of complaints, and failure to investigate serious complaints promptly. Complaints alleging that nurs-
ing home residents were being harmed have gone uninvestigated for weeks or months. During that time, residents may have remained vulnerable to abuse, neglect (which can lead to serious problems like malnutrition and dehydration), preventable accidents, and medication errors. Although the federal government finances more than 70 percent of total expenditures for complaint investigations nationwide, the Health Care Financing Administration (HCFA) plays a minimal role in providing states with direction and oversight regarding these investigations. HCFA has left it largely to the states to decide which complaints put residents in immediate jeopardy and should be investigated immediately. More generally, HCFA's oversight of state agencies that certify federally qualified nursing homes has not focused on complaint investigations. GAO recommends (1) stronger federal requirements for states to promptly investigate serious complaints alleging situations that may harm residents but are not classified as posing an immediate threat, (2) more federal monitoring of states' efforts to respond to complaints, and (3) better tracking of the substantial findings of complaint investigations.

**Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit.** (GAO/HEHS--99--157, June 30, 1999).

GAO has previously reported that one in four of the nation's nursing homes has deficiencies so serious that they have harmed residents or placed them at serious risk of death or injury. (See GAO/HEHS--99--46, Mar. 1999.) Forty percent of the homes with serious deficiencies were cited for repeat deficiencies. The Health Care Financing Administration (HCFA), which oversees the quality of nursing home care, has announced plans to beef up enforcement at homes found to have repeatedly harmed residents. This includes expanding the definition of homes classified as poor performers. HCFA's proposal to include homes with repeated isolated actual harm deficiencies would significantly increase the number of homes that would be subject to immediate sanctions without a grace period to correct the problems. If this revised definition had been in effect as of April 1999, GAO estimates that the number of nursing homes meeting HCFA's poor-performer criteria would have risen from about one percent to nearly 15 percent of facilities nationwide. Two-thirds of the poor-performing nursing homes GAO surveyed had repeated violations. As a result, they would have been subject to immediate sanction under HCFA's revised poor performer definition. The current definition allows them an opportunity to correct the problems without sanctions. 40 percent of the repeat violators were cited for the same deficiency, and another one-third were cited for closely related problems. These findings suggest that HCFA's enhanced enforcement of homes found to repeat these serious care problems has merit.

**Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives.** (GAO/HEHS--00--197, Sept. 28, 2000).

Pursuant to a congressional request, GAO provided information on federal and state initiatives to improve the quality of nursing homes, focusing on: (1) progress in improving the detection of quality problems and changes in measured nursing home quality; (2)
the status of efforts to strengthen states' complaint investigation processes and federal enforcement policies; and (3) additional steps taken at the federal level to improve oversight of states' quality assurance activities.

GAO noted that: (1) overall, the introduction of the recent federal quality initiatives has generated a range of nursing home oversight activities that need continued federal and state attention to reach their full potential; (2) the states are in a period of transition with regard to the implementation of the quality initiatives, in part because the Health Care Financing Administration (HCFA) is phasing them in and in part because states did not begin their efforts from a common starting point; (3) efforts at the federal level toward improving the oversight of states' quality assurance activities have commenced but are unfinished or need refinement; (4) federal initiatives were introduced to strengthen the rigor with which states conduct required annual nursing home surveys; (5) the states GAO visited have begun to use the new methods introduced by the initiatives to spot serious deficiencies when conducting surveys, but HCFA is still developing important additional steps; (6) GAO's results showed a marginal increase nationwide in the proportion of homes with documented actual harm and immediate jeopardy deficiencies, although there was considerable variation across states; (7) the states GAO contacted also have made strides in improving their investigations of and follow-up to complaints, but not enough time has elapsed to consider these efforts complete; (8) for some states, the provision of federal funding to support the nursing home initiatives came too late in the state budget cycle for agencies to capitalize on the additional funds for fiscal year 1999; (9) it is too early to assess the effect of the additional funding intended to reduce the large number of pending appeals by nursing homes because the new HHS staff were only hired within the past year and other changes in enforcement policy are expected to increase the volume of nursing home appeals; (10) to improve nursing home oversight at the federal level, HCFA has made recent organizational changes to address past consistency and coordination problems between its central office and 10 regional offices; (11) it also intends to intensify its use of management information data systems and reports to verify and assess states' oversight activities and view more closely the performance of the homes themselves; and (12) GAO's review showed that an examination of previously available information could have identified shortcomings in a state's survey activities even before they came to light as the result of a criminal investigation.


The Medicare Incentive Payment program pays doctors a 10-percent bonus for Medicare services they provide in areas identified as having a shortage of primary care physicians. GAO found that the program is not an effective way to improve the ability of Medicare beneficiaries to obtain health care. Since the program began, Congress has taken additional action to address this concern. This action generally increased reimbursement rates for primary care
services and reduced the geographic variation in physician reimbursement rates. In addition, survey data from the Health Care Financing Administration show that Medicare beneficiaries who have access problems, including those who may live in underserved areas, generally cite reasons other than the unavailability of a physician—such as the cost of services not paid by Medicare—for their access problems. Moreover, the program does not appear to play a significant role in attracting and retaining physicians in shortage areas. The relatively small bonus payments most doctors receive—a median payment of $341 for the year in 1996—are unlikely to have a significant impact on physician recruitment and retention. The Department of Health and Human Services has not developed goals or related performance measures for the program to clarify what the program is expected to accomplish. As it stands, the program provides no assurance that the more than $90 million spent each year is improving access to care in underserved areas. HCFA's oversight of the program also has shortcomings that allow physicians and other providers to receive and keep bonus payments they claimed in error.

**Prescription Drug Benefits: Implications for Beneficiaries of Medicare HMO Use of Formularies.** (GAO/HEHS–99–166, July 20, 1999).

More than 90 percent of the 6 million beneficiaries enrolled in Medicare+Choice have outpatient drug coverage. However, before they enroll in Medicare health maintenance organizations (HMO), beneficiaries may not be aware of how the HMOs manage the cost of providing drugs through formularies, or lists of drugs that they prefer that their physicians prescribe. Comparing HMO plans is difficult for beneficiaries because the plans vary widely in the drugs they cover in their formularies, how they manage them, the copayments they require, their annual coverage limits, and the methods they use to notify beneficiaries of formulary changes and to consider exceptions from formulary changes. Beneficiaries in some plans may not learn about formulary changes until they are at the pharmacy counter. Some plans also make it difficult for physicians to obtain an exception to allow patients to remain on their existing medication at no additional cost if it is dropped from the formulary.

**Prescription Drugs: Drug Company Programs Help Some People Who Lack Coverage.** (GAO–01–137, Nov. 16, 2000).

As Congress considers Medicare beneficiaries' access to prescription drug coverage, there is increased interest in the range of options available to help vulnerable populations obtain access to needed medications. Patient assistance programs, offered voluntarily by drug companies, are generally designed to provide prescription drugs to low-income persons who lack drug coverage. These programs typically rely on health care providers' involvement with some or all stages of applying for and receiving drugs from the programs. Drug companies characterize their programs as a last-resort source of prescription drugs, and most programs are not designed to provide long-term prescription drug coverage. To comply with the programs' eligibility criteria, which are intended
to target patients who need assistance, application procedures require information about the patient’s financial and insurance status. The provider’s role in the application process is significant, involving obtaining applications, completing all or part of the forms, and receiving and dispensing drugs.


Pursuant to a congressional request, GAO provided information on the expansion of Medicare beneficiaries’ access to prescription drugs, focusing on the: (1) federal drug price discounts available to federal and nonfederal purchasers and the size of those discounts; and (2) potential effects that extending such discounts to nonfederal purchasers may have on outpatient drug prices paid by federal and nonfederal purchasers.

GAO noted that: (1) federal departments and agencies, state Medicaid programs, and numerous nonfederal public health entities have access to prescription drugs at substantially lower prices than many other purchasers; (2) federal entities can purchase drugs from the federal supply schedule at prices that are the same or lower than those drug manufacturers charge their most-favored private purchasers; (3) federal law also specifies that state Medicaid programs and certain nonfederal purchasers can receive substantial discounts on prescription drug prices; (4) under the Omnibus Budget Reconciliation Act of 1990, drug manufacturers must provide rebates to state Medicaid programs for their outpatient drugs in exchange for Medicaid coverage; (5) the Public Health Service Act also provides some nonfederal purchasers, such as community health centers and certain public hospitals, access to drug prices based on Medicaid rebates; (6) mandating that federal prices for outpatient prescription drugs be extended to a large group of purchasers, such as Medicare beneficiaries, could lower the prices they pay but raise prices for others; (7) such price changes could occur because drug manufacturers would be required to charge beneficiaries and federal purchasers the same prices; (8) to protect their revenues, manufacturers could raise prices for federal purchasers; (9) furthermore, because federal prices are generally based on prices paid by nonfederal purchasers, manufacturers would have to raise prices to these purchasers in order to raise the federal prices; (10) in particular, large private purchasers that tend to pay lower prices, such as health maintenance organizations and other insurers, could see their prices rise; (11) while it is not possible to predict the extent or timing of any changes in manufacturer pricing strategies if Medicare beneficiaries gained access to the same prices available to federal purchasers, the experience following implementation of a Medicaid rebate suggests that manufacturers would adjust prices quickly; and (12) the magnitude of these potential effects would vary by drug and would depend on a number of factors, including the relationship between the specific federal price extended to Medicare beneficiaries and the price paid by nonfederal purchasers, as well as the number of Medicare beneficiaries with access to the federal price.

Because many rural ambulance providers serve a large geographic area with a low population density, they face a set of unique challenges. Unless they rely on volunteers, they tend to have high per-trip costs because of the lower volume of transports as compared to urban and suburban providers. The proposed Medicare fee schedule will alter the way rural ambulance providers are paid. Much of the variation in payment rates among similar rural providers will be eliminated. In addition, providers that transport beneficiaries in rural areas will receive enhanced payments intended to help to sustain essential service in sparsely populated areas. However, this adjustment does not sufficiently distinguish the providers serving beneficiaries in isolated areas. Therefore, we recommended that HCFA refine the payment adjuster to better target the necessary fixed costs of essential providers in isolated areas.

We also found in a review of 1998 claims data that payment denials have varied widely among the contractors that process claims for freestanding ambulance providers. Different practices among these contractors, including increased attention to potential fraud, differences in local policies, and failure to apply the coverage criteria appropriately, may have contributed to the variation in claims denials. Additionally, the absence of a national coding system that readily identifies the beneficiary’s medical condition at the time of transport has impaired providers’ ability to convey information to carriers in a way that facilitates review of claims.


Pursuant to a congressional request, GAO provided information on skilled nursing facilities, focusing on: (1) the initial effect of the skilled nursing facility (SNF) prospective payment system (PPS) on Medicare beneficiaries’ access to care; (2) the initial effect of the SNF PPS on providers; and (3) the role the SNF PPS has played in the poor financial performance of large nursing home chains.

GAO found that: Medicare beneficiaries’ ability to obtain needed care does not appear to have decreased since the implementation of the SNF PPS, although some patients may stay longer in the hospital before being admitted to a nursing home or may receive care from other post-acute-care providers. The PPS does appear, however, to have affected the willingness or ability of some nursing homes to accept certain types of Medicare patients. Hospital discharge planners reported that facilities are reluctant to admit patients requiring certain high-cost services, indicating that the payments for some types of SNF patients may be too low. Hospital discharge planners also reported that Medicare patients needing short-term rehabilitation are preferred by nursing homes, raising concerns that payments for these patients may be too high. Although the new payment system changes in financial incentives, GAO believes it is likely that aggregate SNF payments to providers are adequate, given that inflated costs were used to establish the per diem payment rates. However, the case-mix classification sys-
tem used to adjust payments to reflect the needs of patients may not appropriately allocate payments across patients and providers. Payments, therefore, may be too low for certain types of patients and too high for others. Nevertheless, the generally low proportion of patient-days covered by Medicare at most nursing homes will dampen the initial effects of PPS on providers, and the transition to the full PPS rates will give them time to adjust. Some facilities will have to make bigger changes in their treatment patterns, particularly facilities with a large proportion of patient-days covered by Medicare, those with inefficient practices, and those that historically furnished excessive services to patients to maximize revenues. Other facilities may be more selective in their admission policies until refinements in the classification system fully account for differences across patients. GAO also found that the SNF PPS is only one of the many factors contributing to the poor financial performance of Sun Healthcare Group, Inc., and Vencor, Inc., two corporations that operate a large number of nursing homes. The large total losses reported by the corporations stem from high capital related costs that have shrunk SNF margins; reduced demand for ancillary services, related to several provisions of the Balanced Budget Act of 1997; and substantial nonrecurring expenses and write offs, reflecting reductions in future anticipated earnings.


The Balanced Budget Act of 1997 replaced Medicare’s cost-based payment method for skilled nursing facility (SNF) care with a prospective payment system (PPS). Concern has arisen over whether rates under the new system are adequate, and legislation has been proposed to raise them. GAO found that total Medicare payments for all SNFs are likely to be adequate, if not generous, to cover the costs of nontherapy ancillary services. However, the PPS may not appropriately account for the variation in nontherapy ancillary costs and thus may not correctly raise or lower payments across patient groups to reflect expected differences in need. Therefore, Medicare payments for certain patient groups may be too high or too low, relative to the average. Assessing the adequacy of total Medicare payments to any SNF would require considering total Medicare costs and payments over the entire year. Aware of concern about the issue, the Health Care Financing Administration has commissioned relevant research. Meanwhile, GAO suggests that the extent of any maldistribution of SNF payments be assessed. If problems are found, the payment weights should be recalculated to better target payments to patients with high expected nontherapy ancillary needs.

State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets. (GAO/HEHS-00–162, Sept. 6, 2000).

Pursuant to a congressional request, GAO examined state-administered pharmaceutical assistance programs and described (1) the characteristics of state programs designed to provide prescription drug access to eligible populations, and (2) the administrative and
policy issues that states have encountered in operating drug assistance programs.

GAO noted that: (1) in 1999, 14 states were operating independent, state-funded and administered programs that provided more than 760,000 elderly and other low-income persons with access to prescription drugs; (2) most programs are funded with the state's general revenues, but some receive earmarked funds; (3) all state pharmacy programs provide benefits for low-income elderly state residents, but specific eligibility rules differ; (4) the programs vary in the number of people enrolled and their size relative to the number of Medicare beneficiaries in the state; (5) states attempt to provide access to drugs and manage program costs through coverage restrictions such as dollar caps on benefits, deductibles, copayments, and limits on the types of drugs covered; (6) among state programs, copayments and coinsurance are more common than benefit caps and deductibles, but the amount of cost sharing varies widely across programs; (7) all state programs obtain rebates from drug manufacturers to offset part of their expenditures—most state programs receive manufacturers' rebates that are calculated on terms similar to rebates under the Medicaid program; (8) to provide a pharmacy assistance benefit to a low-income and largely elderly population, while remaining within the program budget, states have taken a variety of approaches to administering their programs; (9) these include developing adequate systems to administer benefits and coordinating payment with and recovering payment from other insurers; (10) states have also attempted to encourage enrollment by mitigating the perceived stigma attached to assistance programs, which could inhibit enrollment, and by providing information to eligible persons so that they are aware of the program and know how to apply; (11) three program administrators said that drug assistance programs were intentionally administered apart from Medicaid programs to avoid the perceived stigma attached to Medicaid; (12) however, several states administer aspects of their programs through and employ the policies of the agency administering Medicaid; (13) administering programs using Medicaid systems allows states to avoid duplicating program functions, such as eligibility determination and claims processing and adjudication; and (14) nevertheless, some states have encountered administrative challenges in developing adequate eligibility determination and claims processing systems and in recovering payments from insurers when program enrollees have other drug coverage.

INCOME SECURITY ISSUES


Pursuant to a congressional request, GAO provided information on the United Mine Workers of America Combined Benefit Fund. GAO noted that: (1) both the net average cost per beneficiary of providing benefits under the fund and per beneficiary premium increased each fiscal year for the past 5 years; (2) the percentage in-
crease in the average net cost per beneficiary of providing benefits under the fund for the past 5 fiscal years fluctuated from 1 to 14 percent, while the percentage increase in the medical component of the Consumer Price Index (CPI) for those years was relatively stable, fluctuating from 3 to 4 percent; (3) according to Fund officials, while the increase in the medical component of the CPI is driven primarily by price increases, the increase in the fund's average net cost of providing benefits per beneficiary is driven by the increased use of medical care in addition to price increases; (4) income during fiscal years 1996 through 2000 was derived from three primary sources: (a) coal company premiums; (b) the Health Care Financing Administration; and (c) transfers of interest from the Abandoned Mine Land Reclamation trust fund; and (5) these three sources provided over 85 percent of the fund's total income for each of the past 5 years.


Pursuant to a congressional request, GAO reviewed the administration's proposal to ensure solvency of the United Mine Workers of America (UMWA) Combined Benefit Fund, focusing on the impact of the proposal to: (1) extend the Abandoned Mine Land (AML) Reclamation fees; (2) reverse the effects of National Coal v. Chater; (3) reverse the effects of Dixie Fuel Company v. Social Security Administration; and (4) appropriate federal funds.

GAO noted that: (1) if the administration's proposal is not adopted, the federal government potentially would have to provide $513 million over the next 8 years to ensure the Fund's solvency through 2008, assuming that the Dixie Fuel decision is not implemented; (2) however, if the Dixie Fuel decision is implemented, the Fund may have to refund an estimated net $57 million in premiums to coal companies and would have to find funding for 10,000 additional unassigned beneficiaries; (3) although an estimate of the cost has not yet been developed, nationwide implementation of the Dixie Fuel decision would increase the Fund's projected deficit; (4) according to GAO's review of available financial data, while the administration's proposal improves the projected financial position of the Fund, reducing the fiscal year 2008 anticipated cumulative deficit, not including borrowing costs, from $513 million to $83 million, it does not ensure the solvency of the Fund; and (5) additional funds will be needed to ensure the solvency of the Fund.


Pursuant to a congressional request, GAO provided information on cash balance plans for retirement income, focusing on the: (1) prevalence and features of cash balance plans; (2) factors employers considered in making a decision about whether or not to use a cash balance formula; (3) effects of using cash balance formulas on the adequacy of individual workers' retirement income; and (4) effects of current disclosure practices on plan participants' ability to address issues regarding the adequacy of their retirement funds.
GAO noted that: (1) its survey of 1999 Fortune 1000 firms indicated that about 19 percent of these firms sponsor cash balance plans covering an estimated 2.1 million active participants, more than half of these plans have been established within the last 5 years; (2) firms in many sectors of the economy sponsor these plans, but greater concentrations are found in the financial services, health care, and manufacturing industries; (3) of the firms GAO surveyed that sponsor such plans, about 90 percent previously covered their workers under a traditional defined benefit plan; (4) as with traditional defined benefit plans, there is significant variation in the design and operation of cash balance plans; (5) cash balance plans have had such visibility in recent years that most firms GAO surveyed had at least considered adopting such a plan; (6) these firms reported that their decisions to adopt or not to adopt a cash balance plan were based on many factors, including corporate philosophy, the need to remain competitive, and the potential impact on workers; (7) cash balance plans offer both opportunities and challenges to workers seeking to ensure adequate retirement income; (8) cash balance plans generally are structured such that workers accrue benefits earlier in their careers than they would under most traditional defined benefit plans; (9) this feature, combined with the lump sum payouts also common to such plans, provides opportunity for more mobile workers to secure and retain higher benefits, even when they change jobs, than they would under most traditional defined benefit plans; (10) older workers may be disadvantaged if their employer converts from a traditional defined benefit plan to a cash balance plan or if they leave a firm with a traditional plan for one with a cash balance plan; (11) to mitigate the impact of conversion, many Fortune 1000 employers provide transition provisions for workers previously covered under their traditional defined benefit plans; (12) because the decisions of individual participants play a more significant role in maximizing retirement income under such balance plans than under traditional defined benefit plans, cash balance plan participants have a particular need for clear and timely information about their plans; (13) most plans provided insufficient information to allow a participant to make informed career-and retirement—related decisions; and (14) GAO found a wide variation in the quantity and quality of information that firms provided to participants in cash balance plans.

*Determining the Taxable Portion of Federal Pension Distributions.*


Pursuant to a congressional request, GAO provided information on: (1) what reasons, if any, exist for the Office of Personnel Management (OPM) to report the taxable portion of annuity benefits for newly retired federal employees on the Form CSA 1099R (Statement of Annuity Paid); and (2) the feasibility of OPM's doing so. GAO noted that there are three reasons for OPM to report on Form CSA 1099R the taxable portion of the annuity for newly retired federal employees; (1) the task of calculating this portion can be burdensome from the retirees' perspective; (2) the complexity of the requirement could result in retirees' miscalculating the taxable portion of their annuity for income tax purposes; and (3) reporting the taxable portion of the annuity on Form CSA 1099R would allow
the Internal Revenue Service (IRS) to use it for computer matching purposes. Computer matching of information and tax returns is one way that IRS verifies a taxpayer's income to determine the proper tax owed.

According to OPM officials, it would be feasible for OPM to report the taxable portion on Form CSA 1099R for federal employees with annuities starting after November 18, 1996, when the Simplified Method became the only method allowed. Before that date, retirees could use either the Simplified Method or the General Rule method, and OPM would not know which method the retiree preferred. OPM has the necessary data, which are computerized, to make the Simplified Method calculation. The officials GAO spoke with said that a calculation formula could easily be programmed to determine the tax-free amount and subtract it from the retiree's gross annuity amount. They also said the costs of doing so would not be large. OPM expects to report taxable amounts on tax year 2000 Forms CSA 1099R in January 2001 for employees who retired after November 18, 1996. The officials said that OPM has taken other actions to help retirees calculate the taxable amount.


The Judicial Survivors' Annuities System (JSAS) is one of several survivor benefit plans applicable to specific groups of federal workers. JSAS provides annuities to the surviving spouse and dependent children of deceased federal judges and other judicial officials. GAO is required to review JSAS' costs every three years and determine whether the participants' contributions covered one-half of the costs. If the contributions are less than one-half of these costs, GAO is to determine what adjustments would be needed to achieve the 50-percent figure. GAO found that participating judges did not pay one-half of the JSAS normal cost during fiscal years 1996 through 1998 and that the judges' contribution would need to increase 0.3 percentage points to cover one-half of the future costs. However, increasing required contributions could affect judges' rate of participation and increasing participation was one of the major reasons for prior changes made to JSAS. GAO issued its first report on this subject in 1997. (See GAO/GGD—97–87.)


Federal workers covered by either of the government's two main retirement programs could retire with dramatically different benefits depending on whether and how they plan for retirement throughout their careers. Agencies' retirement education programs play an important role in helping federal employees make well-informed decisions about retirement planning. However, little is known about how agencies fulfill this role. This report discusses the views of the Office of Personnel Management (OPM) and retirement experts on the recommended elements of retirement education programs and describes OPM's and agencies' retirement education roles, responsibilities, and practices in the context of these elements.

Pursuant to a congressional request, GAO reviewed the United Mine Workers of America (UMWA) Combined Benefit Fund, focusing on: (1) the status of the Fund's financial position and its financing mechanism; (2) the impact of major court decisions on the assignment of beneficiaries; and (3) significant litigation and its related costs.

GAO noted that: (1) the Fund has been experiencing financial difficulties due to rising costs and a financing mechanism that has been negatively affected by recent court decisions; (2) according to the Fund's September 30, 1999, audited financial statements, the Fund had a cumulative deficit of $12.2 million; (3) the Fund's actuarial estimates that the cumulative operating deficit will increase to approximately $513 million by 2008; (4) in addition, the actuarial projection includes borrowing costs of $101 million during the same time frame, which results in a total deficit of $614 million; (5) the Fund is involved in extensive litigation arising from the Coal Act and normal business operations; (6) Fund officials classified their significant litigation into seven major categories: (a) constitutional cases; (b) Dixie Fuel court cases; (c) companies challenging assessments; (d) premium rate cases; (e) bankruptcy cases; (f) successorship cases; and (g) Evergreen cases; (7) Eastern Enterprises v. Apfel (1998) and Dixie Fuel Company v. Social Security Administration (1999) are two of the significant cases that have affected or may affect the assignment of beneficiaries; (8) Eastern resulted in approximately 8,000 beneficiary reassignments; (9) Dixie Fuel, which has not yet been implemented, could potentially result in the reassignment of 10,000 beneficiaries; and (10) the Fund has incurred legal costs of over $11 million for all significant cases since its inception.


Pursuant to a congressional request, GAO: (1) determined why some older persons do not use federal food relief programs; and (2) identified strategies that could be used to increase participation in these programs.

GAO noted that: (1) older persons do not participate in federal food assistance programs for many reasons; (2) some of these reasons cut across programs; (3) for example, older persons are often reluctant to accept food assistance because they believe such acceptance would compromise their independence; (4) additionally, some older persons associate accepting food assistance with welfare, which many older persons view negatively; (5) furthermore, funding constraints limit participation in several of the programs; (6) older persons' lack of awareness of the availability of programs and problems with access to transportation hinder participation in several of the programs; (7) other problems, however, are more program-specific; (8) state food stamp directors told GAO some eligible older persons believe the burden of applying for food stamps outweighs the expected low benefits; (9) unlike the other programs, the Child and Adult Care Food Program is limited in the benefits
it provides to senior citizens because a limited number of facilities participate in the program; (10) program officials, providers, and advocacy groups have identified a number of actions that might increase older persons' participation in nutrition assistance programs; (11) in some instances, the options suggested would likely require a large infusion of resources; (12) for example, nearly all of the state food stamp directors endorsed increasing the minimum benefit level from $10 to $25 per month; (13) GAO estimates that the annual cost of this increase in Food Stamp Program benefits would be about $102 million for older persons who participate and could increase participation resulting in additional annual costs of about $26 million; (14) similarly, Elderly Nutrition Program providers and officials administering the Commodity Supplemental Food Program suggested that additional funding is needed to expand both programs to serve more people; (15) at this time, neither the Food and Nutrition Service nor the Administration on Aging has estimated the additional cost that might result if more people were attracted to these programs; (16) other suggestions are not likely to be as costly; and (17) for example, state food stamp directors endorsed proposals to simplify the application process, such as automatically making older persons eligible for food stamps when they are approved for other means-tested programs, such as Medicaid.

_Pursuant to a congressional request, GAO provided information on the Food Stamp Program and its state activities to increase older Americans' participation and the number of elderly food stamp participants in each state. GAO reported on: (1) states' activities to encourage elderly participation in the Food Stamp Program; (2) states' actions, during the last 3 years, to implement suggestions by the Food and Nutrition Service to increase elderly persons' access to the program; (3) the number and percentage of older Americans' households in each state receiving food stamps in fiscal year 1998, the most recent year for which complete data are available; and (4) the average benefits received by elderly households in each state._

_Food Stamp Program: Information on the Costs of Special Diets. (GAO/RCED–00–144R, May 8, 2000)._ Pursuant to a congressional request, GAO provided information on the costs of food stamp recipients' special diets, focusing on the: (1) number of food stamp recipients whose special dietary costs exceed the maximum food stamp benefit; and (2) costs of recipients' special diets compared with the maximum food stamp benefit.

GAO noted that: (1) the federal government does not have the information to determine the number of food stamp recipients whose special diets exceed the maximum food stamp benefit; (2) while two federal government surveys provide some information about the number of food stamp recipients with special diets, no information is collected about the costs of these diets or the degree to which the special dietary needs of food stamp recipients are unmet due to their limited financial resources; (3) the costs of recipients' special diets can vary, according to Department of Agriculture (USDA) offi-
cials; (4) they explained that the costs of some of these diets can fall within the maximum food stamp benefit, or they can exceed it; (5) but they do not know how frequently special dietary costs exceed the maximum or to what extent the maximum is exceeded; (6) USDA officials were, however, able to identify situations in which the maximum benefits could fail to meet special dietary needs; (7) for example, they cited diets that require cans of oral nutritional supplements, which can each cost about half of the maximum daily benefit of $3.51; (8) GAO's comparison of the weekly costs of one special diet for hypertension showed that its costs were 41 percent more than the food stamp benefit; and (9) hypertension was the primary reason that food stamp recipients reported changing their diets in a prior 12-month period.

Food Stamp Program: Relatively Few Improper Benefits Provided to Individuals in Long-Term Care Facilities. (GAO/RCED–99–151, June 4, 1999).

In the seven states it reviewed, GAO identified about 4,500 people living in long-term care facilities who were potentially improperly included as members of households receiving food stamps. These households could have received an estimated $500,000 in food stamp overpayments during 1997. These potential overpayments represented a very small percentage of the $8.5 billion in benefits distributed in the seven states that year. In view of the relatively small number of potential food stamp overpayments involving residents of long-term care facilities, GAO concludes that computer matching may not be practical for all of the seven states included in its review.


This publication is part of GAO's performance and accountability series, which provides a comprehensive assessment of government management, particularly the management challenges and program risks confronting federal agencies. Using a "performance-based management" approach, this landmark set of reports focuses on the results of government programs—how they affect the American taxpayer—rather than on the processes of government. This approach integrates thinking about organization, product and service delivery, use of technology, and human capital practices into every decision about the results that the government hopes to achieve. The series includes an overview volume discussing governmentwide management issues and 20 individual reports on the challenges facing specific cabinet departments and independent agencies. The reports take advantage of the wealth of new information made possible by management reform legislation, including audited financial statements for major federal agencies, mandated by the Chief Financial Officers Act, and strategic and performance plans required by the Government Performance and Results Act. In a companion volume to this series, GAO also updates its high-risk list of government operations and programs that are particularly vulnerable to waste, fraud, abuse, and mismanagement.

This volume reports the major management challenges at the Social Security Administration. Among the challenges are:
the long-term solvency of the Social Security system (the most critical overarching issue facing SSA);

- the implementation of new computer equipment, which is intended to play a major role in SSA’s redesigned work processes and in better serving of a larger beneficiary population;

- redesign of its disability programs to reduce long waiting times for case adjudication; and

- address long-standing problems associated with the Supplemental Security Income program regarding increasing program overpayments, inability to collect program debt, and vulnerability to fraud and abuse.


Pursuant to a congressional request, GAO reviewed the Social Security Administration’s (SSA) fiscal year (FY) 1999 performance report and FY2001 performance plan required by the Government Performance and Results Act of 1993.

GAO noted that: (1) SSA considers customer service one of its key priorities, and according to its FY1999 performance report, SSA met many of its goals related to providing accurate, timely, and useful service to the public; (2) SSA met key goals related to overall customer satisfaction and the timely processing of retirement claims; (3) however, SSA’s progress lagged in some areas, such as waiting times for persons with appointments and the accuracy of the handling of calls to its toll-free number; (4) in its FY2001 plan, as with its FY2000 plan, SSA has demonstrated its desire to use an even broader range of measures for customer satisfaction through its new Market Measurement Program; (5) the FY1999 report clearly indicates that making accurate and timely disability determinations remains one of SSA’s most challenging service areas; (6) in those cases where performance data were available, SSA did not meet any of the key goals it set for itself; (7) unmet goals included average processing times and other timeliness measures of disability decisions at both the initial application and appellate levels; (8) SSA’s FY2001 performance plan reflects some improvements in how SSA assesses its progress; (9) the FY1999 report also reflects that minimal progress has been made in reducing long-term disability benefits as a result of returning beneficiaries to work; (10) however, the FY2001 plan includes improvements; (11) SSA’s progress toward providing decisionmakers timely information necessary to address program policy issues in FY1999 was also unclear; (12) while SSA listed a number of research activities it conducted during the fiscal year, it was difficult to determine how timely or useful they were; (13) the FY2001 performance plan, however, reflects significant improvements; (14) the FY1999 report indicates that SSA met all key goals related to reducing fraud, waste, and error in the Supplemental Security Income (SSI) program; (15) the FY2001 plan reflects a continued commitment of effort and resources and contains additional measures for assessing error; (16) of the 9 management challenges known to SSA at the time it developed its FY2001 performance plan, SSA has established goals and measures for five, including long-term
program solvency, SSI program integrity, redesigning the disability claims process and focusing on return to work, program complexity, and service to the public; and (17) however, room for improvement both in measuring and achieving progress exist for each of these challenges.


About 53 percent of the employed labor force lacked a pension plan in 1998, a decrease of 5 percentage points from a decade earlier. The economic expansion since 1991 may have encouraged companies to offer pensions as part of their compensation packages and may have increased interest in pension coverage by persons in the labor force. About 39 percent of the employed labor force lacked a pension plan because their firms did not sponsor a plan, while 14 percent were ineligible or chose not to participate in their firm's plan. About 85 percent of those who do not have a pension plan had relatively low income, were employed part-time or part of the year, worked for a relatively small firm, or were relatively young. About 48 percent of retirees lacked pension income or annuities in 1998. These retirees were more likely to be single, female, less educated, and nonwhite. About 21 percent of retired persons without pension income had incomes below the federal poverty threshold, compared with three percent with pension income.


Pursuant to a congressional request, GAO provided information on private pensions, focusing on: (1) the prevalence and major features of cash balance plans, and reasons why firms adopt them; (2) how the use of cash balance plans affect the pension benefits for workers of different ages and tenure, particularly after conversion; and (3) what information employers converting to cash balance plans typically provide to plan participants and how disclosure might be improved.

GAO noted that: (1) GAO's survey of 1999 Fortune 1000 firms indicates that the number of firms sponsoring cash balance plans has increased within the last few years, with few firms sponsoring such plans prior to the early 1990s, but increasing to about 19 percent of all Fortune 1000 firms this year; (2) these plans cover an estimated 2.1 million workers; (3) firms in many sectors of the economy sponsor these plans but greater concentrations are found in the financial services, health care, and manufacturing industries; (4) about 90 percent of the firms GAO surveyed that sponsor such plans previously covered their workers under a traditional defined benefit plan; (5) most of the conversions occurred within the past 5 years; (6) key reasons firms gave for converting include lowering total pension costs, adding a lump sum feature to increase the portability of pension benefits, thereby improving the firm's ability to recruit more mobile workers, and facilitating communication of the value of plan benefits; (7) as with traditional pension plans, cash balance plan designs vary significantly; (8) conversions to cash balance plans can be advantageous to certain groups of workers, for example, to those who switch jobs frequently, but can lower pen-
sion benefits for others; (9) cash balance plans provide a larger share of a participant's accumulated benefit earlier in a career, compared with a traditional defined benefit plan that is based on final average pay; (10) as a result, conversions can increase the value of some workers' benefits, especially younger or short-tenured workers who leave firms before retirement; (11) unlike traditional defined benefit plans, cash balance plans can result in a declining rate of normal retirement benefit accrual over time; (12) this declining accrual rate can result in older workers receiving lower benefits at retirement from a cash balance plan than they would have from a traditional final average pay plan if it had not been converted; (13) current disclosure requirements provide minimum standards for the information plan sponsors must give participants about plan changes; (14) GAO found wide variation in the type and amounts of information workers receive; (15) the communications provided to employees vary from general statements about plan changes to specific examples of how a conversion to a cash plan might affect workers of different ages and tenure; and (16) often, sponsors did not ensure that participants received sufficient information about plan changes that can reduce future benefit accruals.


Pursuant to a congressional request, GAO reviewed the Internal Revenue Service's (IRS) programs for resolving pension-plan deviations from tax-exemption requirements, focusing on: (1) the frequency and types of pension plan qualification failures that were detected and corrected through IRS audits; (2) the frequency and types of pension plan qualification failures that were identified by pension plan sponsors and reported to IRS for approval of the correction; (3) the sanctions established under IRS' audit program with the compliance fees that could have been imposed if the same qualification failures had been self-reported by the pension plans to IRS; and (4) whether any cost-effective means, other than pension plan audits, have been identified that would detect unreported qualification failures.

GAO noted that: (1) of all IRS fiscal year (FY) 1999 qualification failure case closings, GAO's review showed that of 1,802 affected pension plans: (a) 42 percent experienced plan document failures (i.e., the documents governing plan operations did not comply with tax law requirements); (b) 66 percent experienced at least one operational failure (i.e., the plan did not operate in accord with plan documents); (c) less than 2 percent experienced demographic failures (i.e., the plans had failed certain tests for ensuring that pension benefits were provided in a nondiscriminatory manner); (d) 9 percent had both operational and document failures; and (e) in general, all types and sizes of plans were represented among those with qualification failures; (2) of a random sample of FY1999 closed audit cases, on average, pension plan sponsors were assessed monetary sanctions that GAO estimated were 10 times greater than the compliance fees that could have been assessed if the plan sponsors had reported the qualification failures to IRS for supervised correction; (3) however, there were substantial differences in this ratio, depending on the type of reporting program available to the plans
and the manner in which IRS applied its guidelines for assessing audit sanctions; (4) IRS officials said that, because of concerns expressed by pension groups, they had initiatives under way to ensure consistency among amounts assessed within compliance programs and coordination across compliance programs; (5) the pension experts GAO talked with at IRS and outside of the government generally viewed audits as an integral part of the government's efforts to promote voluntary compliance and preserve pension benefits for the U.S. workforce; and (6) while they did not identify any cost-effective alternatives to replace IRS audits, both IRS and the pension experts thought that enhancements could be made to existing IRS programs.


(PGAO/HEHS-00-141, Aug. 31, 2000).

Pursuant to a congressional request, GAO reviewed top-heavy rules in relation to other pension laws and regulations intended to ensure that workers benefit equitably from their pension plans, focusing on: (1) key differences between top-heavy rules and the general rules for nondiscrimination and vesting in contributions and benefits; (2) the most recent data available for GAO analysis on the characteristics of new plans that report being top-heavy; and (3) what is known about the overall effects of top-heavy rules on numbers of plans and participants and on employer costs.

GAO noted that: (1) top-heavy rules for measuring how benefits are apportioned, together with required minimum benefits and vesting, ensure that workers get certain minimum benefits that they would otherwise not receive under the general nondiscrimination and vesting rules; (2) top-heavy rules are designed to address situations prevalent in owner-dominated firms; (3) the rules identify pension plans in which the majority of benefits accrue to owners and officers, and they require higher minimum benefits and faster vesting for workers in such plans; (4) top-heavy rules utilize a single measure of the value of participants' accumulated contributions or benefits; (5) in contrast, nondiscrimination rules permit employers to choose among many optional measures for valuing the amount of benefits, a number of which may rely on projections that overstate the value of pension benefits workers actually receive; (6) use of certain nondiscrimination rules can leave workers who are outside the top employee group with annual employer contributions or benefits accruals that are well below those that are required if the top-heavy rules are applied; (7) new plans reporting top-heavy status tend to be small, defined contribution plans in the service sector of the economy; (8) approximately 84 percent of all top-heavy plans established in 1996, most recent year for which data were available, had fewer than 10 participants; (9) the vast majority of all new plans, and of new top-heavy plans, were defined contribution plans; (10) whereas plans of service firms comprised 52 percent of all new plans, service firm plans constituted 70 percent of new top-heavy plans in 1996; (11) within the service sector, two-thirds of plans started by physicians, dentists, and legal service firms were top-heavy, a rate far higher than for other parts of the service sector; (12) little is known about the overall effects of top-heavy rules on plan formation; (13) formidable data and meth-
odological challenges make it difficult to isolate the incremental effect of top-heavy rules form the many other economic and regulatory factors that influence employers' behavior regarding pension plan formation; (14) GAO found no research that has quantified the overall effects of top-heavy rules on the number of pension plans and participants; and (15) in evaluating top-heavy rules' impact, the federal government must weigh the extent to which top-heavy rules discourage coverage against the higher participant benefits they provide.


Pursuant to a congressional request, GAO reviewed the Pricewaterhouse Coopers (PwC) report on the actuarial projections for the trust funds of the Old Age, Survivors, and Disability Insurance programs, focusing on whether the Social Security Administration's (SSA) Board of Trustees' (1) 1999 long-range intermediate actuarial projections—their best estimates—as presented in the Trustees' 1999 report are based on generally accepted actuarial methods and techniques and include economic and demographic assumptions that contain no material defects because of errors or omissions and are individually reasonable; and (2) sensitivity tests include all assumptions that could have a significant effect on the projections and are reasonable.

GAO noted that: (1) PwC found that the actuarial methods and techniques used in preparing the long-range intermediate projections of the Social Security trust funds were sound; (2) it also found that the assumptions used in preparing the projections in the Trustees' report were individually reasonable at the time of the projections; (3) 7 months after the Trustees' 1999 report, on October 28, 1999, the Department of Commerce's Bureau of Economic Analysis released revised estimates of gross domestic product and other economic indicators for the period from 1959 through the second quarter of 1999; (4) PwC noted that these revisions may affect some economic assumptions and as a result, some assumptions may no longer be reasonable for future reports; (5) according to SSA officials, SSA actuaries have already begun reviewing the impact of these revisions for the Trustees' 2000 projections; (6) with regard to one of the demographic assumptions—mortality—the recent Technical Panel report concluded that the long-range cost of the Social Security system as currently designed is likely to be higher than previously projected; (7) the panel based its conclusions largely on indications that life expectancy will increase faster in the next century than currently assumed by the Trustees; (8) in contrast, PwC concluded that in the aggregate, the mortality assumptions used by the Trustees were reasonable; and (9) in addition, the sensitivity tests shown in the Trustees' report were reasonable.


The aging of the U.S. population poses a financing challenge for the Social Security program. Some have suggested including individual investment accounts as an element of Social Security re-
form. To help Congress better understand the potential implications of individual accounts, this report describes how such accounts could affect the (1) private capital and annuities markets as well as national savings, (2) potential returns and risks to individuals, and (3) disclosure and educational efforts needed to inform the American people about such a program.


Some proposals to restructure Social Security include individual retirement savings accounts that would either supplement or partially replace the current program’s benefits. Proponents say that such accounts would substantially improve rates of return that individuals could receive on their retirement contributions. Others say that the rate of return concept should not be applied to Social Security because it is a social insurance rather than an investment program.

Implicit rates of return on Social Security contributions vary significantly by birth year, reflecting the program’s income transfers to the first generations of retirees from subsequent generations. They also vary by earnings level, number of dependents and survivors, and life expectancy, reflecting other income transfers. Rates of return on private market assets vary substantially, depending on the risk of asset price volatility and the risk of firms’ defaulting on obligations. Individuals’ choice of assets in a portfolio and timing of investment decisions ultimately help determine their returns and risks.

A simple comparison between rates of return for the current Social Security program and private market investments would be misleading because it would not reflect all the costs associated with a new system of individual accounts. Rates of return under the new system would depend on how unfunded liabilities are paid and on costs for managing and annuitizing the new accounts. Also, future market investment returns could differ from historic averages, and risks differ between Social Security and market investment. Comparisons should be made instead between comprehensive return estimates for specific reform proposals that include both individual accounts and the Social Security components of the resulting system. However, this is only one criterion for comparing proposals; other criteria include the adequacy and predictability of benefits, the extent of solvency improvement, and the effect on the federal budget and national saving.


Pursuant to a congressional request, GAO reviewed the Social Security Administration’s (SSA) efforts to implement a National Performance Review (NPR) recommendation to reduce its management-to-staff ratio, focusing on the: (1) progress SSA has made to date in achieving the directive to reduce its management-to-staff ratio, particularly for staff graded GS–12 and above; and (2) steps SSA has taken to reduce the number of supervisory positions.
GAO noted that: (1) SSA is making progress in its efforts to achieve a supervisor-to-staff ratio of 1-to-15 by the close of fiscal year (FY) 1999; (2) by the end of FY1998, the agency had reduced its supervisor-to-staff ratio to 1-to-12.4 from about 1-to-7 in FY1994; (3) SSA achieved these reductions, consistent with the Office of Personnel Management guidance, by use of a number of special initiatives available to federal departments and agencies; (4) according to SSA officials, these initiatives included early retirements, employee buyouts, and reassignment of supervisory staff to newly created nonsupervisory positions; (5) since FY1993, SSA has created a total of 1,900 new nonsupervisory positions—550 team leader positions in headquarters and an additional 1,350 management support specialists and area systems coordinator positions in field offices; and (6) all of the 550 headquarters positions and 1,222 of the 1,350 regional office positions have been filled.


Pursuant to a congressional request, GAO assessed the equality of the Social Security Administration’s (SSA) letters to the public, focusing on the: (1) problems that make SSA’s letters difficult to understand; and (2) status of SSA’s actions to fix the problems.

GAO noted that: (1) the majority of letters in each of the four categories GAO reviewed did not clearly communicate at least one of the following key points: (a) SSA’s decision (that is, the action SSA was taking on a claim that prompted the agency to send the letter); (b) the basis for SSA’s decision; (c) the financial effect of SSA’s decision on the person addressed in the letter; or (d) the recourse the person could take in response to SSA’s decision; (2) the lack of clarity was caused by one or more problems, such as illogically sequenced information, incomplete or missing explanations, contradictory information, and confusing numerical information; (3) an unclear explanation of the basis for SSA’s decision was the most widespread problem among the four categories of letters; (4) for example, it was difficult to understand the basis for SSA’s decision in Supplemental Security Income (SSI) award letters because the letters did not explain the relationship between program rules and the amount of the SSI benefit; (5) a subgroup of SSI award letters—those sent to about 13 to 15 percent of SSI awardees who are eligible for previous but not a future month’s benefits—were unclear in communication all four key points; (6) SSA acknowledges that these letters contain the problems GAO identified; however, for many of the problems, the agency has not taken any corrective action; (7) many of the problems GAO identified are not amenable to quick fixes but, rather, will require a comprehensive revision of the language used in the letters and rewriting the agency’s software applications that generate them; (8) the agency has repeatedly rescheduled plans to make comprehensive changes for its Social Security benefit adjustment letters because of competing demands of computer systems resources; the agency allocated resources to other priorities, such as making computer system changes that resulted from legislation; (9) however, the agency announced plans to make significant changes to this category of let-
ter, but few details are yet available; (10) major improvements to SSI letters were also delayed, but in this case SSA was waiting for resolution of a nationwide court case involving these letters; (11) in September 1999, a federal court ordered SSA to develop and implement a plan to improve its SSI letters, prompting SSA to begin a major, multiyear initiative to improve its SSI award and benefit adjustment letters; (12) this initiative is still in the early phase; and (13) SSA has not placed a high priority on improving its letters to the public.


Pursuant to a congressional request, GAO provided information on the Social Security Administration’s (SSA) efforts to prepare its workforce to meet future service delivery challenges. This information was requested subsequent to our February 2000 testimony, SSA Customer Service: Broad Service Delivery Plan Needed to Address Future Challenges (GAO/T-HEHS/AIMD-00-75, February 10, 2000).


Proposals to protect the Social Security program’s future solvency and sustainability include creating a system of individual accounts for accumulating retirement savings. Available studies of the costs to run a system of individual accounts do not capture all the likely costs. For example, the costs of government oversight, enforcement activities, and public education are generally not included. Designers of a system of individual accounts must make critical decisions about who would assume the new administrative and record-keeping responsibilities, how much choice individuals would have in selecting and changing their investment options, and how retired workers would receive their benefits. Administrative costs would vary, depending on these decisions and the types and level of customer service offered. They could be higher for more decentralized systems and for those offering broader investment choices, more customer service options, or both. In GAO’s analysis, a man who had average annual earnings every year for 45 years would accumulate $125,430 (in 1998 dollars) in his account under a 0.1-percent annual administrative cost, as opposed to $75,995 under a two-percent administrative cost. If individuals bought an annuity, ensuring a steady stream of income throughout retirement, the average administrative cost in the current market would be five percent of the amount being converted into the annuity.


This report applies GAO’s criteria for assessing Social Security reform proposals to the plan outlined by Senator Phil Gramm. GAO’s report is based on an analytical framework that the agency provided to Congress last March. That framework consists of the following three criteria: the extent to which the proposal achieves
sustainable solvency and how it would affect the U.S. economy and the federal budget; the balance struck between the twin goals of income adequacy (level and certainty of benefits) and individual equity (rates of return on individual contributions); and how readily such changes could be implemented, administered, and explained to the public.


This report applies GAO's criteria for assessing Social Security reform proposals to the plan outlined by Congressman Nick Smith. GAO's report is based on an analytical framework that the agency provided to Congress last March. That framework consists of the following three criteria: the extent to which the proposal achieves sustainable solvency and how it would affect the U.S. economy and the federal budget; the balance struck between the twin goals of income adequacy (level and certainty of benefits) and individual equity (rates of return on individual contributions); and how readily such changes could be implemented, administered, and explained to the public.


Under an option available to state and local governments until 1983, three Texas counties withdrew from Social Security in 1981 and replaced it with a system of individual accounts that provided retirement, survivor, and disability benefits to their employees. Social Security faces a long-term funding shortfall, and some have suggested that the experience of these three counties underscores the advantages of individual accounts as an element of Social Security financing reform. GAO found that although Social Security and the alternate plans of the three Texas counties offer retirement, disability, and survivor benefits, there are fundamental differences in the purpose and the structure of the two approaches. Social Security is a social insurance program designed to provide a basic level of retirement income to help retired workers, the disabled, and their dependents and survivors avoid poverty. Social Security benefits are tilted to provide relatively higher benefits to low-wage earners and the benefits are fully indexed to protect against inflation. Social Security, a pay-as-you go system, is projected to produce a negative cash flow in 2013 and become insolvent by 2032. In contrast, the alternate plans are advance-funded; that is, the contributions made by workers and their employers, which total 13.915 percent of workers' pay, and the earnings from those invested contributions are used to fund retirement benefits. At retirement, a worker can withdraw the money in the account as a lump sum or choose from several monthly payment options, including the purchase of a lifetime annuity. GAO's simulations of how workers for the three Texas counties and their dependents might fare under the two systems revealed that outcomes generally depend on individual circumstances and conditions. For example, the alternate plans provide larger benefits for high-wage workers than Social Security would, but in some cases, such as when spousal benefits are involved, Social Security benefits could also eventually
exceed those of the alternate plans. GAO notes that the alternate plans' performance is not necessarily indicative of how well individual accounts might perform within Social Security. For example, the alternate plans have followed a very conservative investment strategy that precludes investing in common stocks.


Social Security is one of the nation's most important and visible programs. Although individual accounts offer the possibility of an improved rate of return on individual contributions, a flawed or failed system of individual accounts could have devastating effects on individuals' retirement security and undermine public confidence in government. GAO believes that the following three critical questions need to be addressed in designing and implementing a system of individual accounts: Who would assume new administrative and record-keeping responsibilities? How much choice would individuals have in selecting and controlling their investment options? How much flexibility would workers have when they retire and begin to draw on their accounts? This report discusses the fundamental choices associated with each question and several options that could be considered.


The private annuities market would likely be able to provide annuities for individual accounts in a reformed Social Security system, but their structuring would significantly affect retirees' income. Requiring workers to buy annuities with their individual account balances would help preserve their retirement income but would also expose them to risks and costs in retirement that they do not currently face. Some options that would mitigate the effects of various costs on annuity payments would require limiting retirees' payout choices. In a reformed Social Security system in which individuals were required to buy annuities, they would need to fully understand the factors affecting their annuity income and its protection. The federal government would need to play some role in ensuring that insurance markets worked efficiently or in providing annuities if the private market failed to do so. To protect annuitants and ensure their equal treatment, the government might have to establish uniform guaranty protections for them and standardized solvency requirements for insurance companies. Policymakers would need to balance the states' longstanding authority to regulate insurance markets with the desire for uniform protections for the annuitants.


Raising the normal or earliest eligibility age or both could have substantial net positive effects on the financial integrity of the Old-Age and Survivors Insurance and Disability Insurance Trust Funds. These measures would reduce the retirement benefits paid out and increase the payroll taxes collected. Raising the retirement age would boost the number of older workers in the labor force, as
more workers would be employed for longer periods of time. Increasing the number of older workers in the labor force, however, could also create the potential for additional unemployment. An understanding of the cumulative effects of any reform proposal is essential to preventing a disproportionate burden from falling on vulnerable groups, such as minorities, who are most likely to be in blue-collar jobs and to experience unemployment.


This report applies GAO's criteria for assessing Social Security reform proposals to the plan outlined by Congressmen Archer and Shaw. GAO's report is based on an analytical framework that the agency provided to Congress last March. That framework consists of the following three criteria: the extent to which the proposal achieves sustainable solvency and how it would affect the U.S. economy and the federal budget; the balance struck between the twin goals of income adequacy (level and certainty of benefits) and individual equity (rates of return on individual contributions); and how readily such changes could be implemented, administered, and explained to the public.


This report discusses the design components of retirement programs that states offer to their general employees and compares them to the design components of the two principal federal retirement programs for federal workers—the Federal Employees' Retirement System and the Civil Service Retirement System. GAO also describes the changes that the states have considered and made to their retirement programs.


A GAO analysis of the Internal Revenue Service's (IRS) accounts receivable data as of September 1997 found that more than 1.9 million self-employed taxpayers were delinquent in paying $6.9 billion in self-employment taxes on 3.6 million returns. These taxpayers generally have low incomes and multiple delinquencies. More than 144,000 taxpayers with delinquent self-employment taxes of $487 million were receiving about $105 million in monthly Social Security benefits. The income on which the self-employment taxes had not been paid resulted in an estimated $2.5 million in monthly benefits that would not have been paid if those earnings had not been included in the benefit computation. Self-employed taxpayers can get Social Security benefits on the basis of earnings for which they did not pay taxes because the law requires the Social Security Administration (SSA) to grant earnings credits, which are used to determine benefit eligibility and amounts, and pay benefits without regard to whether the Social Security taxes have been paid. However, not all self-employed taxpayers can receive credit for their earnings. Under the law, when taxpayers do not file their tax returns within 3 years, 3 months, and 15 days after the end of the year in which the income was earned, they are not to receive Social
Security credit. Of the 3.6 million returns with delinquent self-employment tax, SSA did not post earnings to its records for nearly 474,000 returns. For an estimated 81.9 percent of the returns with unposted earnings, taxpayers filed the returns after the statutory time limit. Many of the taxpayers may have been unaware of the statutory time limit because neither SSA's nor IRS' widely available publications discuss it. GAO notes several ways to enhance the collection of taxes from self-employed persons.

VETERANS AND DOD ISSUES

Defense Health Care: Improvements Needed to Reduce Vulnerability to Fraud and Abuse. (GAO/HEHS-99-142, July 30, 1999.)

It is impossible to quantify precisely the amount lost to fraud in the military health care system, but the Defense Department (DOD) and the health care industry generally agree that fraud and abuse could account for as much as 20 percent of all health care costs. Because DOD spent 5.7 billion on managed care contracts between 1996 and 1998, DOD could have lost more than $1 billion to fraud and abuse during this time. Fraud and abuse can also undermine the quality of care provided and can harm patients' health. For example, patients might receive incorrect diagnoses and inadequate treatment when a provider bills DOD for fabricated test results. DOD and its contractors have had limited success in identifying fraud and abuse in TRICARE—DOD's managed health care system. To its credit, DOD recognizes that it needs to reduce its vulnerability to fraud and abuse and has identified several revisions it could make to its antifraud policies and requirements. However, it has been slow to implement these policy changes, which would require contractors to establish a more aggressive fraud and abuse identification program.


GAO has been working with the Department of Defense (DOD) to develop and report a reliable estimate for the post employment health care benefits due to military retirees, their dependents, and survivors. To help accomplish this, the DOD Office of Actuary prepared a sensitivity analysis that identified the health care liability's key data elements and assumptions and determined what amount of change in each element was required to raise or lower the resulting liability by a set amount. Because of the technical nature of actuarial projections, GAO hired a contractor to evaluate the completeness and accuracy of the DOD sensitivity analysis and also review the methodology that DOD used to calculate the retiree health care benefits liability. This report provides a non-technical summary of the contractor's findings and includes GAO's recommendation that DOD implement the improvements discussed in the contractor's reports. In general, the contractor found that the sensitivity analysis did a good job of identifying the factors that affect the liability and of evaluating their relative impact on the liability calculation. However, the contractor did identify several issues that should be addressed in order to make the analysis more complete and a few areas where an additional breakout of informa-
tion is needed in order to adequately analyze its impact on the calculation. Finally, the contractor found that DOD's methodology was generally reasonable but it was not fully documented and one of the five calculations that were tested by the contractor was erroneous.


In a report on the government's consolidated financial statements for fiscal year 1997, GAO noted that the Department of Veterans Affairs' (VA) estimated liability for veterans' compensation benefits was materially understated primarily because it did not include estimates for anticipated changes in disability ratings and for incurred claims not yet reported. (See GAO/AIMD–98–127, Mar. 1998.) Because of these limitations, VA's methodology for computing the liability did not comply with Statement of Federal Financial Accounting Standards (SFFAS) No. 5, which prescribes accounting standards for the federal government's liabilities. VA revised its model to comply with SFFAS No. 5 before issuing its own audited financial statements for the Department in April 1998. Using the revised model, VA's estimated liability as of September 30, 1997, in its April 1998 report was $466 billion—an increase of $270 billion over that reported in the government's consolidated financial statements for fiscal year 1997. This report discusses the improvements that VA has made to the model and makes recommendations for additional improvements that should enhance the reliability of estimates produced by the model.


To improve information technology (IT) investment decision-making at the Department of Veterans Affairs (VA), GAO recommends that the agency (1) establish and monitor deadlines for completing formal in-process reviews at key milestones in a project's life cycle, (2) provide decisionmakers with information on lessons learned from IT post-implementation reviews, and (3) develop and implement guidance to better manage IT projects. To fully address these provisions, VA needs to fill the position of assistant secretary for information and technology as quickly as possible, reassess its decision to delegate business process reengineering to the individual administrations, and direct the department's Chief Information Officer or designee to lead the effort to work with VA business owners to develop a logical architecture as a step toward an integrated IT architecture.


This publication is part of GAO's performance and accountability series which provides a comprehensive assessment of government management, particularly the management challenges and program risks confronting federal agencies. Using a "performance-based management" approach, this landmark set of reports focuses on the results of government programs—how they affect the American taxpayer—rather than on the processes of government. This
approach integrates thinking about organization, product and service delivery, use of technology, and human capital practices into every decision about the results that the government hopes to achieve. The series includes an overview volume discussing governmentwide management issues and 20 individual reports on the challenges facing specific cabinet departments and independent agencies. The reports take advantage of the wealth of new information made possible by management reform legislation, including audited financial statements for major federal agencies, mandated by the Chief Financial Officers Act, and strategic and performance plans required by the Government Performance and Results Act. In a companion volume to this series, GAO also updates its high-risk list of government operations and programs that are particularly vulnerable to waste, fraud, abuse, and mismanagement.

This report addresses the major management challenges at the Department of Veterans Affairs. Among the challenges are:

- Obsolete infrastructure in VA's health care system;
- Poor monitoring of the effects of health-care delivery changes on patient outcomes;
- Inadequate data to ensure that veterans have access to needed health-care services;
- Ineffective management of non-health-care benefits; and
- Ineffective management of VA's management information system.


Pursuant to a congressional request, GAO reviewed the Department of Veterans Affairs' (VA) fiscal year (FY) 1999 performance report and FY2001 performance plans required by the Government Performance and Results Act.

GAO noted that: (1) VA's FY1999 performance showed progress in providing quality health care at a reasonable cost; (2) although VA did not meet all of its FY1999 performance goals, it met one of its most important goals—to reduce the average health care cost per patient by 13 percent since FY1997—actual performance reported was a 16-percent reduction; (3) VA failed to meet its FY1999 performance goals related to the timely and accurate processing of veterans' benefit claims; (4) these goals covered the accuracy and timeliness of VA decisions on claims for compensation and pension benefits, and the timeliness of resolution of veterans' appeals of claims decisions; (5) VA set a FY1999 goal to complete decisions on compensation and pension claims in an average of 99 days—actual performance was 166 days; (6) another goal was to resolve initial decisions appealed to VA's Board of Veterans Appeals within an average of 590 days—actual performance was 745 days; (7) the revised FY2001 goal for claims processing timeliness is 142 days, the goal for appeals resolution timeliness is 650 days; (8) in FY1999, VA achieved both performance goals related to helping disabled veterans acquire and maintain suitable employment; (9) in particular, 53 percent of veterans who exited the vocational rehabilitation program obtained and maintained suitable employment—technically exceeding the performance goal of 45 percent; (10) while
this rehabilitation rate generally shows VA's progress in moving the vocational rehabilitation program's focus toward helping veterans find employment, it does not fully measure program results because it: (a) focuses on veterans who left the program, rather than on all veterans eligible for the program; and (b) does not consider how long it took veterans to complete the program; (11) VA does not have any performance goals and measures directly related to reducing the availability and use of illegal drugs; (12) however, VA slightly exceeded its one performance goal indirectly related to this outcome; (13) in FY1999, 56 percent of the patients with primary addictive disorders showed improvement in their addiction severity index (ASI) composite scores at 6 months after their initial assessment; and (14) in its FY2001 performance plan, VA changed its goal to assess the percentage of patients who receive a 6-month follow-up ASI assessment.


GAO recommends that the Department of Veterans Affairs (VA) implement more effective health care capital asset planning and strengthen its budgeting processes to avoid spending billions of dollars operating hundreds of unneeded buildings over the next five or more years. VA should focus on Office of Management and Budget guidelines that suggest that agencies use market-based assessments to determine target population needs, evaluate the capacity of existing assets, identify excesses and deficiencies, estimate assets' life-cycle costs, and compare these with alternatives for meeting the population's needs. VA has 40 markets with two to nine VA locations that have utilization significantly below inpatient capacity and that compete with other VA locations to serve rapidly declining veteran populations. VA could restructure these assets and enhance veterans' benefits. VA has 66 other markets with a single VA location, many in areas with rapidly declining inpatient workloads and veteran populations, where assets could be restructured and benefits enhanced. VA's centralized budget development process, which reviews and approves capital investments of $4 million or more under its major construction appropriation relies on inconsistent or incomplete information for decision-making. The 22 regional offices that make less expensive investment decisions in VA's decentralized assessment process generally do so without systematically assessing ways to redesign or simplify work processes or explore lower-cost alternatives. Such decisions account for more than 85 percent of VA's total health care investment dollars requested for fiscal year 2000. Over the past 3 years, VA has significantly reduced the number of high-cost investment proposals involving alterations or improvements by dividing them into less expensive ones, which require less information about benefits, risks, and alternatives. This has resulted in VA's decentralized process having approved investments that VA's centralized process considered, or would consider, to be a low priority or unsound.

Pursuant to a congressional request, GAO reviewed how the Department of Veterans Affairs (VA) manages its national formulary and how drugs other than those on the formulary are made available to veterans. GAO noted that: (1) VA's national formulary is administered by the Pharmacy Benefits Management Strategic Healthcare Group (PBM), a strategy modeled after one commonly used in private health care systems; (2) PBM adds drugs to, and deletes drugs from, the national formulary on the basis of a review of current literature related to drugs' safety and efficacy and the contributions they can make in treating veterans; (3) PBM also performs drug class reviews that determine which drugs are therapeutically interchangeable—essentially equivalent in terms of efficacy, safety, and outcomes; (4) this determination allows VA to obtain better prices for one or more of these drugs by using competitively bid contracts; (5) PBM safeguards against inappropriate use by requiring that clinical guidelines be followed when some drugs are used, limiting prescribing privileges in certain cases to specially trained physicians; and in other cases, requiring consultation with a specialist before a drug can be prescribed; (6) drugs not on the national formulary may be available to veterans through independent formularies maintained by Veterans Integrated Service Networks (VISN) and some medical centers; (7) these formularies are designed to provide local facilities flexibility by giving physicians access to additional drugs that meet the special needs of their patients; (8) if prescribers believe that a patient needs a drug that is not on the national, VISN, medical center formulary, they may request a nonformulary drug waiver, which would allow the prescriber to provide the nonformulary drug; (9) new drugs may be added to VISN and medical center formularies immediately upon Food and Drug Administration approval; (10) however, VA policy states that new drugs generally may not be added to the national formulary until they have been on the U.S. market for at least 1 year because VA believes veterans may be exposed to potential side effects that are not identified during the drug review and approval process; and (11) this potentially allows veterans treated in some facilities to benefit from new drugs before veterans in other locations, but it may also expose them to any side effects that are identified within the first year of a drug's general use.

VA Information Systems: Computer Security Weaknesses Persist at the Veterans Health Administration. (GAO/AIMD-00-232, Sept. 8, 2000).

In conjunction with the Department of Veterans Affairs (VA) required annual financial audit, GAO reviewed information system general controls over financial and sensitive veteran medical information maintained by the Veterans Health Administration (VHA), focusing on: (1) specific computer security weaknesses GAO identified at the New Mexico and North Texas health care systems in conjunction with the audit of the Department of Veterans Affairs (VA) fiscal year (FY) 1997 financial statements; and (2) departmentwide computer security initiatives that GAO reported in October 1999.
GAO noted that: (1) in September 1998, GAO reported that computer security weaknesses placed critical VA operations, including health care delivery, at risk of misuse and disruption; (2) since then, VA’s New Mexico and North Texas health care systems have corrected most of the specific computer security weaknesses that were identified in 1998; (3) however, serious computer security problems persist throughout VHA and the department because: (a) VA has not yet fully implemented an integrated security management program; and (b) VHA had not devoted adequate resources to effectively manage computer security at its medical facilities; (4) consequently, financial transaction data and personal information on veteran medical records continue to face increased risk of inadvertent or deliberate misuse, fraudulent use, improper disclosure, or destruction, possibly occurring without detection; (5) GAO identified additional computer security problems at the New Mexico and North Texas health care systems and also found similar serious weaknesses at the VAMaryland Health Care System; (6) these medical facilities had not adequately controlled access granted to authorized users, prevented employees from performing incompatible duties, secured access to networks, restricted physical access to computer resources, or ensured the continuation of computer processing operations in case of unexpected interruption; (7) the access and service continuity weaknesses GAO found are similar to problems consistently identified since 1998 at VHA medical facilities by VA’s Office of Inspector General (OIG), internal VHA reviews, and consultant studies; (8) VA’s OIG has reported departmentwide information system security as a material internal control weakness since the FY1997 consolidated financial statement reporting period; (9) VA recognized the significance of these problems and began reporting information system security as a material weakness in its Federal Managers’ Financial Integrity Act of 1982 report for 1998; (10) one reason for VA’s continuing information system control problems is that the department had not implemented a comprehensive, integrated security management program; (11) initiating a process to review and build on security practices developed by other VA organizations could expedite VA efforts to develop departmentwide guidance in these areas; and (12) until VA develops and implements a comprehensive, coordinated security management program and ensures that adequate resources are devoted to this program, it will have limited assurance that financial information and sensitive veteran medical records are adequately protected from misuse, unauthorized disclosure, and/or destruction.


The Department of Veterans Affairs (VA) pays monthly compensation benefits to veterans with injuries or diseases incurred or aggravated while on active military duty and monthly pension benefits to wartime veterans who have low incomes and are permanently and totally disabled for reasons not connected to their service. The Veterans Benefit Administration’s (VBA) new accuracy measurement system, deployed at the beginning of fiscal year 1999, indicates that VBA needs to give more attention to ensuring that
the regional offices that process compensation and pension claims make correct decisions the first time so that veterans need not make unnecessary appeals or be unnecessarily delayed in receiving benefits. Compared with VBA's previous system, the new one focuses more on regional office decisions that are likely to contain processing errors, uses a stricter method for computing accuracy rates, provides more data on the performance of VBA's organizational levels, collects more data on processing errors, and stores more accurate review results in a centralized database for review and analysis. However, VBA should (1) further strengthen its ability to identify error-prone cases by collecting more detailed data on the human body systems, specific impairments, and deficiencies in medical evidence and examinations involved in disability claims, (2) implement a system for reviewing claims-processing accuracy that meets standards on separation of duties and organizational independence, and (3) keep Congress informed on its progress in establishing stricter employee accountability and developing more effective training for claims adjusters.

MULTIPLE ISSUES


This statement, which was originally prepared for a hearing before the Senate Budget Committee, discusses the President's Midsession Review and the implications of the President's proposals for fiscal policy and the federal budget. After years of budgetary belt tightening and difficult policy decisions, the goal of budget balance has finally been achieved. Congress and the President now face a series of choices that will have a major impact on the nation's economic future. Despite the euphoria surrounding the projected surpluses, the reality is that the country has run up a large debt from years of deficit spending. Using a significant portion of the surplus to pay down the debt would ultimately lower interest costs and spur economic growth. The miracle of compounding means that interest payments saved today will yield huge dividends tomorrow. Few, however, expect the entire projected surplus to go to debt reduction, and choices will have to be made about shoring up entitlement programs, boosting defense spending, and providing tax cuts. At the same time, looming demographic trends demand that the surplus be put to good use. The fact remains that our society is aging. Less than 10 years from now, the baby boomers will begin drawing retirement benefits. GAO projects that even if the country were to save the entire surplus and adhere to the budget caps, the combined spending pressures of Social Security, Medicare, and Medicaid would eventually reignite the vicious circle of escalating deficits, debt, and interest costs. Debt reduction must be accompanied by entitlement reform. In his midsession budget review, the President proposes to reduce publicly held debt more than he did in his February budget. He also wants to increase spending in several areas. But the big items in the budget continue to be Social Security and Medicare. Until these two programs are fundamentally reformed, their long-term solvency and sustainability will remain in doubt. The surplus presents both an oppor-
tunity and an obligation: to reduce the debt burden, to provide a strong foundation for future economic growth, and to ensure that government's future commitments are both adequate and affordable.


Pursuant to a congressional request, GAO provided information on federal mandatory spending on the elderly.

GAO noted that: (1) GAO estimates that federal mandatory spending on the elderly for the applicable programs as a share of gross domestic product (GDP) will grow from 6 percent in 2000 to 6.5 percent in 2010; (2) in the following decade, as the baby boom generation begins to retire, this spending will accelerate, reaching 8.4 percent of GDP in 2020; (3) this represents a growth of about 30 percent in federal mandatory spending on the elderly as a share of GDP between 2010 and 2020; (4) not surprisingly, Social Security and Medicare comprise the largest share of federal spending on the elderly; (5) Medicaid's spending on the elderly as a share of GDP is projected to grow the fastest, doubling over the next 20 years; (6) on the other hand, GAO's estimates show that federal spending on civilian and military retirees is projected to remain relatively constant as a share of the economy; (7) future claims of the elderly on the economy are likely to be larger than indicated by GAO's estimates; (8) for example, GAO's estimates do not include federal tax expenditures targeted to the elderly, such as the extra standard deduction for those elderly taxpayers who do not itemize deductions, Veterans Administration expenditures for the elderly, other federal programs targeted to or used by the elderly (including those for housing and food assistance), or spending by state and local governments; and (9) GAO's estimates also do not include private spending on the elderly, such as for pensions, prescription drugs, or long-term care including out-of-pocket costs and hours of work foregone by those caring for elderly parents.


The Balanced Budget Act of 1997 authorized a three-year test—called Medicare subvention—that allows Medicare-eligible military retirees, their dependents, and survivors to enroll in a new Department of Defense (DOD) health maintenance organization (HMO). The goal is to offer accessible, quality care while keeping costs down for DOD and Medicare. Care for these beneficiaries at military treatment facilities is now provided on a space-available basis that lacks the continuity often important to many older retirees. Under the Medicare subvention demonstration, Medicare will pay DOD for health care provided to retirees at six sites. DOD will provide enrollees with the full range of Medicare-covered services as well as some additional ones. In principle, beneficiaries, DOD, and Medicare could all gain under subvention. Because of data inaccuracies in DOD's medical cost accounting systems, portions of DOD's baseline costs may be understated, and this, if not adjusted, could lead to Medicare overpayments. Data problems also make the
demonstration project more difficult to manage at both the national and local levels. DOD officials have developed a management improvement plan to begin addressing data weaknesses and HCFA plans to hire a contractor to review DOD's data.


Many military retirees would like to use their Medicare benefits at military medical facilities, but federal law does not allow Medicare to pay the Defense Department (DOD). Many retirees can get health care at military facilities only when space is available and cannot rely on them for comprehensive, continuous care. DOD is willing to provide such care to these retirees if the law is changed so that Medicare could reimburse DOD. In light of these concerns, recent legislation authorized a three-year, six-site demonstration project, called Medicare subvention, which allows Medicare-eligible military retirees to enroll in a new, DOD-run health maintenance organization (HMO). Medicare can pay DOD for the health care provided to retirees enrolled in the demonstration project, subject to certain conditions. The demonstration's goal is to implement an alternative for delivering accessible and quality care to these "dual-eligible" retirees without increasing the cost to Medicare or DOD. This report examines enrollment in DOD's pilot HMOs for seniors. GAO discusses (1) how successful the demonstration has been in enrolling eligible beneficiaries, (2) what influenced retirees to join DOD's pilot HMOs, and (3) what factors accounted for differences in enrollment rates across demonstration sites.

**VA Health Care: Supply of Nursing Home Beds Is Sufficient to 2005 in the Detroit, Michigan, Area.** (GAO/HEHS-00-164R, Aug. 21, 2000).

Pursuant to a congressional request, GAO reviewed the Department of Veterans Affairs' (VA) needs assessment of nursing home care in Detroit, Michigan. GAO noted that: (1) VA's conclusion in its assessment—that the supply of beds available to VA in 2005 will be sufficient to meet VA's needs—is likely to be correct; (2) even allowing for underestimates by VA regarding demand for nursing home care and overestimates of the supply of nursing home beds, the supply of beds available is likely to be sufficient to meet demand; (3) to determine whether the number of nursing home beds would be adequate, VA used 1996 national nursing home use rates and current population projections to estimate the total demand for nursing home beds in 2005; (4) it then used current Detroit-area data from the Health Care Financing Administration on nursing home bed availability to project the likely number of beds that would be available in 2005; and (5) VA concluded that the supply would be sufficient to meet projected demand.
CALENDAR YEARS 1999 AND 2000 TESTIMONIES ON ISSUES AFFECTING OLDER AMERICANS

GAO testified 68 times before Congressional committees during calendar years 1999 and 2000 on issues relating to older Americans. Of these testimonies, 49 were on health issues, 10 on income security issues, 7 on veterans and DOD issues and 2 were on multiple issues.

HEALTH ISSUES


This testimony summarized our January report, Adverse Drug Events: The Magnitude of Health Risk Is Uncertain Because of Limited Incidence Data. (GAO/HEHS–00–21, Jan. 18, 2000).

Adverse Events: Surveillance Systems for Adverse Events and Medical Errors. (GAO/T-HEHS–00–61, Feb. 9, 2000).

Adverse events are injuries to patients caused by medical treatment. Medical errors are mistakes in medical care that may or may not harm a patient. Identifying adverse events and evaluating their causes are important parts to any strategy to reduce harm to patients. Several recent GAO reports have considered surveillance systems for medical products, particularly drugs and medical devices. (See GAO/HEHS–00–21, Jan. 2000, and GAO/HEHS–97–21, Jan. 1997.) GAO testified that although adverse events are recognized as a serious problem, the full magnitude of their threat to the American public is unknown. At the same time, gathering valid and useful information on adverse events is extremely difficult. For example, systems that rely on health care providers to take the initiative to make a report suffer from serious limitations. Moreover, many of the injuries that patients suffer as a result of medical treatment do not stem from errors but reflect the inherent risks of treatments that are administered correctly. It can be difficult to identify these adverse reactions and distinguish them from medical errors or from the course of a patient's underlying illness.


The National Blood Data Resource Center projects that the demand for blood will outstrip its supply by next year. GAO believes that the Center has overstated the decline in supply. Most of the decline the Center found was in donations targeted for specific individuals, not in the community supply available to everyone else in need. Also, blood banks fear that supply losses will exceed estimates of losses arising from the Food and Drug Administration's recommended exclusion of blood donated by individuals who spent six or more months in the United Kingdom between 1980 and
1996. The exclusion is based on concern over the transmissibility of a new variant of so-called "mad cow" disease among humans. The Department of Health and Human Services has proposed removing barriers to donations from individuals with hemochromatosis, a treatable iron-overload disease, to make up for some of the loss from U.K. donors, but consequent increases in blood supply would have to wait for changes in current regulations. GAO concludes that the blood supply is not in crisis but that there is cause for concern about the possibility of some regional shortages and shortages of some types of blood.


Pursuant to a congressional request, GAO discussed the Health Care Infrastructure Investment Act of 2000 (H.R. 4401), which calls for the development of an immediate claim, administration, payment resolution and data collection system, focusing on the: (1) effects of the system on the claims processes of both the Medicare Part B program and the Federal Employees Health Benefit program (FEHBP); and (2) the role and composition of a proposed Health Care Infrastructure Commission. H.R. 4401 would establish a Health Care Infrastructure Commission within the Department of Health and Human Services (HHS) to design, construct, and implement an immediate claim, administration, payment resolution, and data collection system that would initially be used by the Medicare part B program. However, most Medicare claims could be paid more quickly using current processes by simply eliminating the mandatory delay in paying claims. One drawback to eliminating this delay is that the Supplementary Medical Insurance Trust Fund, which funds part B, would lose some of the interest it earns on its balance. A drop in interest earnings could require additional appropriations or an increase in beneficiaries' premiums. Because a real-time claims processing system could open the process to a possible risk of improper payments, appropriate internal controls are needed. Current program safeguards, such as the edit process, must not be compromised. Because a real-time claims processing system is vulnerable to code manipulation, problem providers should be excluded from participating, and adequate documentation controls must ensure that the electronic trail is not lost or tampered with. The project's return on investment, links to a strategic plan, and evidence of compliance with the organization's overall systems architecture must also be considered as well as the possibility of computer viruses and computer attacks. Developing a single real-time claims processing system for both Medicare part B and the Federal Employees Health Benefits program would be challenging because the programs are so different. Further, if a real-time processing system is to be developed, consideration should be given to including key Health Care Financing Administration (HCFA) and carrier officials with health care claims processing, program integrity and financial management expertise on the Infrastructure Commission, as well as OPM and providers, since the system would affect HCFA, OPM, and the providers.

The Health Care Financing Administration (HCFA) pays for health care coverage for nearly a quarter of the population. Two programs that HCFA administers—Medicare and Medicaid—cost taxpayers about $370 billion in fiscal year 1998. Over the years, GAO has reported on problems in HCFA's management that have weakened the fiscal integrity of HCFA programs, leading to increased monetary loss from fraud, abuse, and erroneous payments. GAO has included Medicare on its list of government programs that are especially vulnerable to waste, fraud, abuse, and mismanagement. (See GAO/OCG-99-7, Jan. 1999.) Medicare's long-term financial condition is now one of the nation's most pressing problems. Recent legislation gave HCFA substantial new authorities and responsibilities for reforming Medicare in order to extend the solvency of Medicare's Hospital Insurance Trust Fund beyond 2008. The legislation also established the Bipartisan Commission on the Future of Medicare to develop more long-term solutions for further ensuring Medicare's integrity and solvency. This testimony updates GAO's assessment of HCFA's progress in implementing these new authorities and administering its programs. Specifically, GAO reviews HCFA's progress in (1) addressing its most immediate priorities and (2) strengthening its internal management to effectively discharge its major implementation and oversight responsibilities.


The Community and Migrant Health Center program and the National Health Service Corps, administered by the federal Health Resources and Services Administration (HRSA), are designed, respectively, to increase the availability of primary and preventive health care services for low-income people living in medically underserved areas and to offer scholarships and educational loan repayments for health care professionals, who, in turn, agree to work in these centers and other sites in communities where there is a shortage of providers. GAO found that HRSA could increase the centers' effectiveness by establishing a systematic best practices program so centers can learn from each other and by improving the completeness and accuracy of the data it uses to monitor them. Also, the Health Care Financing Administration could help ensure the centers' ability to continue serving Medicaid beneficiaries and uninsured persons by monitoring state Medicaid programs' compliance with federal requirements for reimbursing the centers. The National Health Service Corps program would be improved by shifting some resources from the scholarship program to the loan repayment program. Furthermore, a better system is needed for identifying and measuring where health care professional placements are needed.


Across the country, career criminals and organized crime have become involved in health care fraud. Both the House and Senate have introduced bills designed to combat waste, fraud, and abuse in Medicare programs. Under the proposed legislation, the purchase, sale, or distribution of two or more Medicare or Medicaid beneficiary identification numbers will be a felony. In the rent-a-patient scheme, organizations pay for—or "rent"—persons to go to clinics for unnecessary diagnostic tests and examinations. Medicare, Medicaid, and other insurers are billed for these services and for other services and equipment that is never provided. In a variation of this scheme, perpetrators buy individual health care insurance identification numbers for cash. In the pill mill scheme, separate health care individuals—usually including a pharmacy—collude to generate a flood of fraudulent claims that Medicaid pays. The patient sells the prescription medications to pill buyers on the street who then sell the drugs back to the pharmacy. The drop box scheme uses a private mailbox facility as the fraudulent health care entity's address, with the entity's suite number actually being its mailbox number at the private mailbox facility. The perpetrator then retrieves the checks and deposits them into a commercial bank account. The third-party billing scheme revolves around a third-party biller who prepares and remits claims to Medicare or Medicaid on behalf of health care providers. The biller may or may not be in on the scheme. Enacting the proposed legislation will give the Department of Human Services' Office of Inspector General additional enforcement tools with which to pursue health care swindlers.

Long-Term Care Insurance: Better Information Critical to Prospective Purchasers. (GAO/T-HEHS-00-196, Sept. 13, 2000).

Pursuant to a congressional request, GAO discussed the challenges the baby boom generation and society face in planning for and financing its future long-term care needs, and the role that private long-term care insurance may play in meeting those challenges, focusing on: (1) the increased demand the baby boom generation will likely create for long-term care; (2) an overview of current spending for long-term care of the elderly, including recent changes in Medicaid and Medicare financing of long-term care; and (3) the potential role of private long-term care insurance in helping finance this care, including who buys this insurance, its affordability, and the critical need for consumer information and protections.

GAO noted that: (1) estimates of the magnitude of the baby boomers' future long-term care needs vary, with estimates of the
number of disabled elderly when the baby boom generation becomes elderly ranging from 2 to 4 times the current number; (2) estimates of cost are even more imprecise due to the uncertain effect of several important factors, including how many will be needing care, the types of care they will need, and the availability of public and private sources to pay for that care; (3) spending for long-term care for the elderly is an estimated $123 billion this year; (4) Medicaid and Medicare will pay for nearly 60 percent of these services, contributing $43 billion and $29 billion respectively; (5) Medicaid funds go primarily to nursing homes and other institutional settings of long-term care, but home and community-based services represent a growing share of Medicaid spending and recipients; (6) Medicare primarily covers acute care services, and thus plays a lesser role in financing nursing home care but has grown to play a significant role in covering long-term care through its home health benefit; (7) recent federal legislative changes in response to rapid and inexplicable growth in spending for long-term care services in Medicare have already resulted in a reduction in home health spending, but it remains uncertain how much Medicare will be spending for long-term care services in the future; (8) several recent congressional initiatives, including establishing a program to make group long-term care insurance available to federal employees and proposals to provide tax subsidies to individuals purchasing long-term care insurance, aim to expand the role of private long-term care insurance; (9) less than 10 percent of the elderly and an even lower percentage of near-elderly individuals have purchased long-term care insurance, although these numbers are increasing; (10) questions remain about the affordability of policies and the value of the coverage relative to the premiums charged; (11) if long-term care insurance is to have a more significant role in addressing the baby boom generation’s upcoming chronic health care needs, the policies offered must be viewed by consumers as good, affordable products that are easily understandable; and (12) the National Association of Insurance Commissioners has recently strengthened its model regulation for long-term care insurance, including recommending that states enact laws requiring additional disclosure to consumers about the potential for future policy rate increases and better ensuring that long-term care insurers accurately price their policy premiums.

Managed Care: State Approaches on Selected Patient Protections. (GAO/T-HEHS-99-85, March 11, 1999)

Health insurance statutes and regulations in 15 states, which collectively account for about two-thirds of all Americans enrolled in health maintenance organizations, address consumers’ concerns about access to health care and information disclosure with differing approaches, scope, and form. For example, California and Minnesota address some aspects of seven types of patient protection: coverage of emergency services, access to obstetricians and gynecologists, access to pediatricians, access to other specialists, continuity of care for enrollees whose providers leave their plans, drug formulary provisions, and open patient-provider communication. Colorado addresses three of these protections, Massachusetts only one. The most prevalent protections address open patient-provider
communication, emergency care coverage, and access to other specialties. Continuity-of-care provisions differ; about half of the states specify pregnancy as a condition subject to this coverage. An effective approach to ensuring quality and efficient health care for managed care enrollees would balance the regulatory assurance of minimum standards with quality-based competition among providers.


In deliberating Medicare and the rising availability, cost, and use of prescription drugs, Congress faces a policy dilemma: The lack of a prescription drug benefit may impede beneficiaries’ access to treatment advances while adding that benefit could be costly to the program. One possible resolution would be to model the benefit after Medicaid’s drug rebate program; price discounts could be substantial, but beneficiaries would have no incentive to make cost-conscious decisions about drug use. Another possible resolution would be to do what the private sector does in negotiating price discounts from manufacturers in exchange for shifting market share. However, Medicare’s using pharmacy benefit managers to process claims, negotiate with manufacturers, establish preferred drug lists, and develop beneficiary incentives for controlling spending would be difficult because of the program’s size, need for transparency, and imperative for equity.


Payment reforms under the Balanced Budget Act of 1997 that sought to curb unnecessary Medicare spending are beginning to have their intended effect, but pressure is building to return to more generous payment policies. Adjustments based on thorough quantitative assessments may be necessary. For home health care, the prospective payment system, a more appropriate tool for the long term than the earlier interim payment system, will likely require adjustment after it is implemented and more information on home health costs, utilization, and users becomes available. The Health Care Financing Administration is trying to solve problems with access to skilled nursing care facilities under the new system. A need-based payment system, rather than the per-beneficiary cap on payments for outpatient physical, speech, and language therapy, might help target beneficiaries better. Medicare+Choice payments may need to be modified by establishing an appropriate base rate and a risk adjustment method that pays more for serving beneficiaries with serious health problems and less for serving those who are relatively healthy.

Medicare: Concerns About HCFA’s Efforts to Prevent Fraud by Third-Party Billers. (GAO/T–HEHS–00–93, Apr. 6, 2000).

To help ensure the integrity of Medicare, the Health Care Financing Administration (HCFA) and its contractors need to develop reliable and sophisticated approaches to identify potentially fraudulent billing practices. It is especially important that they be able to match up third-party billers with the providers they represent.
so contractors can identify potentially questionable billing patterns and subject these claims to more scrutiny. Although HCFA has various efforts under way to better identify providers’ questionable claims and their associated third-party billers, there continue to be gaps in its safeguards. HCFA needs to complete its provider recertification program as soon as possible so that it will have comprehensive information on all Medicare providers and their billers. GAO is also concerned about inherent problems with data reliability.


Proposals to add a Medicare prescription drug benefit have come during a period of rapid growth in national spending for pharmaceuticals and transformations in the prescription drug market. What remains unchanged since 1965, however, is the absence of coverage for outpatient prescription drugs by traditional Medicare. One third of the Medicare population lacks the supplemental drug coverage provided to most beneficiaries through employer-sponsored plans, managed care organizations, Medicaid, or Medigap insurance. Moreover, high drug use among Medicare beneficiaries translates into a potentially daunting financial burden. The implications of adding prescription drug coverage to Medicare depend on the choice made about details, such as its scope and financing. Its design and implementation will also shape the impact of this benefit on beneficiaries, Medicare spending, and the pharmaceutical market. Recent experience suggests at least two approaches for implementing a drug benefit. One would involve the Medicare program obtaining price discounts from manufacturers. Such an arrangement could be modeled after Medicaid’s drug rebate program. The second approach would draw from private sector experience in negotiating price discounts from manufacturers in exchange for shifting market share.


Use of colorectal cancer screening and diagnostic services by Medicare beneficiaries is very low relative to recommended use rates and has remained almost unchanged over the past 5 years. Although guidelines recommend annual fecal occult blood testing for all people aged 50 and older, only 9 percent of fee-for-service beneficiaries received that test each year. Use rates for flexible sigmoidoscopy are significantly lower and have remained constant at about 2 percent of beneficiaries. Women’s use of some colorectal cancer screening and diagnostic services was slightly higher than men’s, and white beneficiaries received the services at somewhat higher rates than African Americans, Asians, and Hispanics. Although use data are not available for Medicare beneficiaries in HMOs, research suggests that enrollees in managed care plans are at least as likely to have colorectal cancer screening as those in fee-for-service Medicare. Key among the reasons for low use of screening and diagnostic services are poor patient awareness of recommendations and coverage for screening, physician reluctance to perform the procedures because of the time and complexity in-
Medicare: HCFA Faces Challenges to Control Improper Payments. (GAO/T-HEHS-00–74, Mar. 9, 2000).

Major information gaps exist in the Medicare program in both traditional Medicare and Medicare+Choice that impede HCFA's ability to minimize program losses attributable to improper payments. In traditional Medicare, HCFA does not have a clear picture of the individual or relative performance of Medicare's claims administration contractors, which are responsible for safeguarding the program's fee-for-service payments that totaled $171 billion in fiscal year 1999. HCFA also lacks sufficient information on newly designed payment systems to determine whether providers have delivered excessive services or stinted on patient care to inappropriately maximize payments. For Medicare+Choice, HCFA similarly lacks the data needed to monitor the appropriateness of payments made to health plans and the services Medicare enrollees receive. Owing to a failed attempt in the 1990s to modernize Medicare's multiple information systems, HCFA's current systems remain seriously outmoded. Without effective systems, the agency is not well-positioned to collect and analyze data regarding beneficiaries' use of services information that is essential to managing the program effectively and safeguarding program payments.


This testimony summarizes the July 1999 report, Medicare: Improvements Needed to Enhance Protection of Confidential Health Information. (GAO/HEHS–99–140, July 20, 1999).


The Health Care Financing Administration (HCFA) paid its Medicare fee-for-service claims administration contractors $1.6 billion in fiscal year 1998 to serve as the program's first line of defense against inappropriate and fraudulent claims. Since 1993, eight contractors have been convicted of criminal offenses, have been fined, or have entered into civil settlements. Several of their employees engaged in improprieties and covered up poor performance to allow contractors to keep their Medicare business. Improper activities included improperly screening, processing, and paying claims; destroying claims; and failing to properly collect money providers owed Medicare. Contractors also falsified their performance results and tried to deceive HCFA and circumvent its performance reviews. HCFA often failed to detect improper activities because it gave contractors too much advance notice of its oversight visits and record reviews. Weaknesses in HCFA's current oversight might allow the same types of activities to continue undetected. GAO believes that HCFA plans to act on recommendations GAO made in July 1999 regarding its contractor management policy and plans, assessment, evaluation, and oversight. Although this will help im-
prove its management and oversight of the contractors, it will not make Medicare less vulnerable to their abuses.


Weak oversight of Medicare fee-for-service claims administration contractors has left the Health Care Financing Administration (HCFA) with few guarantees that contractors are doing their jobs, including paying providers appropriately. Since 1993, at least six contractors have settled civil and criminal charges arising from allegations that they were not checking claims to ensure proper payment, were allowing Medicare to pay claims that other insurers should have paid, or were committing other improprieties. For years, HCFA left decisions about oversight priorities entirely in the hands of regional reviewers, did not evaluate regional oversight to achieve consistency, and set few performance standards to hold contractors accountable. GAO recommends that Congress amend the Social Security Act to allow the Secretary of Health and Human Services explicit authority to more freely contract with appropriate types of companies for claims administration. Also, HCFA should be required to report to the Congress with an independent evaluation on the impact of any new authorities on the Medicare program.

**Medicare: Improper Third-Party Billing of Medicare by Behavioral Medical Systems, Inc.** (GAO/T–OSI–00–9, Apr. 6, 2000).


**Medicare: More Beneficiaries Use Hospice; Many Factors Contribute to Shorter Periods of Use.** (GAO/T–HEHS–00–201, Sept. 18, 2000).

Pursuant to a congressional request, GAO discussed issues related to the use of Medicare's hospice benefit, focusing on: (1) the patterns and trends in hospice use by Medicare beneficiaries; (2) factors that affect the use of the hospice benefit; and (3) the availability of hospice providers.

GAO noted that: (1) the number of Medicare beneficiaries choosing hospice services has grown substantially during the past decade—nearly 360,000 beneficiaries enrolled in 1998, more than twice the number that elected hospice in 1992; (2) cancer patients account for more than half of Medicare hospice users, but the most dramatic growth in use is among persons with other terminal conditions, such as heart disease, lung disease, stroke, or Alzheimer's disease; (3) although more beneficiaries are choosing hospice, many are doing so closer to the time of death; (4) half of Medicare hospice users are enrolled for 19 or fewer days, and service periods of 1 week or less are common; (5) many factors influence decisions about whether and when to begin hospice services, including physician practices, patient preferences and circumstances, and general awareness of the benefit among professionals and the public; (6) along with these factors, federal oversight of compliance with Medi-
care eligibility requirements may also have affected hospice use; (7) growth in the number of Medicare hospice providers in both urban and rural areas and in almost every state suggests that hospice services are more widely available to program beneficiaries than in the past; (8) at the same time, hospice officials report increased cost pressures from shorter patient enrollment periods and the use of more expensive forms of palliative care; (9) because data on provider costs are not available, however, the effect of these factors on the overall financial condition of hospice providers is uncertain; and (10) the Health Care Financing Administration is beginning to gather information from hospice providers about their costs, which should allow the adequacy Medicare hospice payment rates to be evaluated in the relatively near future.


The Comptroller General's statement discusses the competing concerns at the heart of the Medicare reform debate and provides a conceptual framework for evaluating the possible combinations of reform options. To qualify as meaningful reform, a proposal should make a significant down payment toward ensuring Medicare's long-range financial integrity and sustainability—the most critical issues facing the program. Fundamental reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and fiscal resources. At the same time, Medicare is outmoded from a programmatic perspective. To address the need for an updated benefit package and adequate tools to moderate program spending, proposals have been advanced that would expand benefits while introducing changes to make beneficiaries more cost-conscious and incentives to make health care providers efficient. Ideally, the unfunded promises associated with today's program should be addressed before or concurrent with proposals to add new ones, such as prescription drug coverage. To so otherwise might be politically attractive but not fiscally prudent. If benefits are added, policymakers need to consider targeting strategies to fully offset their costs. Because of the size of Medicare's unfunded liability, it is realistic to expect that reforms intended to bring down future costs will have to proceed incrementally. As reform options come under greater scrutiny, the importance of design details should not be overlooked. GAO's work on efforts to implement recent reforms suggests that those details will determine whether reform options will be both effective and acceptable.


The Comptroller General has repeatedly cautioned that, even without expanding program benefits, projected Medicare spending threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. In the absence of meaningful reform, demographic and cost trends will drive Medicare spending to levels that will prove unsustainable. Under the Balanced Budget Act of 1997 (BBA) and the Balanced Budget Refinement act of 1999, pro-
providers have had to adjust their operations because of tightened payment policies. The adjustments have been particularly disruptive for providers that took advantage of Medicare's previous payment policies to finance inefficient and unnecessary care delivery. Industry representatives are advocating the partial restoration of payment cuts since the BBA's implementation developments have occurred in the areas of home health services, skilled nursing facilities (SNF), and the Medicare+Choice program. Use of home health services has dropped substantially, well below what would have been required to remain within the BBA-imposed payment limits. The new Medicare payment system, scheduled for implementation in October, should generally provide agencies a comfortable cushion to deliver necessary services. Some corporate SNF chains have declared bankruptcy. The new Medicare payment system will adequately cover the cost of beneficiary services but not support extensive capital expansions or ancillary service business that the chains relied on to boost revenues. Many plans are withdrawing from Medicare because of the changes to the Medicare program and plans' business decisions. Ongoing GAO work shows that payments to plans for Medicare enrollees continue to exceed the expected fee-for-service costs. This finding is significant: Medicare managed care, although originally expected to achieve program savings, continues instead to add to program cost.


Key problems that undermine the ability of the Health Care Financing Administration (HCFA) to manage Medicare effectively can be solved. Currently, no one senior official in HCFA is responsible for managing only Medicare; instead, HCFA's Administrator also oversees Medicaid and other state-centered programs' worthy competitors for agency management attention. Frequent changes in agency leadership make it difficult to develop and implement a consistent long-term vision. And constraints on HCFA's ability to acquire appropriate resources and expertise limit its ability to modernize Medicare's operations and carry out the program's growing responsibilities. Elements of recent Medicare reform proposals, together with alternatives from other federal agencies, suggest ways of addressing the focus, leadership, and capacity issues. Options could include creating an entity that would administer Medicare without any non-Medicare responsibilities; establishing a tenure for the program's administrator that, at minimum, would overlap presidential terms; and granting the entity administering Medicare greater operational flexibility.


The President proposes to use about two-thirds of the projected budget surpluses over the next 15 years to reduce publicly held debt. At the same time, he also proposes to transfer a like amount to the Social Security and Medicare trust funds in the form of non-marketable Treasury securities, which is projected to extend the
life of Medicare's Hospital Insurance (HI) trust fund from 2008 to 2020. His proposal would trade debt held by the public for debt held by the Social Security and Medicare trust funds. These new Treasury securities would constitute a new unearned claim on general funds for the HI program—a marked break with the payroll tax-based financing structure of the program. This change could undermine the remaining fiscal discipline associated with the self-financing trust fund concept and could induce a false complacency about the financial health of the HI program. Without change, however, Medicare is projected to more than double its share of the economy by 2050, and Social Security, health, and interest will take nearly all the revenues the federal government takes in. Real and substantive Medicare reform, not simple financing shifts among funds within the budget, is essential. Acting now would allow changes to benefits and health care delivery systems to be phased in gradually so that stakeholders and participants would have time to adjust their saving or retirement goals.


This testimony is related to our September report, Medicare Improper Payments: While Enhancements Hold Promise for Measuring Potential Fraud and Abuse, Challenges Remain. (GAO/AIMD/OSI–00–281, September 15, 2000)


This testimony is related to our June report, Medicare Quality of Care: Oversight of Kidney Dialysis Facilities Needs Improvement. (GAO/HEHS–00–114, June 23, 2000).


This testimony summarizes the April 1999 report, Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature (GAO/HEHS–99–92, April 12, 1999).


Medicare provides managed care plans with a fixed monthly payment, called a capitation payment, for each beneficiary they enroll. However, the enrollment of beneficiaries in managed care plans has yet to save the government money, mainly for two reasons. First, Medicare's capitation rates are excessive because payments
are based on health care spending for the average non-enrolled beneficiary, while the plans’ enrollees tend to be healthier than average. Second, instead of diminishing as more beneficiaries enrolled in managed care, excess payments per enrollee continued to grow. To solve these problems, the Balanced Budget Act of 1997 changed the rate setting formula used by the Health Care Financing Administration (HCFA), which runs Medicare. It required that most of the rate-setting provisions be in place in 1998 and required that HCFA replace Medicare’s current risk-adjuster—the mechanism that modifies a plan’s average capitation rate to better reflect an enrollee’s expected medical costs—with a new one to be implemented in 2000. The risk adjuster has been widely criticized as a major factor in the health maintenance organization overpayment problem. This testimony discusses (1) the important of improving the current risk adjustment method, (2) the implications of rate-setting changes implemented in 1998, and (3) the advantages and drawbacks of HCA’s proposed new interim risk adjuster.


Budgetary pressures and public concern have forged a consensus that major reforms are needed if Medicare is to be sustainable in the future. Medicare reform proposals have generally focused on two areas: expanding Medicare's benefit package and containing costs. Two commonly discussed benefit expansions are the inclusion of a prescription drug benefit and coverage for extraordinary out-of-pocket costs, known as catastrophic coverage. Financing reforms include modernizing the fee-for-service program and the Medicare+Choice program and adopting premium support for Medicare fashioned after the Federal Employees Health Benefits Program. In reforming Medicare, attention should be paid to lessons learned from recent experience in implementing reforms mandated by the Balanced Budget Act of 1997, particularly regarding new payment mechanisms, provider behavior in evolving markets, and Medicare+Choice information initiatives.


The Balanced Budget Act of 1997 created the Medicare+Choice program to give Medicare beneficiaries a broader range of health plans, such as those of preferred provider and provider-sponsored organizations. It also continued the movement away from Medicare's paying skilled nursing facilities, home health agencies, hospital outpatient departments, and rehabilitation facilities for services on the basis of their incurred costs toward using prospective rates that set their payment levels in advance. This testimony discusses the implementation of (1) the Medicare+Choice program, particularly the payment method and consumer information efforts, and (2) prospective payment systems for skilled nursing facilities and home health agencies in Medicare's traditional fee-for-service program.

The Balanced Budget Act of 1997 seeks to make Medicare a more efficient and prudent purchaser of post-acute care services. The act's payment reforms are changing home health care, skilled nursing facility, and rehabilitation therapy service delivery practices. There is still not enough information to distinguish desirable from undesirable consequences, so that calls to amend or repeal the Act are premature. But imperfections in the design of the payment system require attention. The prospective payment system is an appropriate long-term tool for access to Medicare's home health benefits but will require adjustment when more information on cost, use, and users becomes available. The Health Care Financing Administration is working on a solution to the problem that prospective payment system rates may underpay for high-cost skilled nursing facility care, leading to beneficiaries' staying longer in acute care hospitals. A system for basing outpatient rehabilitation therapy payments on need, rather than on dollar caps, might help better target the beneficiaries who genuinely require services.


The affordability of Medicare reform proposals should be considered in relation to the long-term sustainability of Medicare expenditures, the fairness to providers and beneficiaries, the adequacy of resources for allowing appropriate access and cost-effective and clinically meaningful innovations for addressing beneficiaries' needs, the feasibility for implementation and monitoring, and the transparency about costs and policy tradeoffs. Current proposals would modernize Medicare's financing and organization by changing fee-for-service or Medicare+Choice options or offering premium support, such as that of the Federal Employees Health Benefits Program. Benefit options being considered include covering outpatient prescription drugs and limiting beneficiaries' cost liability. Congress should consider fiscal incentives to control costs and a targeting strategy when deliberating these options. Reform will be done best with lead time to phase in changes and with prudent decisions about how to use current and projected budget surpluses.


Recent GAO testimony before Congress has raised concerns about the expanded use of general revenues to pay for the Medicare program and has urged comprehensive reforms to help ensure the program's long-term sustainability. (See GAO/T-HEHS/AIMD-00–77, Feb. 2000, GAO/T-HEHS/AIMD-00–103, Feb. 2000, and GAO/T-AIMD/HEHS-99–236, July 1999.) Leading Medicare reform proposals that include comprehensive reforms, such as those of the President and Breaux-Frist, would use general funds as part of their financing mechanisms. General fund infusions may well be a necessary part of program reform, but caution is warranted in considering the commitment of additional general revenues. The testi-
mony discusses the specifics of Medicare's financial health and issues raised by growing reliance on general revenue financing.


The Comptroller General's statement focuses on two leading Medicare reform proposals: the President's Plan to Modernize and Strengthen Medicare for the 21st Century and S.1895, commonly known as the Breaux-Frist proposal. Both proposals recognize the need for more comprehensive reform—a position consistent with GAO's belief that the unfunded promises associated with today's program should be addressed before adding new benefits, such as prescription drug coverage. Such additions must be considered in the context of broader efforts to correct Medicare's current fiscal imbalance and sustain the long-term viability of this popular program. Also, any reform package should include a mechanism to monitor aggregate program costs over time and establish funding thresholds that would trigger a call for fiscal action. In the case of both proposals, the details will need to be worked out. And those details will determine whether the reforms will be effective and acceptable.


The President's Medicare reform proposal is an important first step in the debate over how the country will deal with the explosive costs of medical care for older Americans in the coming decades. The President has included a first step toward Medicare reform as part of a broader plan that would use a significant share of the surplus to pay down the debt, ultimately lowering interest rate costs and spurring economic growth. The President would use 13 percent of the projected budget surpluses during the next 15 years to help shore up the Medicare Hospital Insurance Trust Fund and to offset the cost of the proposed prescription drug benefit. Although the surplus transfer in the form of additional Treasury securities would extend the Fund's solvency, this move would represent a significant departure from the long-standing use of payroll taxes to finance the Fund. GAO is concerned that without underlying program reform, the transfers would simply extend the Fund's solvency on paper but do nothing to make Medicare more sustainable—that is, they would not reduce the program's projected share of gross domestic product or the federal budget. More importantly, the proposed transfer, by extending the solvency of the Hospital Insurance program through 2027, well into the baby boomers' retirement years, could end up masking the Fund's underlying condition and remove any sense of urgency among policymakers to address the program's underlying fiscal imbalance. The President wants to make two major program changes to Medicare. First, he would have Medicare's health plans compete on the basis of price. However, the administration has yet to provide specifics on the design and implementation of this proposal. Second, the President would add a prescription drug benefit. GAO is concerned about (1) the cost of the benefit and who would be targeted, (2) the fact that some costs now
borne by employers and retirees could become the responsibility of taxpayers, (3) uneven impact across states, and (4) obstacles to the government realizing savings from the use of pharmacy benefit managers.


Pursuant to a congressional request, GAO discussed the causes of the bankruptcies of large corporations owning nursing homes and the implications for nursing home residents, focusing on: (1) the adequacy of Medicare's payment rates for skilled nursing services furnished in nursing homes; (2) the relationship between the changes wrought by the Balanced Budget Act and recent nursing home bankruptcies; and (3) what exists to protect patients.

GAO noted that: (1) aggregate Medicare payments for covered nursing home services likely cover the cost of care needed by beneficiaries, although some refinements to the payment system are needed; (2) Medicare policy changes have required many nursing homes to adjust their operations; (3) the adjustments have been particularly disruptive for homes that took advantage of Medicare's previous payment policies to finance inefficient and unnecessary care delivery and for those companies that invested heavily in the provision of ancillary services (such as rehabilitation therapies) to nursing homes; (4) the problems experienced by some providers of nursing home and ancillary services are therefore the result of business decisions made during a period when Medicare exercised too little control over its payments; (5) filing for bankruptcy protection under Chapter 11 of the U.S. Bankruptcy Code allows these providers time to restructure their debts and streamline their operations while continuing to care for their nursing home residents; and (6) should any of these providers not emerge from bankruptcy, however, the nursing homes will be sold or the residents may have to find alternative care arrangements.


In a March report, GAO cited nursing home problems in 14 states, including Maryland. These deficiencies ranged from procedures that may limit the filing of complaints to failures to investigate serious complaints promptly. Compared with other states, Maryland devoted fewer resources to investigating complaints, recorded substantially fewer complaints than Michigan or Washington, generally classified similar complaints as needing less prompt investigation, did not meet the assigned time periods for investigating many complaints, and had a large backlog of uninvestigated cases and poor tracking of the status of investigations. Consequently, serious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months in Maryland. Such delays can prolong situations in which residents may be subject to abuse or neglect resulting in serious care problems like malnutrition and dehydration, preventable accidents, and medication errors. In response to GAO's findings, the Health Care Financing Administration has told states to investigate any complaint alleging actual harm to a resident within 10 workdays. The
Maryland General Assembly recently approved funding to significantly increase the number of nursing home surveyors. However, the seriousness and systemic nature of the weaknesses GAO identified require sustained commitment and strengthened oversight to help ensure adequate care to nursing home residents.


The federal government will pay an estimated $39 billion for nursing home care in 1999. Working with the states, the federal government also plays a key role in ensuring quality care at these facilities. GAO has issued three reports that focus on problems in California nursing homes as well as the enforcement and complaint investigation processes nationwide. (See GAO/HEHS-98–202, July 1998, GAO/HEHS–99–46, Mar. 1999, and GAO/HEHS–99–80, Mar. 1999.) GAO found that one-fourth of nursing homes nationwide had serious deficiencies that actually harmed residents or placed them at risk of death or injury; 40 percent of these homes had repeated deficiencies. Complaints alleging serious care problems often went uninvestigated for weeks or months. Even when serious deficiencies were found, state and federal enforcement policies were ineffective in ensuring that deficiencies were corrected and stayed that way. HCFA agreed with GAO’s recommendations and has developed about 30 initiatives to strengthen federal standards, oversight, and enforcement for nursing homes. This testimony discusses (1) the overall scope of HCFA’s initiatives, (2) the early experiences of initiatives for which HCFA has already issued revised guidance to the states, (3) the implications of a proposed expansion of the category of nursing homes that would face more intensive review and immediate sanctions for deficiencies, and (3) the initiatives that will require a long-term commitment for HCFA to implement.


Pursuant to a congressional request, GAO discussed its study of the Health Care Financing Administration’s (HCFA) implementation of two of its nursing home initiatives.

GAO noted that: (1) HCFA’s mechanisms for assessing state agency survey performance are limited in their scope and effectiveness and are not being applied consistently across each of HCFA’s 10 regional offices; (2) as a result, HCFA does not have sufficient, consistent, and reliable data to evaluate state agencies or to measure the success of its other nursing home initiatives; (3) given the wide range in the frequencies with which states identify serious deficiencies, HCFA cannot be certain whether states with lower rates of deficiencies have better quality homes or are failing to identify deficiencies that harm nursing home residents; (4) this uncertainty results, in part, because HCFA makes negligible use of independent inspections, known as comparative surveys, that could surface information about whether states appropriately cite deficiencies; (5) generally, only one to three comparative surveys per state were conducted in the more than 17,000 nursing homes over the last
year; (6) nevertheless, two-thirds of these surveys found deficiencies that were more serious than those found by state surveyors during their reviews conducted typically 1 or 2 months earlier; (7) about 90 percent of the inspections HCFA conducts nationwide are, instead, observational surveys; (8) these surveys, in which HCFA surveyors accompany state survey teams, are useful in helping HCFA to provide training to state surveyors, but are limited as a method for evaluating state agencies' performance; (9) beyond these surveys, HCFA also relies on a quality improvement program that is largely based on states' self-reported performance measures, which do not accurately or completely reflect problems in state's performance; (10) these limitations in HCFA's oversight methods are compounded by inconsistencies in how the methods are applied by its regions; (11) for example, the regions vary in how they select nursing home surveys to review and how they choose samples of residents to review; (12) regions also commit differing amounts of time to conduct observational surveys, ranging on average from 27 to 71 hours, which raises questions about whether the level of effort some regions dedicate to observational surveys is sufficient to thoroughly review state surveyors' performance; and (13) furthermore, if HCFA finds a state agency's performance to be inadequate, HCFA has not developed a sufficient array of alternatives to encourage state agencies to improve their performance.


This testimony summarizes the March 1999 GAO report, Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents. (GAO/HEHS-99-80, March 22, 1999).

Nursing Homes: Success of Quality Initiatives Requires Sustained Federal and State Commitment. (GAO/T-HEHS-00-209, Sept. 28, 2000).

Pursuant to a congressional request, GAO discussed the quality of care in nursing homes, focusing on: (1) progress in improving the detection of quality problems during annual surveys; (2) how the prevalence of identified problems has changed; (3) the status of efforts to strengthen states' complaint investigation processes and federal enforcement policies; and (4) additional activities occurring at the federal level to improve oversight of states' quality assurance activities.

GAO noted that: (1) overall, the series of federal quality initiatives begun 2 years ago has produced a range of nursing home oversight activities that need continued federal and state commitment to reach their full potential; (2) certain of the federal initiatives seek to strengthen the rigor with which states conduct their required annual surveys of nursing homes; (3) others focus on the timeliness and reporting of complaint investigations and the use of management information to guide federal and state oversight efforts; (4) the states are in a period of transition with regard to the implementation of these initiatives, partly because the Health Care Financing Administration (HCFA) is phasing them in and partly because states did not begin their efforts from a common starting
Critique of Nursing Home Oversight and Performance

(1) The results from states’ recent standard surveys provide a picture of federal and state efforts in progress; (2) while it was expected that more deficiencies would be identified owing to the increased rigor in nursing home inspections, the survey results could also suggest that nursing homes may not have made sufficient strides to measurably improve residents’ quality of care; (3) the results also show a wide variation across states in the proportion of homes with identified serious care deficiencies; (4) these proportions are expected to vary somewhat from one state to another, the wide range may reflect the extent to which the inspection of homes is inconsistent across states; and (5) in GAO’s view, the full potential of the nursing home initiatives to improve quality will more likely be realized if greater uniformity in the oversight process can be achieved.


In earlier congressional testimony, GAO has addressed considerations for adding a prescription drug benefit to Medicare. If a prescription drug benefit were added to the Medicare program, the federal government would face cost pressures similar to those experienced by private insurers, managed care plans, and employers. The private sector has attempted to manage the high and rising costs of prescription drugs by adopting cost and utilization control techniques. The challenge in adding prescription drug coverage to the Medicare program will be in designing and implementing drug coverage to minimize the financial implications for Medicare while maximizing the positive effect of such coverage on Medicare beneficiaries.


Private insurers, managed care plans, and employers have tried to manage the high and rising costs of prescription drugs by adopting cost and utilization control techniques. In many cases, insurers and managed care plans contract with a pharmacy benefit management company (PBM) to develop and implement these strategies. If a prescription drug benefit were added to the Medicare program, the federal government would face similar cost pressures and would need to employ methods to control spending. The experience gained in the private sector can provide useful insights into options for managing a possible Medicare benefit. However, the unique re-
sponsibilities and characteristics of the Medicare program raise a number of issues and introduce questions about applying private sector tools to the traditional Medicare fee-for-service program and the appropriate roles of the Health Care Financing Administration (HCFA) and other entities, such as PBMs, in managing a drug benefit. In adapting, these cost and utilization management techniques, it is important to keep in mind that: (1) the size of the Medicare program and the need for transparency in its actions may reduce the effectiveness of some cost control techniques; (2) using private-sector entities to implement a drug benefit introduces concerns related to beneficiary equity and concentrating market power; (3) private-sector management tools require a capacity to process and scrutinize a large number of claims more quickly than is typical of the traditional Medicare program; and (4) strategies involving coverage restrictions impose an obligation to provide beneficiaries with adequate information about the benefit.


[These similar testimonies were given to different committees.]

Concerns are growing about gaps in the Medicare program, most notably the lack of outpatient prescription drug coverage, which may leave the most vulnerable program beneficiaries with high out-of-pocket costs that they can ill afford. Nearly one-third of Medicare beneficiaries lacked prescription drug coverage in 1996. At the same time, however, the long-term cost pressures confronting the Medicare program are considerable. A consensus appears to be emerging that substantive financing and programmatic reforms are needed to put Medicare on a sound footing in the future. These reforms are vital to reducing the program's growth, which threatens to consume ever-larger shares of the nation's budgetary and economic resources. Continuing economic prosperity and projected federal surpluses provide an opportunity to address the structural imbalances in Medicare, Social Security, and other entitlement programs. Congress faces the difficult decision of how best to guarantee the Medicare program's sustainability while being mindful of the plight of many seniors who cannot afford the latest pharmaceutical breakthroughs. Congress and the President may ultimately decide to include some form of prescription drug coverage as part of Medicare reform. Care must be taken, however, to ensure that any expansion of the program is accompanied by other programmatic reforms that will sustain Medicare's long-term financial integrity. This testimony discusses (1) the factors contributing to the growth in prescription drug spending and efforts to control that growth and (2) the design and implementation issues associated with proposals to improve seniors' access to affordable prescription drugs.
INCOME SECURITY ISSUES


This testimony is liked to our September report, Social Security Administration: Longstanding Problems in SSA's Letters to the Public Need to Be Fixed. (GAO/HEHS-00-179, Sept 26, 2000).


Social Security forms the foundation for the nation's retirement income system and, in doing so, provides benefits that are critical to the well-being of millions of Americans. A wide array of proposals have been put forth to restore the program's solvency. This testimony provides an analytical framework for evaluating these proposals. The Comptroller General discusses the (1) purpose of the Social Security system, (2) basic criteria for assessing reform proposals, and (3) importance of establishing the proper benchmarks against which reforms must be measured. The Comptroller General does not advocate for or against specific reform proposals or elements. Rather, his remarks are intended to help clarify the debate over various proposals as Congress continues to deliberate this important issue. In choosing among proposals, policymakers need to consider three basic criteria: to what extent a proposal achieves sustainable solvency and how it would affect the economy and the federal budget; the balance struck between the twin goals of individual equity (rates of return on individual contributions) and income adequacy (level and certainty of benefits); and how readily these changes could be implemented, administered, and explained to the public. Although the many reform proposals offer a wide range of options, all of them would restore long-term solvency through some combination of benefit cuts, revenue increases, or higher returns from invested contributions. Making Social Security a sustainable program involves difficult choices. At the same time, the strong U.S. economy offers an historic opportunity to deal with this problem. GAO believes that it is possible to craft a comprehensive package of reforms that will protect the benefits of current retirees while striking the right balance of equity and adequacy for future beneficiaries. Regardless of which reform proposal is adopted, better public education and information will be needed so that Americans can adjust their retirement planning accordingly.


Some proposals to ensure the solvency of Social Security would add individual accounts, similar to defined contribution plans, to the current defined benefit plan. By themselves, however, such individual accounts cannot guarantee the system's solvency. The current system is designed to achieve both individual equity (some relationship between contributions made and benefits received) and retirement income adequacy (proportionately larger benefits to lower earners and households with dependents). These two goals are combined in a single defined benefit formula that bases retire-
ment benefits on a worker's lifetime record of earnings, not on the payroll tax the worker contributed. Individual accounts would directly link a portion of the worker's contributions to benefits. This defined contribution structure would enable workers to earn a higher rate of return on their contributions but with some measure of risk. However, individual accounts would do nothing to help Social Security unless incremental investment income either supplement Social Security revenues or offset current promised benefits. Decisions about the appropriate balance between the defined benefit and defined contribution portions will need to consider whether to make individual accounts mandatory or voluntary, who would manage the necessary information and money flow, how much flexibility individuals would have over investment options and access to their accounts, and the mechanisms for paying out retirement benefits.

Social Security: The President's Proposal. (GAO/T-HEHS/AIMD-00-43, Nov. 9, 1999).

Pursuant to a congressional request, GAO discussed the President's proposal for Social Security financing, focusing on: (1) the extent to which the proposal achieves sustainable solvency and how the proposal would affect the economy and the federal budget; (2) whether the proposal balances individual equity and income adequacy; and (3) how readily changes could be implemented, administered, and explained to the public. GAO noted that: (1) according to Administration officials, the President's proposal would constitute a significant down payment on Social Security reform while contributing to achieving the Administration's goal of eliminating publicly held debt by 2015; (2) while the President's proposal for Social Security financing differs in some respects from his earlier proposals, the bottom line of the proposal with respect to sustainable solvency is unchanged; (3) the proposal: (a) reduces debt held by the public from current levels, which reduces net interest costs, and raises national saving, thereby contributing to future economic growth; (b) provides general revenues to the Old Age and Survivors Insurance and Disability Insurance trust funds, thereby representing a fundamental change in Social Security financing; (c) has no effect on the projected cash flow imbalance in the Social Security program's taxes and benefits, which begins in 2014; and (d) represents a financing, rather than a Social Security reform proposal; (4) GAO's analysis shows that the President's Social Security transfer proposal has the same effect on the economy and the federal budget as a policy of No Action that would simply continue spending and revenue along its path while making no change in Social Security or Medicare benefits; (5) the President's Social Security transfer proposal does not address sustainable solvency; (6) because the President proposes no changes to the structure of the current Social Security system, his proposal does not affect income adequacy; (7) specifically, the President's proposal maintains current-law benefits for current and future retirees, including low-income workers and others most reliant on Social Security, and makes no changes to disabled, dependent or survivor benefits; (8) the proposal also makes no changes from the current Social Security structure in the way workers are covered, and it preserves the progres-
Sivity of the system; (9) in addition, it retains the compulsory nature of the current payroll tax; (10) because the President's transfer proposal does not alter the Social Security program in any way, there are no implementation costs, and the program's current administrative costs will remain less than 1 percent of benefit outlays; and (11) without programmatic change, there are no changes that must be explained to the public and no risk of an "expectations gap" with respect to benefits.


The Social Security Administration (SSA) will be challenged to maintain a high level of service to the public in the next decade and beyond. Demand for services is expected to grow significantly. At the same time, the expectations and needs of SSA's customers are changing. Some want faster, more convenient service, while others, such as non-English speakers and the many beneficiaries with mental impairments, may require additional help from SSA staff. SSA's ability to respond to these challenges will be difficult because the number of SSA employees who retire is expected to peak at the same time that large increases will occur in applications for benefits. Although GAO has recommended since 1993 that SSA prepare a service delivery plan, the agency is only now beginning to develop a broad vision for customer service for 2010. In the meantime, SSA is counting on efficiencies from technology to help it cope with its rising workload. SSA has had mixed success with its information technology initiatives, however, and the benefits from its technology investments have largely been unclear. On the other hand, SSA's efforts to prepare for the rising number of retirements among its own workforce and changing customer needs and expectations have shown more promise, although many initiatives are still in the early stages and much work remains. SSA needs to fully assess the skills that its workforce will need to serve its customers in the future. SSA also needs to ensure continuity in leadership through ongoing succession planning efforts. Finally, without a vision for future service followed by a more detailed service delivery plan, SSA cannot be sure that its investments in technology and human capital—that is, its workforce—are consistent with and fully support its future approach to delivering services.


Although Social Security's benefit and contribution provisions are neutral with respect to race, ethnicity, and gender, GAO found that because of socioeconomic characteristics, minorities have benefited from the Social Security program. Because minorities are more likely than whites to have lower lifetime earnings, they are advantaged by Social Security's progressive benefit formula that provides larger relative benefits for lower-paid workers. Moreover, blacks in particular are more likely to receive other important Social Security benefits, such as disability, that protect against lost earnings. Some reforms that would reduce benefits to restore solvency could
have a disproportionate effect on low-wage earners, including blacks and Hispanics, depending on how they are structured. Restructuring Social Security to include individual accounts would also likely have varying effects on different racial and ethnic groups. However, GAO found that education and family income are better predictors of individuals' investment behavior than race. Persons with less education and lower incomes tend to invest more conservatively than those with more education and higher income. Because blacks and Hispanics are more likely to have less education and lower incomes, they would likely earn smaller returns on their accounts, although they would bear less risk. These results suggest that if individual accounts were adopted as part of comprehensive Social Security reform, investor information and education would be needed to help low-income individuals with their investment decisions.


Women have benefited greatly from the Social Security program. Many women who work are advantaged by the progressive benefit formula that provides larger relative benefits to those with lower lifetime earnings. Women who did not work or had low lifetime earnings and who were married benefit from the program's spousal and survivor benefit provisions. However, women typically receive lower monthly benefits than men because benefits are based on earnings and the number of years worked. Any across-the-board benefit cuts to restore solvency might fall disproportionately on women as a group because they rely more heavily on Social Security income than men do. Other reform approaches can have positive or negative effects on women depending on how the reforms are designed. Restructuring Social Security to include individual accounts also will likely have different effects on men and women. Because women earn less than men, contributions of a fixed percentage of earnings would put less into women's individual retirement accounts. Available evidence indicates that women also tend to invest more conservatively than men do, and thus would likely earn smaller returns on their accounts. In addition, how such accounts are structured will be extremely important to women. For example, whether individuals will be required to buy annuities with the proceeds of their accounts at retirement and how the annuities are priced could affect women quite differently from men. How benefits might be distributed to divorcees and how accounts are transferred to survivors could critically affect the retirement income of some elderly women. Understanding the potential consequences of the various reform proposals can help ensure that Social Security continues to protect vulnerable groups, such as elderly unmarried women.

Social Security and Surpluses: GAO’s Perspective on the President’s Proposals. (GAO/T-AIMD/HEHS--99–95, Feb. 23, 1999).


[These similar testimonies were given to three Senate and House committees.] The President’s recent proposal for addressing Social Security and the use of the budget surplus is complex, which makes it all the more important to focus on what it does—and what it does not do—for the nation’s long-term future. In summary, the President’s proposal does reduce debt held by the public from current levels, thereby also reducing net interest costs, raising national saving, and contributing to future economic growth. The President’s proposal also changes Social Security financing in two fundamental ways: it promises general funds in the future by, in effect, trading publicly held debt for debt held by the Social Security Trust Fund and it invests some of the trust fund in equities with the goal of capturing higher returns over the long term. However, the President’s proposal does not have any effect on the projected cash flow imbalance in the Social Security program’s taxes and benefits, which begins in 2013. In GAO’s view, the President’s proposal does not represent a Social Security reform plan and does not come close to saving Social Security.

VETERANS’ AND DOD ISSUES


The Defense Department (DOD) and its managed care support contractors provide prescription drug benefits to about 8.1 million active-duty personnel, their families, and retirees. GAO found that the significant problems that DOD is experiencing delivering its pharmacy benefits result largely from the way in which DOD manages its three pharmacy programs. Rather than viewing the programs as integral parts of a single pharmacy system, DOD manages the programs as separate entities, not taking into account, for example, the merits of establishing a uniform DOD formulary and integrated databases or the effects that initiatives, such as implementing a separate mail-service pharmacy program, will have on other programs. Unless DOD begins to manage the various components of the pharmacy programs as a single system, the problems GAO identified will continue and potentially worsen.


The Department of Veterans Affairs (VA) and Department of Defense (DOD) are the largest direct federal drug purchasers, although their combined purchases are less than two percent of total domestic drug sales. They enjoy varying, but significant, discounts on their drug purchases, the largest when they contract jointly to purchase the same drugs for their systems and through their sepa-
rate national contracts with drug makers. However, their joint and separate contracting have been limited. Only about 19 percent of VA and DOD combined drug purchases are made through such contracts; most are made at smaller discounts. If they could jointly contract for most of the 30 drug classes that now make up about two-thirds of their combined drug purchases, they could save hundreds of millions of dollars annually. Obstacles to overcome include DOD’s need to develop a national drug formulary and the departments' need to mitigate their institutional competitiveness and pursue such joint actions as drug contracting.


Overall, GAO sees no clear indication that the proposed change to the military's retirement system, which would cost an estimated $13 billion in higher costs and unfunded liabilities, will address the retention issue. Although the recently reported downturn in retention rates is of concern, the nature of the retention problem is unclear. Is the problem widespread or is it concentrated in certain military occupations or year groups? Is it a transitory problem attributable to such factors as reduced accessions during the drawdown and the strong economy, or is it the beginning of a long-term problem? Understanding the nature of the retention problem is critical in crafting solutions. According to the Defense Department, the 1986 Military Retirement Reform Act has become a symbol of eroding benefits to military members. Although surveys of military personnel show increasing dissatisfaction with the retirement system, it is not clear what that really means. For example, some surveys do not differentiate between retirement pay and other retirement benefits. The link between retirement pay and retention is also unclear. According to an analysis done by the Congressional Budget Office, retention rates under the act have not been markedly different than rates under the earlier system. Even if the retirement system is found to be linked to retention, it may not be the most cost-effective way to address existing retention problems. In addition, DOD’s proposed pay and retirement changes do not address other military retirement issues and their impact on the structure of the force.

VA Information Technology: Progress Continues Although Vulnerabilities Remain. (GAO/T-AIMD-00-321, Sept. 21, 2000).

This testimony focuses on the status of the Department of Veterans Affairs' (VA) efforts in seven areas of its information technology (IT) program: improving its process for selecting, controlling and evaluating IT investments; filling the chief information officer position; developing a strategy for reengineering its business processes; completing a departmentwide integrated systems architecture; tracking its IT expenditures; implementing the Veterans Health Administration (VHA) Decision Support System and the Veterans Benefits Administration's (VBA) compensation and pension replacement project; and improving the department’s computer security. Progress has been made in some of these areas, such as IT investment decision-making and selecting a chief information of-
ficer. In other areas, plans have changed—the Department no longer plans to develop an overall strategy for reengineering its business processes to function as One VA, nor has it defined the integrated IT architecture needed to efficiently acquire and use information systems across VA. No uniform mechanism is in place throughout VA that tracks IT spending; instead, VA’s different offices use various mechanisms for tracking IT expenditures. VHA’s Decision Support System and VBA’s compensation and pension replacement project continue to face challenges. Although VA has begun to address computer security weaknesses, it will have few guarantees that financial information and sensitive medical records are adequately protected until it develops and implements a comprehensive, coordinated security management program.


The Department of Veterans Affairs (VA) has undertaken several initiatives to better detect and prevent adverse events, including falls, medication errors, missing patients, and suicides. For example, VA has established systems that include bar code technology to prevent blood product and medication administration errors. VA is completing its implementation of a revised mandatory adverse event reporting and prevention process; the success of this initiative depends on VA establishing a culture in which employees feel safe to openly report actual adverse events as well as close calls. VA needs to prepare a detailed implementation plan that identifies how and when VA’s various patient safety initiatives will be implemented, how they are aligned to support improved patient safety, and what contribution each initiative can be expected to make toward the goal of improved patient safety.


The proposed Veterans’ Millennium Health Care Act should help the Department of Veterans Affairs (VA) provide care for veterans in more appropriate settings, reduce per-patient costs, increase the number of its patients, and reduce its reliance on appropriations. The bill’s facility realignment and cost-sharing provisions would help VA reduce budget pressures and generate the resources needed to serve more veterans and enhance their benefits. Its long-term care provisions appear to be designed to reduce variability in veterans’ access to care, addressing GAO’s concern about the potential adverse effect of VA’s transformation on the equity of veterans’ access to care. On facility services realignment, the bill requires (1) VA to develop enhanced-service plans to address veterans’ health care needs, (2) VA’s stakeholders to participate in plan development, and (3) VA to use efficiency savings locally. On long-term care, the bill (1) requires the development of a national program of services, (2) increases the percentage of VA’s budget for noninstitutional services, and (3) mandates coverage for services for certain higher-priority veterans. The bill’s cost-sharing provisions address prescription drugs, outpatient services, long-term care, and certain high-cost supplies.
Veterans Benefits Administration: Problems and Challenges Facing Disability Claims Processing. (GAO/T-HEHS/AIMD-00-146, May 18, 2000).

Claims processing in the disability compensation program is done by the Veterans Benefits Administration (VBA). Congress, the Department of Veterans Affairs, and veterans' service organizations have been concerned about the program for years. The concerns have focused on the backlogs of claims, long waits for disability decisions, and the poor quality of these decisions, all of which have undermined the quality of service provided to veterans. VBA's problems with large backlogs and long waits for decisions have not improved, despite years of studying these problems. Moreover, VBA's new quality measurement system shows that nearly one-third of its decisions are incorrect or have technical or procedural errors. Many performance problems stem from the process's complexity, which is growing as the number of service-connected disabilities per veteran increases and judicial review requires more procedures and documentation. Although VBA has begun several efforts to streamline its claims-processing performance, it is unclear how much improvement will result. Also, VBA may need to collect and analyze additional case-specific data to better understand its claims-processing problems and better target its corrective actions. Furthermore, because some issues affecting VBA's performance are a function of program design, more fundamental changes may have to be considered to realize significant improvements.

MULTIPLE ISSUES

Medicare Subvention: Challenges and Opportunities Facing a Possible VA Demonstration. (GAO/T-HEHS/GGD-99-159, July 1, 1999).

Medicare subvention in the Department of Veterans Affairs (VA) would have the goal of providing an alternative for delivering accessible and quality care to certain veterans eligible for Medicare without increasing the cost to Medicare or VA. Subvention would allow VA to supplement its funds with Medicare payments. In principle, by paying VA a discounted rate, the Medicare program might save money, so long as it does not pay for services that VA would have previously covered. A three-year Department of Defense (DOD) subvention demonstration program involves about 30,000 retirees and limits Medicare payments to DOD to $65 million a year. However, a nationwide DOD subvention program could potentially involve Medicare payments of several hundred million dollars or more. The potential size of a nationwide VA program may be even greater, with nearly all the nine million veterans aged 65 and older covered by Medicare. Proposed legislation before the House and the Senate would authorize VA subvention demonstrations. Under either bill, VA would (1) be challenged to attract veterans who currently enjoy a generous VA benefits package, (2) need to strengthen its billing systems, and (3) need to ensure that access to services is not reduced. VA will need sufficient time to implement a demonstration, and it must carefully design and implement its payment methods to protect Medicare trust funds and to pro-

Medicare-eligible military retirees to get Medicare-covered care from the Defense Department (DOD). Proposals have also been made to allow veterans to use their Medicare benefits at Department of Veterans Affairs (VA) facilities. Under subvention, Medicare pays DOD and would pay VA less than the rate paid to private Medicare providers and managed care plans. Although it got off to a slow start, DOD initiated its subvention demonstration and is serving medicare-eligible beneficiaries at six sites. Remaining operational issues include the development of viable payment rules and development of data to manage the demonstration. GAO's complete evaluation will not be available until after the demonstration ends. Meanwhile, DOD's early experience suggests that, if medicare subvention is permitted for VA, it would need to consider, in collaboration with the Health Care Financing Administration, how to determine its baseline costs and payment rules and the need for good data for implementing, managing, and controlling costs. VA would need to make its regular enrollment of veterans who wish to use VA health care services interface smoothly with subvention enrollment and would need to be concerned about crowding out other, currently higher-priority veterans. VA would succeed better if it had enough time to plan and establish its demonstration and to reconsider the value and feasibility of implementing fee-for-service and managed care subvention models simultaneously.

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ITEM 22—LEGAL SERVICES CORPORATION

SERVICE TO THE AGING

In 1974, Congress created the Legal Services Corporation (LSC) to provide civil legal aid access to low-income Americans. LSC receives an annual appropriation from Congress. In 1999, LSC funded 237 local legal aid programs across the country, serving every county in the nation.

Legal services clients are as diverse as our nation, encompassing all races, ethnic groups, and ages. The problems that bring people to local legal services offices arise out everyday of life. Usually, they relate to matters of family law, housing, employment, government benefits, or consumer disagreements. Frequently, they represent matters of crisis for clients and their families. Possible consequences may be as serious as the loss of a family’s only source of income, homelessness, or the breakup of a family.

In 1999, LSC-funded programs served 136,854 Americans ages 60 and over. Older Americans represented 13 percent of the clients served by legal services programs. Because of their special health, income, and social needs, older people often require legal assistance, especially in coping with the government-administered benefits on which many depend for income and health care.

Some local legal services programs have special elderly law units, but every program provides services to the elderly. Most LSC programs are listed in the blue or yellow pages of the phone book, usually listed under “Legal Aid” or “Legal Services.” You can also obtain a referral by calling LSC at (202) 336–8800; going to the LSC web site (www.lsc.gov); or writing to Public Affairs, LSC, 750 First St., NE, Washington, DC 20002.
ITEM 23—NATIONAL ENDOWMENT FOR THE ARTS

SUMMARY OF ACTIVITIES RELATING TO OLDER AMERICANS FISCAL YEARS 1999–2000

INTRODUCTION

As part of its overall mission, the Endowment encourages greater access to and participation in the arts as a way of contributing to the quality of life for all citizens. Most important, the energy, wisdom and creative potential that older adults bring to the arts are an important part of our cultural heritage. The National Council on the Arts has long been committed to making the arts available to underserved populations, including older adults, as stated in its 1973 resolution:

“No Citizen, regardless of physical and mental condition and abilities, age or living environment, should be deprived of the beauty and insights into the human experience that only the arts can impart.”

Everyone should have the opportunity to learn through the arts from childhood into their oldest years. However, access to cultural activities is often denied to older and disabled people because of architectural, programmatic, financial, logistic and attitudinal barriers. Surveys, including the Endowment's Survey of Public Participation in the Arts, indicate that participation in arts activity declines with age, and that disabled and older people are underrepresented in arts audiences. An individual's ability to participate in the arts with dignity and independence has a direct effect on arts programming and facility design.

OFFICE FOR ACCESSABILITY

This Office serves as the advocacy and technical assistance arm of the Arts Endowment for people who are older, disabled, or living in institutions. The Endowment’s AccessAbility Coordinator works in a myriad of ways to assist grantees and applicants in making arts programs available to these important segments of our citizenry. A broad range of cooperative efforts have been developed with Endowment disciplines, grantees, arts service groups, private groups representing older and disabled populations and with other Federal agencies—to assist in achieving the Endowment's goal of increased access to the arts for all Americans. For example, the Coordinator worked with the Consortium of New York Geriatric Education Centers and the Gerontological Society of America (GSA) to chair a symposium on “Innovative Research and Programs on Creativity and Aging” at GSA's November 18–20, 2000 conference in Washington, DC. The discussion highlighted three best practices
that demonstrate the universality and importance of the arts in the lives of older adults, assessment of community's resources for arts and aging programs, and creating linkages between arts and aging activities nationwide.

The focus of these efforts is inclusion, opening up existing programs and outreach to citizens who would not otherwise have opportunities to be involved in the best arts.

The report that follows outlines many of our leadership and technical assistance efforts that involve older adults.

**REGIONAL SYMPOSIA**

The Office provides technical assistance to applicants and grantees on the most effective and efficient ways to make the arts more available to underserved populations. This work includes workshops, seminars and how-to publications. While the doors of a theater or museum are theoretically open to everyone, many are denied such opportunities because the appropriate accommodations, such as assistive listening systems for people who are hard-of-hearing, audio description for individuals with vision loss or an elevator for those with limited mobility.

During this reporting period, the Endowment supported two regional symposia that were convened by the New England Foundation for the Arts and the Western States Arts Federation. The New England symposium, "Clearing the Path: Art and Accessibility," took place on March 1–3, 1999 in Boston, MA with 260 participants from its six-state region. It included acknowledged leaders in the arts, aging and accessibility communities presenting sessions on best practices and policies; technologies such as audio description; universal design; effective ways to achieve community involvement; staff training and resources for change.

The Western States Arts Federation convened "From Insight to Innovation: Art and Accessibility in the West" for its twelve state region on December 14–16, 2000 in Oakland, CA. The 275 participants (arts administrators, artists and representatives from aging and disability organizations) who attended workshops that focused on design, performing and visual arts, media and outreach to people living in institutions. The program featured several performances by older artists, including Stagebridge's senior actor's troupe. Stagebridge is an exemplary arts and literacy program in Oakland that reached 2,000 older adults and 12,000 at-risk youth this year.

These highly successful efforts have a catalytic effect where many state arts agencies have: replicated the symposia in regional meetings throughout their states; organized access evaluation teams to assist arts groups planning and implementing accessible programs; and set up grants programs to assist grantees with accessibility.

**CAREERS IN THE ARTS**

During this reporting period, substantial work was completed to begin implementing recommendations from our interagency, leadership initiative, "Careers in the Arts." This effort began in 1998 when the Arts Endowment initiated and developed interagency agreements with the U.S. Department of Education, Department of
Health and Human Services, the Kennedy Center for the Performing Arts and the Social Security Administration—to look at ways the agencies may advance careers in the arts for people with disabilities. Subsequently, the agencies worked in partnership to convene the first-ever “National Forum on Careers in the Arts for People with Disabilities” in June 1998. Forum participants identified obstacles faced by people with disabilities pursuing careers in the arts and developed strategies to overcome such barriers.

On June 13, 1999, the Endowment renewed its partnership with its Federal partners, and convened three 1-day summits at the Kennedy Center in Nov-Dec 1999 to plan specific activities for implementing the recommendations. They include sponsoring internships with cultural groups and convening state-level careers in the arts’ forums.

With regard to financial disincentives, there are a number of older or disabled artists who receive some form of government benefits, and have lost these essential resources for months or even years when they received some support, such as an apprenticeship, a Heritage Award or selling a quilt. In response to these concerns, the Social Security Administration (SSA) supported a December 7, 1999 policy education meeting to address government financial disincentives that affect artists who receive sporadic income from their art or monetary awards. Convened in the Senate Dirkson Building, artists and government officials talked openly with each other about these issues. SSA staff discussed proposed legislation that would provide people leaving the system for work, the option of continuing government health benefits, including Medicaid. The legislation was signed into law by President Clinton on Dec. 18, 1999.

The reports from the Forum, Summits and SSA meetings are posted on the Kennedy Center’s website at http://artsedge.kennedy-center.org/forum

**Universal Design**

Since 1990, the Arts Endowment has conducted a leadership initiative on universal design, the design process that eliminates "special labels" to create excellent design that make products and spaces functional for people from childhood into their oldest years.

*Universal Design Exemplars*

The Endowment supported the Center for Universal Design at North Carolina State University in Raleigh to conduct a national search to identify, document and produce on CD-Rom the second set of excellent examples of universal design that will be disseminated to designers, educators, city planners and others. The new exemplars include architecture, exhibit design, industrial design, interior design and landscape architecture; and they are displayed on the Center’s website at www.design.ncsu.edu/cud/ude

*June 7–8, 1999 Endowment Meeting on Universal Design*

The Endowment’s AccessAbility Office convened a meeting of thirteen universal design experts from design professions, academia, consumer groups, and government to: assess the current state of universal design; and to identify future opportunities for
encouraging and assisting the practice of universal design. A starting point was the seminal Endowment meeting held a decade ago to outline a blueprint for action to advance universal design practice.

Chairman Ivey addressed the group, and asked for their suggestions on how the Endowment may best serve the field in this area, which stimulated much discussion. The group agreed that universal design has gained a significant foothold in professional organizations and among cultural institutions. At several universities, centers and curricula that incorporate universal design have made substantial contributions to the field. Major publications, international conferences and exhibitions have helped to raise public awareness. The American Association of Retired Persons (AARP) has seized upon it as a leading issue to support healthy aging-in-place.

In spite of the accomplishments, universal design faces challenges in the areas of public and professional misperceptions about what universal design is, and that it extends to every aspect of society and seeks to imbue all design with values of full inclusion regardless of a person’s age or abilities. Participants advised that strategies be developed to broaden the appeal of universal design, to take it out of the disability community into the broad mainstream of society. Public relations efforts in the press, radio and television could assist this goal. Design competitions could reveal exemplars to take to consumers, showing how objects and environments that feature universal design principles add both to the quality of life and to the business’s bottom line. At the same time that the broader society discovers the value of universal design, educators and practitioners need constant reminders of the movement’s activities and philosophy. The meeting report containing a wealth of recommendations is posted on the Endowment’s website at www.arts.gov.

In addition, we developed a universal design working group composed of the Administration on Aging, the AARP, the Association of Collegiate Schools of Architecture, the Industrial Design Society, U.S. Dept. of Housing and Urban Development, Adaptive Environments, Inc., and the American Institute of Architects to look at ways that we may work together to implement some of the recommendations, including a student competition on universal design.

Access to Design Professions

This 1999 leadership project builds on our Careers in the Arts and Universal Design leadership initiatives. We found that there are few designers with disabilities in any design professions. Traditional recruitment methods do not target students with disabilities, and rehabilitation counselors do not direct or support disabled students into design professions. This three-part project will result in an action plan that begins to address this complex problem. It includes conducting research on barriers in education, career planning and work experience. Phase two will convene educators, vocational professionals, and designers with and without disabilities to draft and finalize the action plan. Although next steps will be de-
The desire and ability to create have no bearing on a person's age or physical characteristics. Lifelong learning in the arts continues to me a major goal of the Arts Endowment.
National Database Arts and Older Americans

The Endowment's AccessAbility Office worked with Elders Share the Arts in Brooklyn, NY to update a national data base on arts programs involving older adults. It includes over 600 project descriptions, with resources to assist groups in developing similar programs, networks and partnerships. It is organized state-by-state, with funding and contact information, and will be available on Elders' website in June 2001.

International Year of the Older Person

The AccessAbility Coordinator served on a planning committee for a symposium that was organized by the Administration on Aging and held in conjunction with the United Nations' International Year of the Older Person, "Coming of Age: Federal Agencies and the Longevity Revolution." Convened on June 2, 1999 at the National Institute of Health in Bethesda, MD, it brought together 300 Federal policymakers to look at ways that government agencies may work collaboratively to meet the needs of America's aging population. Two of sixteen policy panels for the meeting focused on the arts, "Universal Design and Independent Living," and "Promoting Active Aging through Life-Long Learning and the Arts." Both presentations were well received and stimulated extensive discussion.

Arts Endowment Funding

The National Endowment for the Arts continues to support arts activities that benefit people of all ages. Many of these projects specifically address older adults as listed in the following examples by arts discipline.

FY 1999 Grants

Dance

Jacob's Pillow Dance Festival, Inc. in Lee, Massachusetts was awarded a grant to support a consortium project entitled "What is Dance?: A Model for Dance Literacy." The consortium of Jacob's Pillow Dance Festival (Lee, MA), The Flynn Theatre of the Performing Arts (Burlington, VT), Bates Dance Festival (Lewiston, ME), and the Hopkins Center at Dartmouth College (Hanover, MA) presented What is Dance?: A Model for Dance Literacy, a program that assists adults of all ages in understanding and appreciating dance as an art form.

Very Special Arts Montana Inc. of Missoula, Montana received a grant to support a consortium project to provide dance programs for children and adults with and without disabilities and concerts for community audiences. Very Special Arts Montana, Young Audiences of Western Montana, and The Montana Transport Company provided school programs and master classes in dance and presented a community performance in modern dance.
FOLK AND TRADITIONAL ARTS

FOLK ARTS FELLOWSHIPS

Eleven National Heritage Fellowships were awarded to artists who are over the age of sixty-two, in recognition of their outstanding contributions to the arts. They include:

Alfredo Campos of Federal Way, Washington is the unsurpassed senior horsehair hitcher of the late 20th century. Raised on a ranch in Arizona, Mr. Campos was fascinated by the beautiful horsegear made from pieces of braided rawhide in the Mexican vaquero tradition. Prized horsehair hitching was difficult to find in the years before Alfredo Campos was "discovered," but the impeccable workmanship and colorful beauty of his quirts, headstalls, bosals, and reins were a key to a renaissance in the art form.

Elliott Mannette, of Morgantown, West Virginia, is the most widely recognized innovator, teacher, and representative of the steel drum tradition. At the end of World War II, Mr. Mannette became the leader of one of Trinidad's greatest and longest-lasting bands, Invaders. Also at this time, oil drum lids became the standard source material for steel drums, and Mr. Mannette, a machinist by trade, applied his skills to improve the pan, helping to propel it to broad popularity. Over the next several decades he brought an even more sophisticated approach to pan tuning, and in 1967 he settled in the United States, where he has taught and become the main source of steel band instruments through his company The Mannette Touch.

Eudokia Sorochaniuk of Pennsauken, New Jersey learned the arts of nyzanka embroidery and weaving as a young girl in Ukraine. Leaving her home with her family following World War II, she eventually settled in the United States. Working days at a garment factory, she wove traditional patterns on a loom at home at night. Over the fifty years that she has been in New Jersey, she has reproduced albums full of nyz patterns, each containing one or more of the intricate designs. Ms. Sorochaniuk's commitment to tradition involves preserving not just the patterns but the practice of the art forms. She has taught and participated in numerous folk arts programs in the United States and Ukraine.

FOLK ARTS GRANTS

Apache Tribe of Oklahoma in Anadarko, Oklahoma received a grant to support workshops in the creating and decorating of material culture items associated with the Apache Tribe of Oklahoma, to be taught by tribal elders. Of importance to community members as a whole is that the patterns, forms, color, and styles of beading, twining of fringe, and the collecting of and use of paint be preserved and passed on to future generations.

Los Reyes de Albuquerque of Albuquerque, New Mexico was awarded a grant to support and perpetuate the traditional Nuevomexicano music, songs and culture of northern New Mexico and southern Colorado through presentations at child day-care centers and urban, rural, and Pueblo senior centers. Each presentation
consisted of brief talks with songs and dances in a relaxed, friendly setting where the audience is encouraged to sing along, dance or simply enjoy the music.

Senior Arts Project in Albuquerque, New Mexico received a grant to support activities that enabled older adults to gain an in-depth understanding of New Mexico's Spanish Colonial cultural heritage. Senior Arts presented Antonia Apodaca and Cipriano Vigil, older folk musicians who specialize in the Spanish Colonial music and dance of Northern New Mexico.

LEADERSHIP INITIATIVES

Accessible Arts, Inc. of Kansas City, Missouri was awarded a grant to support the creation of a community cultural plan. Partners worked together to expand arts/education data bases to include artists with disabilities of all ages throughout the state and identify schools that need training for work with children with disabilities.

Society for the Arts in Healthcare in Washington, DC received a Leadership Initiatives grant to support a national technical assistance project that trains arts administrators and artists as consultants to educate and assist healthcare institutions across the country in establishing comprehensive, professional arts programming within their institutions.

VSA arts of Washington, DC received a leadership initiative grant to support stipends for 50 artist presenters at the ArtCareers Expo, where people with disabilities of all ages explored careers in the arts. ArtCareers Expo was held in Los Angeles, CA, in conjunction with the International VSA Festival in June 1999.

LITERATURE

One literature fellowship went to a writer over the age of sixty-two:

George Economou of Norman, Oklahoma is Professor of English at the University of Oklahoma. He has published six books of poetry, several books on medieval literature, and numerous translations from ancient and modern Greek as well as from a number of medieval languages. His poems, translations, and criticism have appeared in many leading literary and scholarly journals, and he has held fellowships for his writing from the New York State Council for the Arts and the Rockefeller Foundation. He has received two NEA Creative Writing Fellowships in Poetry, in 1988 and 1999.

MEDIA ARTS

Washington, DC International Film Festival received funding to support the 1999 Washington, DC International Film Festival. Held annually in the spring, this event includes free films for children, older adults, and underserved communities.

MULTI DISCIPLINARY

Elders Share the Arts in Brooklyn, New York received funding for the development of new earned income through the establish-
ment of Creative Aging Institutes, which offer training to develop arts programs for older adults. The project includes support for marketing the ESTA training program in San Francisco, CA; Chicago, IL; Boston, MA; and Atlanta, GA.

MUSEUM

The Mint Museum of Art, Inc. in Charlotte, North Carolina received a grant to support the exhibition “Harvey Littleton: Reflections, 1946–1994,” and an accompanying catalogue and education programs. The project will examine Littleton’s long career as a glass artist and his influence as a teacher and advocate for the American studio crafts movement.

MUSIC

AMERICAN JAZZ MASTERS FELLOWSHIPS

Three American Jazz Masters fellowships were awarded to older artists in recognition of their contributions to the field of Jazz.

Dr. David Baker, of Bloomington, Indiana, was one of the first trombonists to incorporate avant-garde effects on the horn. Levels (1973), a concerto for solo double bass, jazz band, wind, and strings was nominated for a Pulitzer Prize, and his compositions have been recorded by many other musicians. David Baker has written extensively on jazz and produced several innovative textbooks and analyses of jazz works. He is well known in his capacity as the Chairman of the Jazz Department in the School of Music at Indiana University, and continues to make a mark on the preservation of jazz in this country by his leadership as Conductor and Artistic Director of the Smithsonian Jazz Masterworks Orchestra.

Dr. Donald Byrd, of Teaneck, NJ, is a trumpet virtuoso who has been one of the most creative and influential figures in jazz for four decades, gaining an outstanding reputation as a composer, arranger, and bandleader. In the mid–1950’s, his career skyrocketed in the areas of bebop and hardbop with Art Blakey’s Jazz Messengers. In the early 1970’s, the jazz fusion movement established Dr. Byrd as a “pioneer of a new sound.” Dr. Byrd has been a seminal figure at the forefront of jazz education, helping to create such jazz programs as those now available at Rutgers, Howard, and North Carolina Central Universities.

Marian McPartland of Port Washington, NY is the host of the National Public Radio’s “Marian McPartland’s Piano Jazz,” winner of the prestigious Peabody Award. Developed into one of jazz’s premiere showcases, Ms. McPartland plays duets with a stunningly diverse array of known and lesser-known musicians (and legends such as Dizzy Gillespie and Benny Carter) and engages them in often intimate interviews some of the best shows are issued on Jazz Alliance CDs. Ms. McPartland is also a gifted composer and writer. Ms. McPartland is a recipient of the Lifetime Achievement Award presented by Downbeat magazine and also the Duke Ellington Fellowship Medal.
MUSIC GRANTS

Amherst Saxophone Society, Inc. of Williamsville, New York was awarded a grant to support a residency in western New York. The residency included a concert series, free outdoor concerts, residency activities at the University of Buffalo, a virtual residency of distance learning through the Center for Applied Research in Technology at Buffalo State College, and a videotape series to reach less-accessible audiences.

DaCapo Chamber Players, Inc. of New York, New York received funding to support artists’ fees and production costs for four concerts and mini-residencies in several states. These concerts and mini-residencies of two separate programs brought American chamber music to rural audiences and to students of all ages and backgrounds, helping expand artistic horizons.

Houston Symphony Society of Houston, Texas was awarded funding to support a community outreach project by the Houston Symphony. During 1999–2000, the Symphony conducted outreach activities to underserved Houston and Harris County communities, including schools, hospitals, and long-term care facilities.


OPERA

New Cleveland Opera Company of Cleveland, Ohio received funding to support education and outreach programs for students kindergarten age to senior adult in underserved urban and rural communities. The project emphasized participatory activities for elementary, middle, and high school students in addition to cross-generational and community partnerships for adults.

THEATER

Center Stage Associates, Inc. in Baltimore, Maryland was awarded a grant to support the expenses associated with the production of a play in which deaf and hearing actors were utilized. Rehearsals for the production of Brendan Behan’s play, The Hostage, explored language and systems of communication that could be implemented onstage.

Deaf West Theatre of North Hollywood, California was the recipient of a grant to support the production of Carmen Zapata’s translation of “The House of Bernarda Alba” by Federico Garcia Lorca. Presented at Actors Alley at the El Portal (North Hollywood) and adapted for a 1-hour, youth-oriented version for school groups, the play was a collaboration between deaf and hearing individuals, co-written by a deaf playwright and a Latino writer.

National Theatre of the Deaf, Inc. of Hartford, Connecticut received funding to support the expenses associated with the development, video documentation, and showcase performance of a new work. It was original piece by playwright Romulus Linney and
based upon the work of Willard R. Trask. Entitled *The Unwritten Song*, it was further developed through a series of workshops and showcase performances during which a documentary of the play and its development process was produced and broadcast in cooperation with Connecticut Public Television.

Non-Traditional Casting Project, Inc. of New York, New York received funding to support costs for Artist Files/Artist Files Online. The two services expand opportunities for, and access to, artists of color, artists of all ages, and artists with disabilities in the American non-profit professional theater.

Stagebridge of Oakland, California received a grant to support expenses associated with Storybridge, an intergenerational literacy project. The project brings older storytellers into elementary schools and offers presentations of a literacy-based play entitled Grandparents Tales.

**VISUAL ARTS**

Grass Roots Art and Community Effort of Hardwick, Vermont received funding to support a weekly community arts workshop for developmentally disabled adults and children in a rural and economically depressed region of Vermont. The project built on GRACE's successful workshop model in the nearby community of Greensboro.

Little City Foundation of Palatine, Illinois received funding to support “Creativity on Wheels,” a series of traveling art classes that serve adults and children with developmental disabilities. Artist/teachers, equipped with mobile art materials, traveled to non-profit and community organizations in the greater Chicago area to conduct art classes from fall of 1999 to the summer of 2000.

Real Art Ways, Inc. of Hartford, Connecticut was awarded funding to support “Access/Real/Art,” an educational program to complement the contemporary exhibitions scheduled at Real Art Ways. The project targeted school-age children and older adults and includes the establishment of a pilot program to train community members as docents.

**FY 2000 Grants**

**DANCE**

Colorado Dance Festival, Inc. in Boulder, Colorado was awarded funding to support Tap 2001, a project examining the legacy and future of the art of tap. This project brings together several generations of leading tap artists to examine essential aesthetic, philosophical, and practical issues for the field in the new millennium.

Professional Flair, Inc. of Cleveland, Ohio received a grant to support the development of a model school for the performing arts and continuation of lecture-demonstrations. Classes at the school introduce dance technique and provide advanced technique training to people of all ages who use wheelchairs for mobility as well as to students with other types of disabilities and participants who are not disabled.

Rhythm In Shoes, Inc. of Dayton, Ohio received funding to support the creation of a new work. Artistic Directors Sharon Leahy
and Rick Good are collaborating with local performing artists, company members, and senior adults from southwestern Ohio to create the final piece of an evening length work titled Nova Town.

DESIGN

Business and Professional People for the Public Interest of Chicago, Illinois was awarded a grant to support a national, two-stage design competition for a new “universal design” elementary school that fully integrates disabled and non-disabled students. Leadership for Quality Education and the Small Schools Coalition will also participate in the project. Universal design accommodates people from childhood into their oldest years.

LINC Housing Corporation of Long Beach, CA received funding to support a limited competition for the design of an innovative, intergenerational residential and educational village. The villages acts as a demonstration project for the integration of affordable housing and existing educational programs.

FOLK AND TRADITIONAL ARTS

NATIONAL HERITAGE FELLOWS

Nine of the thirteen National Heritage Fellows in 2000 are older adults. They include:
Nettie Jackson, a Klickitat basketmaker from White Swan, Washington. She is recognized as one of the most skilled and creative Native American basketmakers of the Klickitat people, and admired as an extraordinary artist, cultural conservator, mentor and role model. Her work is displayed in museums throughout the Northwest.

Frankie Manning, of Corona, New York. Mr. Manning is the quintessential master of the Lindy Hop dance style, having introduced new and dazzling dance elements that included synchronized ensembles, horizontal postures, “freeze” steps and the “aerial,” catapulting a partner in a forward somersault. He appeared with the swing bands of Count Basie, Benny Goodman and Louis Armstrong, and won a Tony Award for his choreography in the Broadway show Black and Blue.

Don Walser, a western singer and guitarist from Austin, Texas. Termed “the Pavarotti of the Plains,” Mr. Walser possesses one of the powerful tenor voices in the field of country music. A yodeler and singer of amazing facility, he preserves a style reminiscent of earlier cowboy singers while adding his own fresh and engaging approach. After forty-five years with the National Guard, Mr. Walser has turned to music full time.

FOLK ARTS GRANTS

Los Reyes de Albuquerque Foundation in Albuquerque, New Mexico received funding to support and perpetuate nuevomexicano folk traditions and to present specially arranged performances of the Fiesta de los Novios. Nuevomexicano presentations are held at urban, rural and Pueblo senior centers, and child day-care centers; the Fiesta de los Novios presentations at Albuquerque Community
Center After School Programs are designed to educate inner city youth ages 6–14.

Montana Asian-American Center of Missoula, Montana received a grant to support the passing on of the artistic repertoire, techniques, and traditions of paj ntaub appliqué and embroidery to Hmong and non-Asian youth in Missoula, Montana; including an exhibition. Two master embroiderers and Hmong elders mentor 20 students through a year-long course in Hmong cross-stitch, tuck-and-fold, crewel, and reverse appliqué.

Senior Arts Project in Albuquerque, New Mexico was awarded a grant to support the Senior Arts Celebration of Native Artists. A series of performances and workshops are taking place in Albuquerque’s public senior facilities featuring Native American art and culture.

University of Missouri at Columbia in Columbia, Missouri received funding to support a consortium project, the Missouri Traditional Arts Apprenticeship Program. The apprenticeship program is designed to encourage the state’s most skilled, active, and communicative tradition bearers to pass their knowledge on the next generation.

LEADERSHIP INITIATIVES

Arts Iowa City in Iowa City, Iowa received a grant to support the design and development of promotional materials to identify the city arts and culture district. Located in the refurbished downtown, the city's cultural district is being identified through a signature sculpture commissioned for the space, banners, maps and other printed materials that promote and inform the public of Iowa City's cultural assets. Partners include: Johnson County/Iowa City Senior Center, the Downtown Association, Iowa City Area Chamber of Commerce, Iowa City/ Coralville Visitors and Convention Bureau, University Relations Office of the University of Iowa, Iowa City Jazz Festival, Iowa Arts Festival, Englert Civic Theatre Association, Iowa City Public Library, city of Iowa City Planning Department, Inner Ear Theatre, Riverside Theater, and the Public Art Program advisory committee.

Delta State University in Cleveland, Ohio received funding to support a series of arts education professional development workshops for arts educators at the Bologna Performing Arts Center. With instructors drawn from both local arts organizations and from the Kennedy Center for the Arts “Partners in Education” program, the primary intent of the workshops is to provide tools for public school teachers to more effectively incorporate the arts into existing school curricula. Partners include: Bolivar Regional Medical Center, Region I Mental Health Department, Delta Area Association for the Improvement of Schools, Benoit School District, North Bolivar School District, Washington County School District, Mississippi Alliance for Arts Education, Crossties Arts Council, Greenville Arts Council, the AmeriCorps Program at Delta State University’s Center for Community Development, DSU’s Department of Education, Junior Auxiliary of Cleveland, and King’s Daughters Hospital Social Services Department.

Elders Share the Arts of Brooklyn, New York was awarded funding to support a Creative Links project. The partnership brings to-
together Union Settlement Association to support the intergenerational after-school program Living History, which pairs teens in East Harlem with older adults who are unable to attend programs and live at home. The students in this project work with two professional artists to transform the elders’ oral history into exhibited artworks. Twenty-one students, ages 14 to 16, and 12 to 20 elders will work together to create an exhibition at Union Settlement’s Community Gallery.

El Puente de Williamsburg, Inc. in Brooklyn, New York was awarded a grant to support a Creative Links project that involves a partnership with the Los Sures Senior Citizen Center for Recipe for Cultural Wellness. This program brings together approximately 30 low-income youth, ages 12 to 21, and 20 older adults in the Latino community to create a mural, theatrical presentation, and documentary video around the theme of food and cultural wellness, utilizing the tradition of oral history and the rituals of cooking.

Greater Akron Musical Association, Inc. in Akron, Ohio received funding to support a Creative Links project. Musicians from the Akron Symphony and Omo Iroko Dance Society provide lessons in Trinidadian steel drum and African drum playing for middle school students participating in a health program for youth of the Children’s Hospital Center of Akron. The youth then teach drum playing to older adults at the Akron Metropolitan Housing Authority’s Saferstein Towers.

Maine Indian Basketmakers Alliance in Old Town, Maine received a grant to support a Creative Links project. The partnership brings together the Passamaquoddy Tribe to organize and lead traditional basketry workshops in four reservation communities in Maine. The program seeks to encourage younger generations of tribal members to learn traditional ash and sweetgrass basketry to preserve this endangered traditional Native American art form.

VSA arts of Michigan in Detroit, Michigan received a grant to support a Creative Links project. The partnership brings together The Arc Detroit, Great Lakes CIL, Detroit Institute of Art, Wayne State University, Michigan Rehabilitation Services, Detroit Public Schools and the Center for Creative Studies to provide after-school vocational training and creative opportunities in visual arts, conducted by professional artists of all ages with disabilities for 30 teens with disabilities.

LITERATURE

LITERATURE FELLOWSHIPS

Three literature fellowships were awarded to individual writers over the age of sixty-two.

Rosa Shand of Spartanburg, South Carolina, currently Professor of English at Converse College, has published short fiction in literary journals such as The Virginia Quarterly Review, The Massachusetts Review, and The Indiana Review. Her first novel, The Gravity of Sunlight, was released by Soho Press in the summer of 2000. The recipient of artist residencies at Yaddo and the MacDowell Colony, she was awarded an Arts Endowment Creative Writing Fellowship in Fiction in 2000.
Margaret E. W. Jones of Lexington, Kentucky holds the Chair of the Department of Spanish at the University of Kentucky. She is a widely published translator of Spanish fiction and essay, and author of numerous scholarly books and articles on contemporary Spanish literature and feminism. She was awarded a 2000 Fellowship in Translation from the NEA to support the translation of a book-length essay by Carmen Martín-Gaite.

Donald A. Yates of St. Helena, California is retired Professor Emeritus of Spanish American Literature at Michigan State University. His translations include: Labyrinths: Selected Writings of Jorge Luis Borges, the first collection of Borges' work to appear in English; and novels by Argentinian authors Manuel Payrou, Marco Denevi, and Adolfo Bioy Casares. He was awarded a 2000 Fellowship in Translation from the Arts Endowment to support the translation of the complete works of Argentinian novelist Edgar Brau.

**LITERATURE GRANTS**

Curbstone Press, Inc. of Willimantic, Connecticut received funding to support the Windham Area Poetry Project, a program of readings and writing workshops serving immigrant communities, senior care homes, juvenile homes, prisons, social service organizations and public schools in northeastern, rural Connecticut.

**LOCAL ARTS AGENCY**

Burklyn Arts Council in Lyndonville, Vermont was awarded a grant to support ticket subsidies for school children and older adults to attend area performances and exhibitions. The arts events are sponsored by Catamount Arts, a major presenter of regional artistry, with scheduled performances by folk musicians Peter Ostroushko and Dean McGraw, actress Billie Jean Young in a one woman show, jazz artist David Liebman, and the Perlman-Nikkonen-Bailey Trio, a chamber music ensemble.

**MEDIA**

Hot Springs Documentary Film in Hot Springs, Arkansas received a grant to support educational activities during the 2000 Hot Springs Documentary Film Festival. These include symposia, forums, discussion groups, and special programs for children and older adults.

L.A. Theatre Works in Los Angeles, California was awarded a grant to support the distribution of up to five audio plays to hundreds of underserved libraries, including facilities that serve blind and visually impaired people. In addition, L.A. Theatre Works is providing the organizations with print materials (large print and recorded versions for visually impaired people) to augment the collection.

Washington, DC International Film Festival received a grant to support the Washington, DC International Film Festival. Held annually in the spring, this event includes free films for children, older adults, and underserved communities.
ARTREACH Inc. in Philadelphia, Pennsylvania received funding to support the development and distribution of a “Cultural Access Guide for the Disabled.” This resource guide includes comprehensive information about access to buildings, programs, and services offered to people with disabilities by a number of cultural venues in a tri-state region of Pennsylvania, Delaware, and southern New Jersey.

Elders Share the Arts in Brooklyn, New York received a grant to support their consortium project, the Center for Creative Aging. The project supports program maintenance and expansion in up to five cities Boston, Miami, New York, Philadelphia, and San Francisco.

Little City Foundation of Palatine, Illinois received funding to support Have Art, Will Travel, a series of traveling arts classes that serve children and adults of all ages with developmental disabilities where they live and work. Artist teachers equipped with movable art materials offer classes in visual, performing, and media arts.

VSA Arts of Massachusetts in Boston, Massachusetts received funding to support the National Cultural Access Initiative. This initiative works with each state to provide local infrastructure for people of all ages with disabilities and the cultural organizations of their communities.

MUSIC

AMERICAN JAZZ MASTERS FELLOWSHIPS

Three American Jazz Masters fellowships were awarded to older artists in recognition of their contributions to the field of Jazz.

John Lewis of New York City, as pianist, composer/arranger, and music director of the Modern Jazz Quartet (formed in 1952), became the architect of a unique sound in the history of jazz, and was instrumental in greatly expanding the audiences for jazz. In the 1950's and 60's he assisted in the establishment of the Jazz and Classical Music Society and Orchestra USA. The latter ensemble performed and recorded “third-stream” compositions the merging of traditional jazz and European Classical forms of composed music. He has held teaching positions at City College of New York and at Harvard University. Leonard Feather wrote in the Encyclopedia of Jazz, “John Lewis is regarded as one of the most brilliant minds ever applied to Jazz.”

Jackie McLean of Hartford, Connecticut was raised in Harlem's Sugar Hill district, and began playing alto saxophone at age 15. He developed his talents to become one of the true masters of his instrument and the “free” jazz sound evolving from bebop. In 1970 he and his wife Dollie established the Artists Collective, Inc., a cultural center that uses arts education for social improvement for the inner-city youth. Mr. McLean also teaches at the Hartt College of Music at the University of Hartford, where he developed the jazz degree program and is chairman of the African American Music Department.
Randy Weston of Brooklyn, New York remains one of the world's foremost pianists and composers today, a true innovator and visionary. A disciple of Duke Ellington and his music, Mr. Weston's formative years were shaped by his mentorship with Thelonious Monk. Visiting parts of Africa in the early 60's and finally settling in Rabat, Morocco in 1968, his artistry became infused with the continent's music and its rhythms. Many of his works have become indelible jazz standards. In addition to being a master jazz artist, Mr. Weston is a pioneer in recognizing important cultural connections and he continues to demonstrate ways to erode barriers that separate nations.

MUSIC GRANTS

Cedar Rapids Symphony Orchestra in Cedar Rapids, Iowa received a grant to support the education program, “Creating the Future: a Plan for the New Millennium.” In 2000-01, the program's many components include an enrichment program for third graders; music education in an older adults housing complex; after-school music lessons for students in grades three through five; a video broadcast of interactive, educational programs to Iowa schools; an early childhood education program for families with special needs and “at risk” children; and music education enhancements in four area colleges.

Composers Conference and Chamber Music Center, Inc. in Wayland, Massachusetts was awarded funding to support a composer's project enabling young composers to study with senior composers and musicians, and for concert presentations and recordings of their work by new music experts at Wellesley College. Ten young composers, selected by a professional jury from an applicant pool of about 100, participated in this project, part of the 56th Annual Composers Conference from July 23 to August 6, 2000.

Concord Community Music School (CCMS) in Concord, New Hampshire received a grant to support the “Music in the Community Initiative,” providing rural and underserved communities with music education opportunities. Statewide in scope, the initiative is taking place through partnerships with schools, senior centers, human service agencies, pre-schools serving at-risk families, and mental health centers during 2000-01.

Houston Symphony Society in Houston, Texas received a grant to support “Music Matters: Community Connections,” an outreach project for underserved communities. During 2000–01, the Houston Symphony's musicians is performing at various sites, including nursing homes, community centers, hospitals, and schools.

Music & Arts Center for the Handicapped, Inc. in Bridgeport, Connecticut was awarded funding to support access to music education for visually impaired people of all ages. During 2000–01, the Music & Arts Center for the Handicapped is providing training to music teachers in Braille music and in the use of computer music technology, including workshops held during various national education conferences.

Rhode Island Philharmonic in Providence, RI was awarded a grant to support “Music After Hours,” a consortium project with the Music School. During 2001, the Rhode Island Philharmonic and the Music School will provide after-school music education pro-
grams to children in grades three to five, particularly youths at risk, and senior adults.

**Musical Theater**

Children's Theatre of Cincinnati in Cincinnati, Ohio received funding to support sign language interpretation and pre-production expenses of a commissioned work entitled "The Beethoven Symphony." The Children's Theatre of Cincinnati will develop and co-produce the new work with the National Theatre of the Deaf of Chester, CT, composed by adults of all ages.

**Opera**

New Cleveland Opera Company in Cleveland, Ohio received funding to support the company's education program encompassing in-school residencies, student/artist opera productions, and student/senior service center partnerships. The program also includes a year-long Music! Words! Opera! project for elementary and middle-school students, and Great Works-teacher and artist-led activities that prepare students in grades 6 through 12 to attend the Cleveland Opera matinee performances.

Opera Association of Central Ohio in Columbus, Ohio received a grant to support the company's educational programs, with emphasis on longer-term residencies and the integration of opera programming into the classroom curriculum. The touring component of Opera/Columbus's education department is conducting as many as 200 educational events in churches, classrooms, community centers, and senior living-facilities during 2000–01.

**Theater**

Indiana Repertory Theatre, Inc. in Indianapolis, Indiana received funding to support the development of a co-commissioned play in consortium with the People's Light & Theatre Company of Malvern, PA. The play, by James Still, explores the 20th century through the eyes of three generations.

New York Deaf Theatre, Ltd. of New York City was awarded a grant to support the development and production of a play written by deaf playwright Harrison Lewis. The production is titled "Remembrance of an Alumni Room." Playwrights Project of San Diego, California received funding to support the expansion of Lifestages, a program that creates theatre from the life experiences of older people. Older adults in convalescent hospitals or residences are paired with professional actor/writers to create and perform autobiographical vignettes from their lives.

Stagebridge of Oakland, California received funding to support expenses associated with an intergenerational literacy project. Storybridge brings young and old together through theater and storytelling to teach language, reading, interpersonal, and artistic skills.

Theater By The Blind Corporation in New York, New York received a grant to support their continuing education of blind and visually impaired actors through a series of reading projects. Theatre By The Blind has established a text/script reading service for
blind and visually impaired actors that culminates in public staged readings of scripts.

**VISUAL ARTS**

Grass-Roots Art and Community Effort of Hardwick, Vermont received funding to support community art workshops for residents in rural and economically distressed areas of Vermont. Designed to reach a diverse spectrum of the community including older adults and developmentally disabled adults and children, the project builds on a 16-year history of workshop opportunities.

St. Mark’s Church in-the-Bowery in New York City was awarded a grant to support workshops and exhibitions in photography, video, and Web site design for youths and seniors residing on New York’s Lower East Side. The project is part of “The Diary Project,” an international exchange program between schools in the United States, Kenya, and South Africa.
Grants awarded by the National Endowment for the Humanities support teaching, scholarship, and programs for the general public in history, literature, philosophy, and other disciplines of the humanities. The purposes that NEH exists to foster the transmission of knowledge to succeeding generations, the creation of new knowledge, and the diffusion of cultural opportunity—are really manifestations of the same thing; they express our national commitment to, in the words of the Endowment's authorizing legislation, "progress and scholarship in the humanities." In the American democratic context, that commitment has meant, among other things, ensuring a continuum of lifelong learning opportunities for everyone, of whatever age.

Guaranteeing the availability of these opportunities for older Americans in particular has never been a greater national priority than it is now. According to projections of the U.S. Census Bureau, the percentage of the population that is 65 or older, currently almost 13 percent, will rise to 20 percent by 2030. Living longer, older Americans are spending more years in retirement and enjoying better health as they do. Not only are older Americans more vigorous, but they are also better educated than ever before; 67 percent of Americans 65 or older have at least a high school diploma, and nearly 15 percent have completed four years of college. The Census Bureau projects that, by 2030, 83 percent of retirement-aged Americans will be high school graduates and 24 percent will have a bachelor's degree.

Active engagement with learning can make retirement more productive and fulfilling, stimulating continued intellectual growth and interaction with others. But, learning is the task of a lifetime, not just of the retirement years. In a special paper prepared for the President's Committee on the Arts and the Humanities, Ronald J. Manheimer, director of the North Carolina Center for Creative Retirement at the University of North Carolina, Asheville, comments as follows:

Most of the research findings in the field of gerontology support the "continuity theory of aging," that people not only remain pretty much the same, in terms of taste, interests and choice of activities from earlier in adulthood, they become even more who they were—preferences, like personality traits, intensifying.
School children whose earliest experience of literature will be more memorable because a favorite English teacher has attended a substantive summer study program; undergraduates whose understanding of history is grounded in the most current scholarship because those who teach that subject in America’s colleges and universities have access to research fellowships and other opportunities for professional growth; and working adults who can find cultural enrichment in libraries and museums or on television in the communities where they live—these are the ultimate beneficiaries of NEH grant programs that help sustain a continuum of lifelong learning opportunities for everyone. The benefits that Americans derive from these experiences will accrue throughout a lifetime, and not least during the years of retirement.

ORAL HISTORY

In November 1999, just in time for the Thanksgiving holiday, the Endowment and the White House Millennium Council launched My History is America’s History, a nationwide family history initiative. Through a widely distributed guidebook and an interactive website (myhistory.org), the project details fifteen things anyone can do to preserve America’s stories. There are easy-to-follow instructions for conducting oral history interviews with elderly relatives; preserving and researching family photographs, letters, and other treasures; constructing a family tree; exploring hometown history; and connecting family stories with the larger narrative of American history. Visitors to the website are encouraged to post favorite family stories that have been told and retold across generations. Stories so far posted include “My Grandfather’s World War II Story,” “Myrtle May Campbell and the Choctaws,” and “Roosevelt Cookies.”

During the past two fiscal years, the Endowment has supported many oral history projects that are helping to save America’s stories, even as they strengthen intergenerational and community ties. For example, the Jewish Women’s Archive in Brookline, Massachusetts received two grants totaling $50,797 to plan Weaving Women’s Words, an effort that will create a web-based archive of oral histories that record the lives of American Jewish women as they have been lived in Seattle, Baltimore, and Omaha during the 20th century. Two small grants were awarded to preserve and catalogue oral history collections at the Centro Alameda in San Antonio, Texas, and at Fort Berthold Community College, a tribal institution in North Dakota. Three projects in Alaska received grants of $10,000 to support the collaborative efforts of scholars and Aleut, Minto Athabascan and Tlingit elders to document Native American traditions. Grants of $10,000 were awarded to the Wing Luke Asian Museum of Seattle to plan the public interpretation of Chinese-American artifacts and oral histories and to the University of Guam to plan oral history interviews and public presentation on Guamanian history. The state humanities councils in Texas and Ohio each received a grant of $20,000 for state-wide oral history projects. And, the Community College Humanities Association is using an NEH grant of $280,367 to support Faces of America: Photographs and Memory. At a series of forums in 30 communities nationwide, scholars and members the public will discuss family pho-
tographs contributed by the participants, relating each to the broader contexts of local and national history.

LIBRARY PROGRAMS

During fiscal years 1999 and 2000, 3,200 NEH-supported reading and discussion programs took place in 800 libraries and other community-based institutions nationwide, attracting approximately 6 million participants. Intellectually and socially engaging activities such as these are open to the general public, but the scholars and other specialists who direct them report especially strong participation by older Americans.

Most NEH-supported reading and discussion programs are geared to intergenerational audiences. All are well suited to the needs of older Americans, based as they are on locally available resources and activities that are intellectually stimulating without being physically demanding. Many of these library-based programs reach urban and rural communities that may have few other sources of cultural enrichment. In FY1999, National Video Resources, Inc. received $282,000 to produce two series of film discussion programs at 45 sites throughout the United States. Entitled From Rosie to Roosevelt: A Film History of Americans in World War II and Post War Years, Cold War Fears, the six-week programs were conducted at each location by a scholar who led the participants in discussions of selected documentary films and readings including specially commissioned essays by John Morton Blum, Sterling Professor of History at Yale University, and Leon Litwack, Morrison Professor of History at the University of California, Berkeley. In FY2000, the American Library Association received $245,000 for a project on American regional literature that—in tandem with a series of library-based reading and discussion programs—will feature thirteen, one-hour call-in programs on public radio. Libraries in eight Midwestern states make available extra copies of books by such regional authors as Carl Sandburg, Sherwood Anderson, Richard Wright, Jane Smiley, and Toni Morrison. Listeners over a broad geographic area will hear a panel of scholars discuss these and other books, and then will have an opportunity to call in questions and reactions via a toll-free 800 number.

MUSEUM EXHIBITIONS

Museum attendance is now one of the most popular recreational activities in the United States. In New York, museums annually generate considerably larger audience figures than do all of the city’s professional sports teams combined. That older Americans should be a part of this burgeoning phenomenon is not surprising; today’s seniors are more active and better educated than ever before. According to a survey commissioned by the National Endowment for the Arts, 28 percent of adults aged 65 to 74 visited an art museum at least once during a 12-month period (1997). Attendance by adults aged 75 and older was nearly as great (20 percent percent). Impressive as these figures are, they do not take account of the additional numbers of older Americans who visited historical and other kinds of museums.

At any time during FY 1999 and FY 2000, approximately 120 different, NEH-funded museum exhibitions could be seen at locations
in each of the fifty states and the District of Columbia. Exhibitions supported by the Endowment are ideally suited to the needs of retirees living on a fixed income; museums agree as a condition of their NEH grant to set aside at least several admission-free hours each week.

*Your Place in Time: 20th Century America,* supported with an NEH grant of $151,029 to the Henry Ford Museum & Greenfield Village, was expressly created by for intergenerational audiences. At the museum’s Dearborn, Michigan, site and at shopping malls and other public places where a traveling panel version of the exhibition was shown, visitors were invited to explore five venues: “The Progressive Generation,” “The War Generation,” “Baby Boomers,” “Generation X,” and “The Next Generation.” Each venue employed artifacts and interactive displays to convey the impact of technology on the lives of a generation that came of age during the 20th century. The Lower East Side Tenement Museum in New York City received $197,553 to recreate a 19th-century sweatshop on its original site and interpret the lives of the owners and the immigrant laborers who worked there. Through an authentically recreated environment and the stories of real individuals, the exhibition will vividly bring to life the history of immigration and the garment industry in New York.

NEH exhibitions are not limited to urban areas. It funds exhibitions accessible to those living in rural communities as well. *Barn Again!* examines that familiar agricultural structure as functional form, monument on the landscape, and symbol of community and country life. Developed by the Utah Humanities Council in cooperation with the humanities councils in Alabama, Georgia, Oregon, Ohio, West Virginia, Illinois, and Missouri, and with a $115,000 grant from NEH, the exhibition has been touring small rural museums and historical societies since 1996.

**TELEVISION DOCUMENTARIES**

Public television reaches virtually every community and home in the United States. During 1999 and 2000, millions across the country watched such NEH-funded documentaries as *MacArthur and Eleanor Roosevelt,* both of which were broadcast on “The American Experience.” For seniors who have limited mobility or who simply prefer to stay home, rewarding and engaging viewing choices such as these provide opportunities for them not only to engage in learning, but to share in a history in which they themselves lived and remember.

**CULTURAL TOURISM**

More and more Americans are discovering the special places in every region of the United States that attest to the history and cultural uniqueness of the American experience. NEH grants for site interpretation, and the historical and archival research that make it possible, continually reinforce this process of self-discovery, helping Americans make tangible connections with the past that is our common patrimony. Older Americans, the generation that has the biggest stake in the past and the time that the retirement years afford for travel, are enthusiastically joining the burgeoning ranks of cultural tourists. In 1997, according to the NEA-commissioned
survey *Arts Participation in America*, 37 percent of American 65 to 74 visited an historical park at least once, and 25 percent of those between 75 and older did so.

Two examples of grants awarded during fiscal years 1999 and 2000 suggest the range of NEH-supported projects underway, in communities large and small, to reclaim our historic places. Historic Hudson Valley of Tarrytown, New York, received $300,008 to implement new interpretive tours of Philipsburg Manor, the site of a working 18th century farm and mill. The redesigned tours will incorporate new research about the lives of African-American slaves who operated the mill circa 1750, shedding light on the little understood story of slavery in the North during the pre-Revolutionary period. The Dubuque County Historical Society received $100,530 to implement a new interpretive plan at the Mississippi River Museum in Dubuque, Iowa. The new exhibition will include a reconstruction of the Dubuque Boat and Boiler Works, which once stood on the museum’s river-front site.

**SENIOR SCHOLARS**

NEH grants support a number of long-term research projects in the humanities that have been directed and sustained over the years by some of the most eminent scholars in their field. Not a few of these renowned scholars are quite senior; yet despite their emeritus status they happily persevere in the research work they know supremely well. Thus, Endowment support of senior scholars benefits the public in two ways; it enables uniquely qualified individuals to continue contributing authoritatively to the advancement of humane learning, and it incidentally furnishes the rest of us with inspirational examples of active engagement well past the traditional age of retirement. Among the senior scholars whose work NEH research grants supported during fiscal years 1999 and 2000 were Ehsan Yarshater of Columbia University, editor of the *Encyclopaedia Iranica*, an internationally renowned resource on the history and culture of a vast area that encompasses much of the Middle East, Central Asia, and the Indian subcontinent; and independent scholar Frederick Burkhardt, who under the auspices of the American Council of Learned Societies is compiling an edition of the correspondence of Charles Darwin.

**NON-DISCRIMINATION**

Older scholars have always been eligible to compete for Endowment support on the same basis as all other similarly qualified applicants. Accordingly, no information regarding age is requested from applicants, and funding application are evaluated and grants awarded exclusively on the basis of the merit of the proposed activities. Each year, numerous projects are funded that involve older persons as primary investigators, project personnel, or consultants. Each year, older persons serve on the NEH peer panels that evaluate grant applications for funding.

NEH publications notify the public that the Endowment does not discriminate on the basis of age. The Endowment also has a special telephone number for the deaf and hearing impaired to use in requesting information. Alternative format publications concerning Endowment programs (i.e., audio tapes, large print) are also made
available upon request. In addition, the Endowment maintains a site on the world wide web that provides information about current projects and grant application requirements. The Endowment encourages applicants to consider issues related to program as well as architectural accessibility in early planning stages of a project. Costs of exhibition and program accommodations for people with disabilities are generally eligible project costs.

STATE HUMANITIES COUNCILS

In addition to activities benefiting older Americans that the Endowment supports directly, library programs, exhibitions, speakers bureaus, and other programs for the general public—in many cases, for older audiences in particular—are provided at the local level by the Endowment's affiliates, the state humanities councils. The Federal/State Partnership of the Endowment makes grants to humanities councils in the 50 states, Puerto Rico, the Virgin Islands, the Marianas, and Guam. The special emphasis of the state humanities councils is to make focused and coherent education possible in places and by methods that are appropriate for adults.
We recently marked the 25th anniversary of the Employee Retirement Income Security Act of 1974 and the Pension Benefit Guaranty Corporation. In looking forward to the next 25 years, we should not forget the lessons of the first 25 years. Defined benefit plans have been and must continue to be an important part of the retirement income security for working Americans. PBGC has played and will continue to play a crucial role in protecting benefits. And, while PBGC is in a strong financial condition today, we must always remain vigilant.

I am proud of the role that the Pension Benefit Guaranty Corporation has played in protecting the retirement income of American workers and retirees. PBGC has paid benefits without interruption to hundreds of thousands of individuals whose pension plans terminated without adequate assets. The PBGC guarantee makes a real difference in people's lives. I attend virtually every meeting that PBGC conducts for participants in terminated plans, and I have seen the look of relief on thousands of faces when we tell them their benefits are protected.

Today, PBGC is responsible for the pensions of more than a half million people in almost 2,800 PBGC-trusteed plans, and they are our priority. These individuals, and the sponsors of the 40,000 ongoing defined benefit plans, are PBGC's customers.

PBGC must be a premier customer service organization for our customers. We have taken a new look from a customer service viewpoint at everything we do—from our computer systems to our regulations to how we respond to phone calls. We have made many changes as a direct result of customers' comments and suggestions. The "Listening to Our Customers" section of this Report describes many of the changes we have made.

I am committed to satisfying our customers' changing needs and expectations. PBGC maintains a continuing dialogue with our customers, through focus groups, surveys, and meetings, to assess how well we are doing and to identify where we must make further improvements. We want our customers to be delighted with the level of service we provide. We will be satisfied with no less.

DAVID M. STRAUSS,  
Executive Director

LISTENING TO OUR CUSTOMERS

Today, we live in an era of rising customer expectations. Excellent customer service is no longer discretionary. Businesses must
not only provide quality products, they must also provide excellent customer service.

Based on the best practices of private-sector businesses, the federal government has adopted a set of customer service principles:
- Identify your customers;
- Ask your customers what they want;
- Set standards so people know what to expect; and
- Measure and publicize the results.

**PBGC’S CUSTOMER SERVICE PLEDGE**

Our customers deserve our best effort as well as our respect and courtesy.

On the first call from you, our customer, we will say:
- what we can do immediately and what will take longer,
- when it will be done, and
- who will handle your request.

We will call you if anything changes from what we first said, give you a status report, and explain what will happen next.

We will have staff available from 8:00 a.m. - 5:00 p.m. Eastern time to answer your calls. If you leave a message, we will return the call within one work day.

We will acknowledge your letter within one week of receipt.

PBGC has put these principles into practice. The agency has opened a continuing dialogue with its customers—participants in PBGC-trusteed plans, and sponsors of PBGC-insured plans and the pension professionals who assist them. Over the last few years, PBGC has conducted numerous focus groups with, and annual surveys of, both participants and practitioners. Through these focus groups and surveys, PBGC asks its customers about the quality of the agency's service and how that service can be improved.

Under its ongoing Reach for Excellence and Customer Happiness (REACH) initiative, PBGC used interdepartmental teams of employees to translate the focus group and survey findings into service improvements. As a result of participant suggestions, PBGC made system enhancements in the Customer Service Center to allow PBGC’s customer service representatives to take routine changes over the telephone and update participant records more efficiently. The agency also simplified the benefit application requirements to make it easier for participants in PBGC-trusteed plans to apply for benefits.

PBGC continued to provide easy-to-find information for its customers on its website at [www.pbgc.gov](http://www.pbgc.gov). The on-line Pension Search Directory, [www.search.pbgc.gov](http://www.search.pbgc.gov), simplifies the search for missing plan participants. During the year, PBGC issued a new publication, “Finding A Lost Pension,” to help people expand the search for missing pensions from former employers.

In addition, PBGC improved the nature and frequency of its communications with participants. The agency rewrote publications and most of its standard letters in plain language. A team of PBGC employees developed a new package of materials that will improve initial communications with participants in newly trusteed plans. PBGC also redesigned the newsletter for participants who have not yet begun receiving benefit payments and began sending the newsletter semiannually instead of annually to keep participants better
informed about the pension insurance program and their benefits. In addition, the agency began developing systems that will make it possible to provide participants with benefit estimates upon request. To capture the agency’s attitude toward customer service, PBGC employees came up with a new slogan, “Working together to guarantee your future,” that encourages a relationship between the agency’s staff and participants.

PBGC also held 21 information sessions across the country for participants in newly trusteed plans. About 1,600 plan participants attended. These meetings help allay participant concerns and explain PBGC’s insurance. Executive Director David Strauss attended each of the sessions to meet the participants and answer their questions.

As a result of suggestions in the first round of practitioner focus groups, PBGC simplified the standard termination process. Practitioners told us that this is a big improvement. PBGC also issued a new publication to help small businesses understand their responsibilities under the pension insurance program.

In 1999, PBGC made further significant changes based on what customers have told us. The agency moved the premium filing date to October 15 for calendar year plans to make it coincide with the filing date for the Form 5500 (with a parallel change for non-calendar year plans). Practitioners told us that this saves time and money. Practitioners also called for improvements in the processing of premium refunds and requests for waivers of premium penalties; PBGC initiated an aggressive effort to address pending refund and waiver requests and, by the end of the year, was processing these requests typically within 90 days of receipt.

Other measures adopted during the year included rewriting premium-related form letters in plain language to make them easier to understand and a regulatory change that would provide additional relief from penalties imposed for late payment or underpayment of premiums.

PROBLEM RESOLUTION

Participants in PBGC-trusteed plans may reach PBGC’s Participant Problem Resolution Officer by calling 1–800–400–PBGC or by e-mail at participant.pro@pbgc.gov.

Plan sponsors, plan administrators, and pension professionals may reach PBGC’s Practitioner Problem Resolution Officer by calling 1–800–736–2444 (202–326–4242 if in the Washington, DC, metropolitan area) or by e-mail at premiums.pro@pbgc.gov.

TTY/TDD users may call the Federal relay service toll-free at 1–800–877–8339 and ask the communications assistant to connect them to the appropriate telephone number.

PBGC also made it easier for customers to get in touch with the agency. This year, PBGC set up a toll-free number, 1–800–736–2444, for practitioner questions about premiums, standard terminations, and plan coverage. PBGC already had set up a toll-free number, 1–800–400–PBGC, for participant questions about benefits. In addition, PBGC now has two problem resolution officers, one for plan participants and another for practitioners, who can be reached through the toll-free numbers.
PBGC’s annual practitioner and participant surveys measure overall satisfaction with service and help PBGC track how well it has been doing. According to the most recent completed surveys, 70 percent of participants and 66 percent of practitioners rated PBGC’s service as “above average” or “outstanding.” Under the agency’s five-year strategic plan, the goal is for 90 percent of participants and 81 percent of practitioners to rate PBGC’s service as “above average” or “outstanding.”

To help reach its service goals, PBGC instituted a “one-call” approach. This means that PBGC staff will return phone calls within 24 hours. We will either answer the question with that first phone call, or we will let the customer know who will handle the problem and when an answer can be expected. If it is found that a request is going to take longer to answer than initially thought, we will call back to keep the customer informed of our progress. PBGC continues to explore ways to expand use of electronic communications to enhance service to plan participants, plan sponsors, and pension practitioners.

PBGC is committed to being a premier customer service organization—for participants who depend on the agency for their pension benefits as well as for plan sponsors and the pension professionals who assist them. PBGC will continue its dialogue with customers through focus groups and surveys. We want and need their input on what is working and what needs improvement, so that we can meet their changing needs and expectations.

PROTECTING BENEFITS

In 1999, PBGC assumed responsibility for the pensions of tens of thousands of additional people even though the pace of plan terminations slackened. The agency continued to issue benefit determinations at near-record levels. The separate multiemployer program again received relatively few requests for financial assistance but provided a far larger amount of assistance than in any other year since the current program’s creation in 1980.

SINGLE-EMPLOYER PROGRAM

Through its single-employer program, PBGC oversees terminations of fully funded plans and guarantees payment of basic pension benefits when underfunded plans must be terminated. The single-employer program covers nearly 34 million workers and retirees in about 38,000 plans.

During 1999 the agency completed the termination of 122 underfunded plans, the vast majority of which were involuntary terminations by PBGC. In most cases termination was necessary because the sponsoring employer had gone out of business, sometimes in earlier years.

After a plan has terminated, PBGC becomes trustee of the plan and administers benefits. During 1999, PBGC became trustee of 130 single-employer plans covering more than 50,000 people. At yearend, the agency was in the process of trusteeing an additional 48 plans terminated in 1999 or earlier. In all, including 10 multiemployer plans previously trusteeed, PBGC was (or was becoming) trustee of a total of 2,785 terminated plans as of the end of the
year. (This total also reflects the elimination of two single-employer plans included in last year's total, which no longer required PBGC to become trustee. One plan was converted to a standard termination; the termination of the other plan was cancelled.)

**Benefit Processing.**—By the end of the year, PBGC was responsible for the current and future pension benefits of about 532,000 participants from single-employer and multiemployer plans. These included 214,890 retirees who received benefit payments totalling $902 million.

In 1999, PBGC issued nearly 67,700 benefit determinations, marking the fifth straight year that the agency has produced more than 60,000 determinations. PBGC routinely pays benefits in estimated amounts until final determinations are completed. In the vast majority of cases, participants' final determinations were within 5 percent of their estimated benefit.

PBGC has now completed benefit determinations for virtually all plans trusteed prior to 1994. The average age of unissued benefit determinations is down to 2.3 years, reflecting the fact that most pending determinations are for plans trusteed within the past two to three years. On average, in 1999 PBGC issued final benefit determinations 5.7 years after the date it had trusteed the participant's plan. The age of the determinations met the performance goal of 5–6 years set for 1999 under PBGC's strategic plan.

PBGC's Customer Service Center for participants in trusteed plans continued to handle a high volume of calls. During the past year, the center handled, on average, more than 21,400 calls each month, spending about 2½ minutes per call. Another 504,000 calls were answered with automated information.

**Appeals Processing.**—PBGC's Appeals Board reviews appeals of certain PBGC determinations. Most of the appeals are from people disputing their benefit determinations. Typically, about 2 percent of all benefit determinations are appealed. During 1999, the Appeals Board received 1,550 appeals. The Board decided 2,005 appeals during the year, more than twice the number of appeals closed in any prior year, and reduced its open case inventory by 10 percent.

**Standard Terminations of Fully Funded Plans.**—The number of standard terminations continued to decline from their peak of about 11,800 in 1990, with 1,969 submitted to PBGC in 1999. Most of these plans had 50 or fewer participants.

As a result of the agency's 1997 revisions to the standard termination regulation, PBGC is finding a higher rate of compliance with legal requirements, and very few errors or omissions that might force cancellation of a termination. The agency's increased flexibility in addressing administrative errors, in particular, is helping to avert many of the problems filers experienced in years past. In 1999, four terminations had to be cancelled for failure to comply with legal requirements, compared to 24 such cases in 1998 and 118 in 1997.

PBGC audits a statistically significant number of completed terminations to confirm compliance with the law and proper payment of benefits. These audits generally have found few and relatively small errors in benefit payments, which plan administrators are required to correct. The errors arise primarily from use of incorrect
interest-rate assumptions in valuing lump-sum distributions to plan participants. Due to PBGC's audits, in 1999 some 4,500 participants (about 5 percent of all participants in audited plans) received about $2.7 million of additional benefits.

Pension Search Program.—PBGC's Pension Search Program consists of three separate, coordinated efforts to locate missing people owed a pension by a terminated plan. Historically, the agency has conducted extensive searches for people missing from underfunded pension plans for which PBGC has taken responsibility. Since January 1996, PBGC also has provided a “missing participants clearinghouse” to assist employers terminating fully funded plans: if an employer is unable to locate a former employee, PBGC will accept payment for the benefit and continue searching for the person to allow the employer to complete the termination. As a last means of finding people who have frustrated all previous searches by either their former employer or by PBGC, the agency has maintained a Pension Search listing on the Internet since December 1996. These efforts have helped PBGC locate thousands of people who were unaware they were owed a pension benefit.

During 1999, 417 companies asked the clearinghouse to find 5,611 missing people, some 4,500 of whom were due benefit payments totalling nearly $7.8 million. The other 1,100 people were covered by annuity contracts that will pay their benefits when they are found. PBGC was able to confirm addresses for 952 of the missing people and to pay 706 of them nearly $2.1 million in benefits. The Internet listing helped PBGC find 351 other people who were owed about $1 million.

The total Internet list, which included people PBGC was unable to find through the clearinghouse, identified almost 9,900 people who were owed more than $19 million in pension benefits. Since inception, PBGC's Internet pension search has helped 1,745 people obtain more than $5 million in owed benefits plus interest. The Internet listing is found at http://search.pbgc.gov.

MULTIEMPLOYER PROGRAM

The multiemployer program, which covers about 8.8 million workers and retirees in about 1,800 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 two or more unrelated employers. 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.

Financial Assistance.—The multiemployer program continues to receive relatively few requests for financial assistance. Since 1980, PBGC has provided assistance to only 23 of the 1,800 insured plans, with a total value of approximately $57 million net of repaid amounts. In 1999, 21 of these plans received assistance totalling about $19 million, including a one-time payment of about $14 million to a terminated insolvent plan that merged into a large national plan during the year. PBGC's payment to the terminated
plan facilitated the merger. As a result of the merger, retirees had their benefit levels restored and participants once again are earning benefits in an ongoing plan.

**TRENDS IN DEFINED BENEFIT PENSION PLANS**

Since the early 1980s, there has been a gradual shift away from defined benefit pension plans in the private sector. The number of PBGC-insured defined benefit plans peaked in 1985 at about 112,000. Since then there has been a sharp decline to about 40,000 plans in 1999.

This reduction has not been proportional across all plan sizes. Plans with fewer than 100 participants have shown the most marked decline, from about 90,000 in 1985 to less than 24,000 in 1999. There also has been a sharp decline for plans with between 100 and 999 participants, from more than 19,000 in 1985 to about 11,000 in 1999.

In marked contrast to the trends for plans with fewer than 1,000 participants, the number of plans with more than 1,000 participants has shown modest growth. Since 1980, the number of plans with between 1,000 and 9,999 participants has grown by about 6 percent, from 4,017 to 4,257 in 1999. The number of plans with at least 10,000 participants has grown from 469 in 1980 to 749 in 1999, an increase of nearly 60 percent.

The growth in the number of large plans is attributable to two factors. First, the rapid increase in inactive participants (retirees and separated vested participants) has pushed some plans into higher size categories. Second, there has been considerable plan merger activity over the thirteen-year period from 1985 through 1997.

In contrast to the dramatic reduction in the total number of plans, the total number of participants in PBGC-insured defined benefit plans has shown modest growth. In 1980, there were 35.5 million participants. By 1999, this number had increased to almost 43 million.

These numbers, however, mask the downward trend in the defined benefit system because total participants include not only active workers but also retirees (or their surviving spouses) and separated vested participants. The latter two categories of participants reflect past coverage patterns in defined benefit plans. A better forward-looking measure is the trend in the number of active participants, workers currently earning pension accruals. Here, the numbers continue to decline.

In 1988, there were 27.3 million active participants in defined benefit plans; by 1996 (the latest data available), this number had fallen to 22.6 million, a decrease of more than 17 percent. At the same time, the number of inactive participants has been growing. In 1980, inactive participants accounted for only 23 percent of total participants in defined benefit plans. By 1988 this number had increased to 31 percent; and by 1996, more than 45 percent of the participants in defined benefit plans were inactive participants. If this trend continues, by the year 2003 the number of inactive participants will exceed the number of active workers.
LEGISLATIVE PROPOSALS

The President's budget for fiscal year 2001 includes numerous provisions to encourage the expansion of retirement plan coverage, including under defined benefit plans. These provisions include:

- a simplified defined benefit plan called SMART (Secure Money Annuity or Retirement Trust) for small businesses with 100 or fewer employees;
- a reduced PBGC premium of $5 per participant for the first five years of a small business's new plan and phase-in of the variable-rate premium over five years for new plans of all sizes;
- expansion of the missing participants clearinghouse to other terminating plans, including multiemployer defined benefit pension plans insured by PBGC, certain other defined benefit pension plans not insured by PBGC, and defined contribution plans;
- simplified rules governing PBGC's guarantee of benefits for a partial owner of a company and the allocation of plan assets to the benefits of these owner-employees;
- doubling PBGC's benefit guarantee for multiemployer plans, which has been at the same level since 1980, from the current maximum guarantee of $5,850 to $12,870 (the guarantee increase would require no change in the multiemployer premium rate);
- a tax credit for part of the administrative expenses that a small business incurs when setting up a new plan;
- a tax credit for part of the cost of the contributions a small business makes to a defined benefit or defined contribution plan; and
- permitting accelerated funding of defined benefit plans.

SAFEGUARDING SOLVENCY

Y2K

Following extensive efforts to test and validate its information systems and software for the Year 2000 century-date change, PBGC announced in August 1999 that it was ready for Y2K. PBGC confirmed that all PBGC mission-critical and secondary systems were Y2K-compliant. PBGC also verified that all building systems at PBGC sites were Y2K-compliant and consulted with business partners on their Y2K readiness.

PBGC focused on improving existing systems rather than introducing new technology or applications. Enhancements improved the major business systems' overall performance and helped frontline staff provide better customer service. The agency also took steps to strengthen the security of information and automated systems and will continue to monitor and test the security of its systems.

Although PBGC's premium income continued to decline, the agency benefited from the healthy economy and strong returns on its equity investments. The single-employer insurance program gained financial strength and the multiemployer program remained strong despite an unusually large loss for the year. The combina-
tion of financial gains, negotiated settlements under the Early Warning Program, and litigation to protect the insurance program kept PBGC on course toward its strategic goal of strengthening its financial programs and systems to keep the pension insurance system solvent.

FINANCIAL MANAGEMENT

While PBGC's single-employer insurance program again posted a significant financial gain, the separate multiemployer program recorded the largest one-year loss in its history.

The single-employer program's gain arose mainly from actuarial credits as the increase in interest rates lowered the value of the program's benefit liabilities. However, the increase in interest rates also resulted in a significant loss for the program's fixed-income investments, causing total investment income to fall to about $730 million. Premium income continued to decline due to companies' reduced risk-based premium obligations, falling to $902 million, nearly $250 million less than the record level reached in 1996. At the same time, the single-employer program sustained sharply lower losses from plan terminations. The actuarial gains in combination with strong returns on equity investments enabled the single-employer program to record net income of more than $2 billion, increasing the program's net surplus to more than $7 billion. This surplus provides the insurance program with a cushion against future losses.

The multiemployer program continued to be financially strong despite a net loss of $142 million. With assets of $692 million and liabilities totalling $493 million primarily for nonrecoverable future financial assistance, the program still had an end-of-year surplus of $199 million. Two factors accounted for the net loss: an increase in the program's allowance for nonrecoverable future financial assistance because a significant portion of one large plan was reclassified as a probable loss for the insurance program, and a decline in value of the program's assets (most of which are invested in U.S. Treasury securities) due to the increase in interest rates in 1999.

PBGC's financial statements have received their seventh consecutive unqualified opinion from the agency's auditors. The 1999 audit was again performed by PricewaterhouseCoopers LLP under the direction and oversight of PBGC's Inspector General.

Investment Program.—The Corporation's investable assets consist of premium revenues accounted for in the Revolving Funds and assets from terminated plans and their sponsors accounted for in the Trust Funds. By law, PBGC is required to invest the Revolving Funds in fixed-income securities; current policy is to invest these funds only in Treasury securities. The agency has more discretion in its management of the Trust Funds, which it invests primarily in high-quality equities. The asset allocation is designed to provide sound long-term performance.

PBGC has structured its investment portfolio to improve the agency's financial condition in a prudent manner. The Revolving Fund assets are invested to earn a competitive return and partially offset changes in its benefit liabilities. The agency's investment in equities provides overall portfolio diversification and a higher long-term expected return, within prudent levels of risk. PBGC uses in-
stitutional investment management firms to invest its assets subject to PBGC oversight. PBGC continually reviews its investment strategy to ensure that the agency maintains an investment structure that is consistent with its long-term objectives and responsibilities.

As of September 30, 1999, the value of PBGC's total investments, including cash, was approximately $18.6 billion. The Revolving Fund's value was $10.8 billion and the Trust Fund's value was $7.8 billion. PBGC's equity allocation increased during 1999 due primarily to strong equity returns. Cash and fixed-income securities represented 60 percent of the total assets invested at the end of the year, as compared to 66 percent at the end of 1998, while the equity allocation stood at 39 percent of all investments compared to 33 percent one year earlier. A very small portion of the invested portfolio remains in real estate and other financial instruments.

<table>
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<tr>
<th>Investment Profile</th>
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<tr>
<td><strong>Fixed-income Assets:</strong></td>
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<tr>
<td>Average Quality</td>
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<tr>
<td>Average Maturity (years)</td>
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<tr>
<td>Duration (years)</td>
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<td>Yield to Maturity (%)</td>
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<tr>
<td><strong>Equity Assets:</strong></td>
</tr>
<tr>
<td>Average Price/Earnings Ratio</td>
</tr>
<tr>
<td>Dividend Yield (%)</td>
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<tr>
<td>Beta</td>
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</tbody>
</table>

The current allocation to equities is the maximum currently allowable to PBGC, given legislative restrictions limiting equity investments to the Trust Funds. The increased equity allocation, adopted in 1994 as part of a strategic change in the agency's investment policy, has significantly improved PBGC's overall financial condition, as equities have substantially outperformed long-term Treasury securities by more than 12 percentage points per year over the past 5 years (22.4 percent versus 10.0 percent). This change in policy has made an important contribution to the insurance program's current surplus and to PBGC's long-term financial viability.

Results for fiscal year 1999 were mixed for capital market investments and PBGC's investment program. For the year, PBGC's fixed-income program returned a negative 7.9 percent while its equity program advanced 24.7 percent. PBGC's five-year returns approximated their comparable market indices, meeting the agency's strategic performance goal. For the year, PBGC reported a loss of $862 million from fixed-income investments and a gain of $1.5 billion from equity investments.
SINGLE-EMPLOYER PROGRAM EXPOSURE

PBGC’s “expected claims” are dependent on two factors: the amount of underfunding in the pension plans that PBGC insures (i.e., exposure), and the likelihood that corporate sponsors of these underfunded plans encounter financial distress that results in bankruptcy and plan termination (i.e., the probability of claims).

Over the near term, expected claims result from underfunding in plans sponsored by financially weak firms. PBGC treats a plan sponsor as financially weak based upon factors such as whether the firm has a below-investment-grade bond rating. PBGC calculates the underfunding for plans of these financially weak companies using the best available data, including the annual confidential filings that companies with large underfunded plans are required to make to PBGC under Section 4010 of ERISA.

For purposes of its financial statements, PBGC classifies the underfunding of financially weak companies as “reasonably possible” exposure, as required under generally accepted accounting principles. As of December 31, 1998, as disclosed in the financial statements, PBGC’s estimated “reasonably possible” exposure ranged from $17 billion to $19 billion.

Over the longer term, exposure and expected claims are more difficult to quantify either in terms of a single number or a limited range. Claims are sensitive to changes in interest rates and stock returns, overall economic conditions, the development of underfunding in some large plans, the performance of some particular industries, and the bankruptcy of a few large companies. Large claims from a small number of terminations and volatility characterize the agency’s historical claims experience and are likely to affect PBGC’s potential future claims experience as well.

Despite the exceptional economic conditions of recent years, it is not reasonable to assume that future experience will be as favorable to PBGC. PBGC has had a surplus for only four years after running a deficit for more than 20 straight years. Furthermore, with premium changes built into the reforms of the Retirement Protection Act of 1994, PBGC expects its variable-rate premium revenues to decline substantially after the year 2000.

After reviewing PBGC’s financial situation, the U.S. General Accounting Office concluded on October 16, 1998, that: “Although PBGC’s financial condition has significantly improved over the past few years, risks remain from the possibility of an overall economic
downturn or a decline in certain sectors of the economy, substantial drops in interest rates, and actions by sponsors that reduce plan assets. These risks could threaten the long-term viability of the insurance programs. Further, PBGC has only a limited ability to protect itself from risks to the insurance programs."

Methodology for Considering Long-Term Claims.—No single underfunding number or range of numbers—even the reasonably possible estimate—is sufficient to evaluate PBGC’s exposure and expected claims over the next ten years. There is too much uncertainty about the future, both with respect to the performance of the economy and the performance of the companies that sponsor insured pension plans.

PBGC uses a stochastic model—the Pension Insurance Modeling System (PIMS)—to evaluate its exposure and expected claims.

PIMS portrays future underfunding under current funding rules as a function of a variety of economic parameters. The model recognizes that all companies have some chance of bankruptcy and that these probabilities can change significantly over time. The model also recognizes the uncertainty in key economic parameters (particularly interest rates and stock returns). The model simulates the flows of claims that could develop under thousands of combinations of economic parameters and bankruptcy rates. (For additional information on PIMS, see PBGC’s Pension Insurance Data Book 1998, pages 10–17, which also can be viewed on PBGC’s website at www.pbgc.gov/databk98.pdf.)

Under the model, median claims over the next ten years will be about $550 million per year (expressed in today’s dollars); that is, half of the scenarios show claims above $550 million per year, and half below. The mean level of claims (that is, the average claim) is much higher, more than $850 million per year. The mean is higher because there is a chance under some scenarios that claims could reach very high levels. For example, under the model, there is a ten percent chance that claims could exceed $2.0 billion per year. Despite PBGC’s recent favorable experience, the financial condition of the agency could seriously deteriorate.

PIMS projects PBGC’s potential financial position by combining simulated claims with simulated premiums, expenses, and investment returns. The mean outcome is an $11.7 billion surplus in 2009 (in present value terms). However, the model also shows the potential for significant downside outcomes. In particular, there is more than a 15 percent chance that the agency could return to a deficit in the next ten years and a ten percent chance that the deficit could exceed $6.3 billion in 2009 (in present value terms). These outcomes are most likely if the economy performs poorly, in which case PBGC may experience large claims amounts and investment losses. PBGC is continuing to analyze the best way to manage and reduce the risk of insolvency.

LOSS PREVENTION

Under its Early Warning Program, PBGC closely monitored about 1,150 companies with pension plans underfunded by at least $5 million in order to identify transactions that could jeopardize pensions and to arrange suitable protections for those pensions and the pension insurance program. During 1999, PBGC reached agree-
ments valued at about $1.1 billion with 21 companies, including RJR Nabisco Holdings Corp. and Republic Engineered Steels, Inc. These agreements provided contributions, security, and other protections for the pensions of about 129,000 workers and retirees. Loss prevention is PBGC's principal performance measure for its strategic goal of protecting existing defined benefit plans and their participants; PBGC's agreements with employers in 1999 protected benefits beyond those the agency would guarantee by reducing plan underfunding. On average, PBGC's loss prevention rate was 161 percent.

LITIGATION

PBGC continued to face challenges in courts across the country, a number of which could impair the agency's ability to recover its losses for underfunded plans from the employers responsible for those plans. At the end of the year, PBGC had 81 active cases in state and federal courts and 621 bankruptcy cases.

Several of the most significant cases concerned the priority and value of PBGC's claims for losses from plan terminations:

Copperweld Steel Company.—PBGC continued to pursue bankruptcy claims to recover amounts due PBGC and Copperweld's three terminated pension plans, which covered about 3,000 workers and retirees. The company's liquidation trustee contests whether PBGC's claims for unpaid minimum funding contributions in excess of $1 million are entitled to tax priority, and whether the assumptions PBGC prescribes in its regulations appropriately measure PBGC's claims for unfunded benefit liabilities. In December 1997, the bankruptcy court ruled for the liquidation trustee's position on both issues. On PBGC's appeal, the district court affirmed the bankruptcy court's adverse decision. PBGC was appealing the lower court decisions to the Sixth Circuit Court of Appeals at year-end.

CF&I Steel Corporation.—In June 1999, the U.S. Supreme Court declined PBGC's request to review an adverse appellate decision, ending the agency's litigation over claims against the reorganized CF&I for a plan that was underfunded by about $221 million when terminated in March 1992. The Tenth Circuit Court of Appeals had ruled against PBGC regarding the treatment of its claims in bankruptcy. The court had found that the regulatory measure of PBGC's claim for unfunded benefit liabilities conflicts with the Bankruptcy Code and affirmed lower court decisions reducing PBGC's claim to about $123 million. The court also found that PBGC's claim for unpaid minimum funding contributions in excess of $1 million is not entitled to tax priority and that only a small portion of this claim is entitled to administrative priority. These issues are central to PBGC's ability to recover its losses from employers in bankruptcy. PBGC will continue to litigate similar cases in other circuits with the hope of convincing the high court to take up these issues at a later date.

Other major cases in 1999 included:

Pineiro, Brooks, and Beaumont v. PBGC.—In 1991, PBGC became trustee of three Pan Am pension plans underfunded by $914 million. Three former employees of Pan American World Airways later filed suit asking a district court to replace PBGC with an
independent trustee. The court dismissed virtually all of the allegations as meritless, leaving open only an allegation concerning the timeliness of PBGC's notices of benefit determination to the Pan Am participants. The plaintiffs filed an amended complaint in January 1998 realleging PBGC delays in issuing benefit determinations as well as most of the dismissed allegations. PBGC's motion to dismiss the amended complaint was pending action by the district court at yearend. Despite the exceedingly poor condition of company records and the difficulties caused by Pan Am's protracted bankruptcy proceedings, PBGC has been paying benefits to Pan Am retirees continuously since taking over the plans. The agency has completed all benefit determinations for the 53,000 former Pan Am workers and retirees.

White Consolidated Industries, Inc.—In July 1999, the district court ruled that White is liable for the unfunded benefits of six pension plans that White transferred to the Blaw Knox Corporation in 1985. PBGC took over the plans because they ran out of money or would have been abandoned after Blaw Knox ceased business in 1994. PBGC seeks to recover approximately $120 million, plus interest, for the plans' underfunding. The court held that White's transfer of the plans was a sham transaction and that the company "ultimately became solely motivated by a desire to unload the BK Plans." The court also held that a principal purpose of White in entering into the transaction was to evade its pension liabilities. The court subsequently dismissed White's misrepresentation counterclaim against PBGC, finding there had been no misrepresentation or misconduct on the part of the agency or its employees. White has appealed the court's decision to the Third Circuit and has filed an administrative appeal with PBGC challenging the agency's calculation of the unfunded benefit liabilities.

Flo-Con Systems, Inc. v. PBGC.—During an audit of Flo-Con's standard termination of its pension plan for hourly employees, PBGC determined that Flo-Con had underpaid plan participants by using improper interest rates to calculate lump sum distributions. Amendments to ERISA and the Internal Revenue Code superseded the PBGC regulation relied on by Flo-Con and required that the company use lower interest rates, which would provide participants with larger lump sums. Flo-Con sought a summary judgment that its plan termination met legal requirements. The company also argued that a favorable IRS tax qualification letter and a PBGC letter directing Flo-Con to proceed with the distribution reflected IRS and PBGC approval of the termination and legally prevented PBGC from challenging the benefit calculations. PBGC filed a counterclaim to enforce its determination and ensure that the participants received the amounts to which they were entitled. In December 1998, a district court rejected Flo-Con's arguments and granted PBGC's motion for summary judgment.

ANNUAL PERFORMANCE REPORT

PBGC's five-year strategic plan has four broad goals that form the framework of the agency's short- and long-term plans. In 1999, PBGC updated the plan to cover the period 1999–2004, in some cases raising the performance targets for future years. The PBGC goals are to:
• (1) protect existing defined benefit plans and their participants, thereby encouraging new plans;
• (2) provide high quality, responsive services; and accurate and timely payment of benefits to participants;
• (3) strengthen financial programs and systems to keep the pension insurance system solvent; and
• (4) improve internal management support operations.

The performance measures track specific results that are significant to PBGC’s customers and gauge PBGC’s solvency and customer service accomplishments. The following table shows the results achieved in 1999 and meets the annual reporting requirement established by the Government Performance and Results Act. More information on PBGC’s strategic plan and annual performance plan may be found on PBGC’s website at www.pbgc.gov/mission.htm.
## 1999 PBGC Corporate Performance Measures

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<tr>
<td><strong>Pension Loss Prevention:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase pension funding protection and the number of participants</td>
<td>(1)</td>
<td>*</td>
<td>161%</td>
<td>88.5%</td>
</tr>
<tr>
<td>helped through PBGC agreements with sponsors of underfunded pension</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total value of loss prevention as compared to total underfunded</td>
<td>(1)</td>
<td>*</td>
<td>129,000</td>
<td>140,000</td>
</tr>
<tr>
<td>vested benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of participants helped</td>
<td>(1)</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Customer Satisfaction:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Achieve “outstanding” or “above average” ratings (on a five point</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>customer satisfaction scale) for inquiries handled:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From people whose plans we trustee</td>
<td>(2)</td>
<td>83%</td>
<td>70%</td>
<td>79%</td>
</tr>
<tr>
<td>From pension practitioners/sponsors</td>
<td>(2)</td>
<td>63%</td>
<td>66%</td>
<td>54%</td>
</tr>
<tr>
<td>Operations:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determine final benefit amount in clear, understandable language and</td>
<td>(2)</td>
<td>80%</td>
<td>84%</td>
<td>90%</td>
</tr>
<tr>
<td>within 5% of the benefit PBGC estimated when it completed the audit of</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>the pension plan.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Send final, accurate benefit determination to participants within 3-4</td>
<td>(2)</td>
<td>5-6 years</td>
<td>5.7 years</td>
<td>5.95 years</td>
</tr>
<tr>
<td>years of plan trusteeship.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce the age of pre-trusteeship inventory to no more than 1 year</td>
<td>(2)</td>
<td>100%</td>
<td>98.6%</td>
<td>98.6% 4 years or less (1998)</td>
</tr>
<tr>
<td>Send the first benefit payment to an eligible person within 3 months</td>
<td>(2)</td>
<td>80%</td>
<td>83%</td>
<td>83% (1999)</td>
</tr>
<tr>
<td>of receiving his/her completed application.</td>
<td></td>
<td></td>
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<tr>
<td>Financial Management:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collect 99% of pension insurance premiums due</td>
<td>(3)</td>
<td>99%</td>
<td>99%</td>
<td>97%</td>
</tr>
<tr>
<td>Approximate comparable 5-year investment indices for PBGC's portfolio</td>
<td>(3)</td>
<td>*</td>
<td>PBGC Index</td>
<td>PBGC Index</td>
</tr>
<tr>
<td>performance</td>
<td></td>
<td></td>
<td>Equities</td>
<td>Equities</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>22.4%</td>
<td>22.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10.0%</td>
<td>10.9%</td>
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<td></td>
<td></td>
<td></td>
<td>14.0%</td>
<td>10.9%</td>
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<td></td>
<td></td>
<td></td>
<td>9.9%</td>
<td>8.9%</td>
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*By their nature, these measures do not lend themselves to setting annual targets or milestones. PBGC measures performance annually based on actual results.*
ACHIEVING PERFORMANCE TARGETS

Pension Loss Prevention:

• Loss prevention is PBGC's principal performance measure for its strategic goal of protecting existing defined benefit plans and their participants. PBGC's negotiated agreements with employers in 1999 resulted in a loss prevention rate of 161 percent. Loss prevention exceeds 100 percent when a plan sponsor agrees to fund benefits beyond those that the agency guarantees. These settlements helped 129,000 participants maintain their pension benefits.

Customer Satisfaction:

• PBGC listens to its customers in a variety of ways including annual satisfaction surveys, and has set performance targets for both participants' and practitioners' satisfaction through 2004.

• The 1999 survey of participants showed about the same satisfaction as the previous year. Retired participants receiving benefits were more satisfied than those due a future pension. For the latter, lack of information about the amount of their future benefits largely explains their lower satisfaction. PBGC is taking steps to improve the accuracy and timeliness of benefit estimates and will be communicating earlier and more frequently with future payees. When these changes are in place, we expect an increase in customer satisfaction.

• Sixty-six percent of pension practitioners rated PBGC's overall service "outstanding" or "above average" in 1999, up from 58 percent in 1998 and exceeding the 1999 performance goal of 63 percent. PBGC attributes the increase in satisfaction to: (1) its shift of the premium filing due date to coincide with other pension reporting requirements; (2) the launch of the new premium payer customer service center and 1–800 telephone number; and (3) continued improvement of service to standard termination filers.

Operations:

• The principal measure of operations is to "send final, accurate benefit determination to participants within 3–4 years of plan trusteeship." Efforts to speed up processing have succeeded, allowing PBGC to raise the performance target for this measure. The agency now plans to issue determinations on average within 3–4 years, versus 3–5 as in the original strategic plan. This is another example of listening to customers and changing processes to make improvements they want. In addition, the average age of unissued benefit determinations was reduced from 3.2 to 2.3 years.

• When PBGC issued final benefit determinations, they were within 5 percent of earlier estimates 84 percent of the time. However, this measure can change significantly from year to year because of the small number of benefit calculations currently used for the measure. PBGC is continuing to monitor the utility of this particular measure.

• PBGC made steady progress in reducing the age of cases to be trusteeed. The goal is that no pending case be more than one year old by 2002, reached in annual milestones. At the end
of 1999, 99.6 percent of cases to be trusteed were three years old or less.

- After eligible participants completed applications, they received pension payments from PBGC within three months 83 percent of the time. PBGC continues to work to improve on this record.

**Financial Management:**

- The premium collection rate is the amount of premiums collected divided by the amount of premiums due. PBGC achieved its 99 percent collection goal. During the year, PBGC extended the final premium filing date by one month to coincide with other reporting requirements. This change demonstrates again how PBGC listens to its customers.
- Investment management results are measured against recognized industry indices aggregated over a five-year period. The five-year period smooths out volatility in annual market performance and provides a more realistic, long-term view of investment success. PBGC regularly approximates the two indices it tracks: the Wilshire 5000 Index for equities, and the Lehman Brothers Long Treasury Index for fixed income.

**PROGRAM EVALUATION**

PBGC conducted customer satisfaction surveys of participants in plans trusteed by PBGC, and of pension practitioners who have dealings with us on premium payment or standard termination matters. Evaluation of the survey responses resulted in improvements in program operations, as discussed earlier in the Annual Report.

**EXECUTIVE DIRECTOR'S MESSAGE (2000)**

I am pleased to report that the federal pension insurance system is in its best shape ever. For the fifth consecutive year, PBGC's insurance programs ended the year with a surplus. Despite declining premium revenues, with low claims and good investment returns PBGC ended Fiscal Year 2000 with a surplus of almost $10 billion. We have built a cushion to protect the insurance program in the event of an economic downturn.

We have laid a firm foundation for the future. Over the past few years, we have made major changes in how we conduct business. We have harnessed the power of computers to improve our operations and lift our productivity. We have begun a new era of customer service, through dedicated customer service centers and use of the Internet. We have a stronger investment program and solid financial management. Although we have not yet mastered paperless transactions, we are moving rapidly toward "electronic government."

It has been an honor and a privilege to serve as PBGC's Executive Director for the last 3½ years. I am proud of what we have accomplished toward making PBGC a financially strong, premier customer service agency. These accomplishments are due to
PBGC's employees, who are dedicated to serving the 43 million workers and retirees in the 38,000 plans that PBGC insures.

DAVID M. STRAUSS,  
Former Executive Director

LISTENING TO OUR CUSTOMERS

The need to provide premier customer service shapes virtually every action now taken or planned by PBGC. Yet we continue to face rising customer expectations as customers become accustomed to higher service levels in other areas of their lives.

The overarching principle of customer service, for federal agencies as well as the private sector, is to provide service to the public that matches or exceeds the "best in the business." This means asking customers what kind and quality of service they want and how well we are meeting their needs. It also means giving customers choices about the services we provide and a means to complain that includes a mechanism to address their complaints.

PBGC has taken this principle to heart. The agency works hard at communicating with and listening to its customers—participants in PBGC-trusteed plans, and sponsors of PBGC-insured plans and the pension professionals who assist them. Every year, PBGC conducts surveys and focus groups with both participants and practitioners. Through these focus groups and surveys, PBGC asks its customers about the quality of the agency's service and how that service can be improved. Then, under its ongoing Reach for Excellence and Customer Happiness (REACH) initiative, PBGC uses interdepartmental teams of employees to translate the focus group and survey findings into service improvements. One major component of our commitment to customer service, discussed later in the "Protecting Benefits" section of this Report, is the agency's continuing success in issuing more benefit determinations—and issuing them more quickly—than in any previous period in its history.

In response to participant suggestions, in 2000 PBGC began providing benefit estimates to participants within 15 days of their request. The agency tested a new introductory package of customer-focused materials that will improve initial communications with participants in newly trusteed plans, which PBGC is refining based on initial results and customer reactions. As a means of keeping customers informed about their benefits, PBGC also tested use of an annual status report for participants who have not yet retired or received their benefit determination.

At the same time, the agency initiated or continued developing a number of other important communication tools. Among these were a letter to remind participants of the approach of their retirement date and a pilot program that will use a special Web page to provide targeted services, including plan-specific information and benefit estimates for participants in newly trusteed large plans. Telephone system enhancements during the year included a new Spanish language greeting on the toll-free customer service number and useful messages providing information about PBGC's commitment to service and general retirement tips for callers who have to be put on hold until their call can be completed.

PBGC continued to provide easy-to-find information for its customers on its Web site at www.pbgc.gov. The Web site now includes
a "Contact Us" section that provides useful PBGC telephone numbers and e-mail addresses for the general public, participants in PBGC-trusteed plans, and pension professionals. During the year PBGC upgraded the Web site to ensure that the agency's information is accessible to users with disabilities.

The agency has found meetings with large groups of participants from newly trusteed plans to be particularly useful in allaying participant concerns and explaining PBGC's insurance. PBGC held 54 such information sessions across the country in 2000, which about 3,400 plan participants attended. Executive Director David Strauss attended each of the sessions to meet the participants and answer their questions.

PBGC continues to make changes to its policies, procedures and regulations to help its customers. For example, a new policy allows PBGC to increase the maximum guaranteed benefit to recipients who are older than 65 either when their plan terminates or, if later, when PBGC begins paying their benefits.

PBGC also broadened its safe harbor relief from premium penalties, committed to publishing PBGC lump sum interest rates indefinitely, and sought the public's input on valuing cash balance plans. The agency also simplified its premium payment forms.

PBGC'S CUSTOMER SERVICE PLEDGE

Our customers deserve our best effort as well as our respect and courtesy.

On the first call from you, our customer, we will say:

What we can do immediately and what will take longer.
When it will be done and
Who will handle your request.

We will call you if anything changes from what we first said, give you a status report, and explain what will happen next.

EMPLOYEE DEVELOPMENT

PBGC primarily uses its own in-house facility, the Martin Slate Training Institute, for the training and development of agency staff. The Institute, established in November 1994 and subsequently named in memory of a former Executive Director, provides a structured learning and networking environment in which PBGC employees can avail themselves of a range of programs, including technical and computer training, customer service training and mentoring programs.

The Institute relies on PBGC employees who serve as internally trained instructors and as subject matter specialists who develop the instructional materials. In keeping with the principle of "listening to our customers," the Institute develops new courses with the assistance of focus groups of PBGC employees.

The Institute adds about 9 new technical courses a year. In 2000, the Institute offered a total of 185 courses, taught in nearly 400 sessions with a total enrollment of nearly 5,600. Among other achievements during the year, the Institute:

- developed its first two "web-based" courses, which can be accessed by employees through their desktop computers rather than in a classroom. These courses allow interactive teaching using multimedia formats. PBGC's use of this new technology
for employee development puts it in the forefront of smaller government agencies. The Institute’s future programs will be a combination of web-based and classroom instruction.
• launched and completed a new round of customer service training, which emphasized practical application of customer service skills. Previous customer service training, which has been a staple of the Institute’s offerings for the past six years, was intended to foster broad customer service awareness and skills.
• continued to build its mentoring program, through which experienced staff members share their knowledge and insights with less seasoned co-workers.
• opened a new, state-of-the-art computer lab for web-based training, testing software for training purposes, and teaching computer systems and applications.

Shortly after the year ended, PBGC announced several additional changes in its premium regulations that simplify procedures and ease burdens for plan administrators. One of these changes allows plan administrators to pay a prorated premium for a short plan year rather than pay a full year’s premium and request a refund or claim a credit against a future premium payment, as has been necessary up to the present. Another change narrowed the definition of “participant” for PBGC premium purposes by allowing administrators to exclude from their participant counts people who have not earned benefits and for whom the plan has no other benefit liabilities. With this latter change, a new plan will not have to pay a premium for its first year unless it provides credit for service before the plan began.

As a result of suggestions from pension professionals, PBGC revised its criteria for taking action under the early warning program and published explicit guidance on the program’s operation. The agency expects the new criteria to significantly circumscribe PBGC involvement in corporate transactions. PBGC also changed the orientation of the premium audit program from its traditional focus on premium collections to one that emphasizes helping premium payers comply with their premium obligations. In addition, the agency began working on ways to make termination- and premium-related audits more understandable and easier for plan sponsors and pension professionals.

Vigorously encouraging customer feedback, PBGC has made it easier for customers to contact the agency and resolve issues affecting their benefits or plans. PBGC has two centralized customer service centers, one for participant inquiries and the other for practitioners, each with its own toll-free number. To improve the service center for practitioners, during 2000 PBGC installed a call tracking system similar to that used in the participant service center to ensure that calls are responded to correctly and timely, and that problems are identified so they can be dealt with quickly. PBGC’s separate problem resolution officers for plan participants and for practitioners provide customers with a highly effective avenue for addressing difficult issues.
PROBLEM RESOLUTION

Participants in PBGC-trusteed plans may reach PBGC's Participant Problem Resolution Officer by calling 1–800–400–PBGC or by e-mail at participant.pro@pbgc.gov.

Plan sponsors, plan administrators, and pension professionals may reach PBGC's Practitioner Problem Resolution Officer by calling 1–800–736–2444 (202–326–4242 if in the Washington, DC, metropolitan area) or by e-mail at practitioner.pro@pbgc.gov.

TTY/TDD users may call the Federal relay service toll-free at 1–800–77–8339 and ask the communications assistant to connect them to the appropriate telephone number.

To measure overall satisfaction with service and help PBGC track how well it has been doing, PBGC uses annual surveys and, beginning in 2000, customer comment cards. The comment cards are particularly useful in obtaining customer feedback soon after a service contact, when memory of the contact is still fresh. According to the most recent completed surveys, 71 percent of participants and 62 percent of practitioners rated PBGC's service as "above average" or "outstanding." Under the agency's five-year strategic plan, the goal is for 90 percent of participants and 84 percent of practitioners to rate PBGC's service as "above average" or "outstanding" by the close of the year 2005.

PBGC's "one-call" approach is perhaps the most critical element of the agency's service pledge. This means that, on the customer's first call, we will either answer the question immediately or we will let the customer know who will handle the problem and when an answer can be expected. If it is found that a request is going to take longer to answer than initially thought, we will call back to keep the customer informed of our progress.

PBGC is committed to being a premier customer service organization—for participants who depend on the agency for their pension benefits as well as for plan sponsors and the pension professionals who assist them. The performance standard that customers now expect is "online, on time, all the time." PBGC is working to keep up with the advances in technology to meet that goal.

PROTECTING BENEFITS

While terminations of fully funded pension plans declined for the 10th straight year, terminations of underfunded plans fell to their lowest level since 1993. At the same time, the agency continued to show progress in its effort to speed up the issuance of final benefit determinations. Despite receiving relatively few requests for financial assistance, the separate multiemployer program provided in excess of $90 million in assistance in 2000, more than in any other year since the current program's creation in 1980.

SINGLE-EMPLOYER PROGRAM

Through its single-employer program, PBGC oversees terminations of fully funded plans and guarantees payment of basic pension benefits when underfunded plans must be terminated. The single-employer program covers more than 34 million workers and retirees in about 36,000 plans.
During 2000 the agency completed the termination of 92 under-funded plans, the vast majority of which were involuntary terminations by PBGC. In most cases termination was necessary because the sponsoring employer had gone out of business, sometimes in earlier years.

After a plan has terminated, PBGC becomes trustee of the plan and administers benefits. In 2000, PBGC became trustee of 103 single-employer plans covering about 27,500 people. By the end of the year, PBGC was responsible for a total of 2,840 trusteeship plans, including 10 multiemployer plans. An additional 34 terminated single-employer plans were pending trusteeship as the year ended. (This total also reflects the elimination of three single-employer plans included in last year’s total, which no longer required PBGC to become trustee. One plan was converted to a standard termination; the other two plans were merged into a third plan.)

Benefit Processing.—By the end of the year, PBGC was responsible for the current and future pension benefits of about 541,000 participants from single-employer and multiemployer plans. These included 226,700 retirees who received benefit payments totaling $903 million for the year.

The past year was a period of sustained progress as PBGC maintained the high pace of activity that has characterized the most recent years. During 2000, the agency issued nearly 63,500 benefit determinations, exceeding 60,000 determinations for the sixth straight year. The number of outstanding determinations awaiting completion also declined for the sixth straight year, leaving about 156,000 determinations to be completed. This represents a dramatic reduction from the situation that prevailed in 1994, when the agency had about 300,000 outstanding determinations and was making little headway in reducing this number. Moreover, this progress came during a six-year period in which PBGC assumed responsibility for the benefits of more than 240,000 additional people from newly trusteed plans.

PBGC has now completed benefit determinations for virtually all plans trusteed prior to 1996. The average age of unissued benefit determinations is down to 2 years, reflecting the fact that most pending determinations are for plans trusteed within the past two to three years. On average, in 2000 PBGC issued final benefit determinations 4.9 years after the date it had trusteed the participant’s plan, meeting the performance goal of 4–5 years set for 2000 under PBGC’s strategic plan.

PBGC routinely pays benefits in estimated amounts until final determinations are completed. Ninety-four percent of PBGC’s final benefit determinations during 2000 were within 10 percent of the estimated benefit provided earlier to participants.

Appeals Processing.—PBGC’s Appeals Board reviews appeals of certain PBGC determinations. Most of the appeals are from people disputing their benefit determinations. Typically, about 2 percent of all benefit determinations are appealed. During 2000, the Appeals Board received 1,275 appeals. The Board decided 1,583 appeals during the year and reduced its open case inventory by 8 percent. Shortly after the end of the year, PBGC began to re-engineer its appeals process with the assistance of a cross-functional team of agency staff and guidance from experts at the Federal Consult-
Completion of the effort, which is intended to improve organizational efficiency and customer service, is scheduled for later in 2001.

**Standard Terminations of Fully Funded Plans.**—The number of standard terminations continued to decline steadily from their peak of about 11,800 in 1990, with 1,882 submitted to PBGC in 2000. More than three-fourths of these plans had 50 or fewer participants.

Compliance with the legal requirements for standard terminations remained high and PBGC again found very few errors or omissions that might force cancellation of a termination. The agency’s increased flexibility in addressing administrative errors, in particular, is helping to avert many of the problems filers experienced in years past. In 2000, only two terminations had to be canceled for failure to comply with legal requirements, compared to 4 such cases in 1999, 24 in 1998 and 118 in 1997.

PBGC audits a statistically significant number of completed terminations to confirm compliance with the law and proper payment of benefits. These audits generally have found few and relatively small errors in benefit payments, which plan administrators are required to correct. The errors arise primarily from use of incorrect interest-rate assumptions in valuing lump-sum distributions to plan participants. Due to PBGC’s audits, in 2000 some 2,300 participants (about 2.2 percent of all participants in audited plans) received more than $1.5 million of additional benefits.

**Pension Search Program.**—PBGC’s Pension Search Program consists of three separate, coordinated efforts to locate missing people owed a pension by a terminated plan. Historically, the agency has conducted extensive searches for people missing from underfunded pension plans for which PBGC has taken responsibility. Since January 1996, PBGC also has provided a “missing participants clearinghouse” to assist employers terminating fully funded plans; if an employer is unable to locate a former employee, PBGC will accept payment for the benefit and continue searching for the person to allow the employer to complete the termination. As a last means of finding people who have not been found in all previous searches by either their former employer or by PBGC, the agency has maintained a Pension Search listing on the Internet since December 1996. These efforts have helped PBGC locate thousands of people who were unaware they were owed a pension benefit. PBGC’s Pension Search Program received a boost during the year when the agency concluded an agreement with the Social Security Administration that allows PBGC to regularly search SSA’s data base for names and current addresses.

During this fiscal year, 340 companies asked the clearinghouse to find 3,901 missing participants, some 2,900 of whom were due benefit payments totaling nearly $6.8 million. The other 1,000 people were covered by annuity contracts that will pay their benefits when they are found. PBGC was able to confirm addresses for 3,465 of the missing people and to pay 765 of them a total of more than $2.7 million in benefits.

Additionally, the Pension Search listing on the Internet helped PBGC find 4,800 other people who were owed about $10 million. When the year ended, the total Internet list, which included people
PBGC was unable to find through the clearinghouse, identified more than 11,500 unlocated people who were owed about $27 million in pension benefits. Since inception, PBGC's Internet pension search has helped nearly 6,600 people obtain more than $21 million in owed benefits plus interest. The Internet listing is found at http://search.pbgc.gov.

MULTIEMPLOYER PROGRAM

The multiemployer program, which covers more than 9.1 million workers and retirees in about 1,750 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 two or more unrelated employers. 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.

Financial Assistance.—The multiemployer program continues to receive relatively few requests for financial assistance. Since 1980, PBGC has provided assistance to only 27 of the 1,750 insured plans, with a total value of approximately $148 million net of repaid amounts. During the year, 21 of these plans received assistance totaling about $91 million, including one-time payments totaling $87 million for two financially troubled multiemployer plans that merged into large national plans. PBGC's payments facilitated the mergers, as a result of which retirees continue to receive their full benefits and participants continue to earn benefits in an ongoing plan.

TRENDS IN DEFINED BENEFIT PENSION PLANS

Since the early 1980s, there has been a gradual shift away from defined benefit pension plans in the private sector. The number of PBGC-insured defined benefit plans peaked in 1985 at about 114,000. Since then there has been a sharp decline to about 38,000 plans in 2000.

This reduction has not been proportional across all plan sizes. Plans with fewer than 100 participants have shown the most marked decline, from about 90,000 in 1985 to less than 23,000 in 2000. There also has been a sharp decline for plans with between 100 and 999 participants, from more than 19,000 in 1985 to about 10,500 in 2000.

In marked contrast to the trends for plans with fewer than 1,000 participants, the number of plans with more than 1,000 participants has shown modest growth. Since 1980, the number of PBGC-insured plans with between 1,000 and 9,999 participants has grown by about 4 percent, from 4,017 to 4,174 in 2000. The number of plans with at least 10,000 participants has grown from 469 in 1980 to 776 in 2000, an increase of 65 percent.

The growth in the number of large plans is attributable to two factors. First, the rapid increase in inactive participants (retirees and separated vested participants) has pushed some plans into
higher size categories. Second, there has been considerable plan merger activity over the fifteen-year period from 1985 through 2000.

In contrast to the dramatic reduction in the total number of plans, the total number of participants in PBGC-insured defined benefit plans has shown modest growth. In 1980, there were 35.5 million participants. By 2000, this number had increased to more than 45 million.

These numbers, however, mask the downward trend in the defined benefit system because total participants include not only active workers but also retirees (or their surviving spouses) and separated vested participants. The latter two categories of participants reflect past coverage patterns in defined benefit plans. A better forward-looking measure is the trend in the number of active participants, workers currently earning pension accruals. Here, the numbers continue to decline.

In 1988, there were 27.3 million active participants in defined benefit plans; by 1998 (the latest data available), this number had fallen to 22.9 million, a decrease of more than 16 percent. At the same time, the number of inactive participants has been growing. In 1980, inactive participants accounted for only 23 percent of total participants in defined benefit plans. By 1988 this number had increased to 31 percent; 46 percent of the participants in defined benefit plans were inactive participants by 1998. If this trend continues, by the year 2003 the number of inactive participants will exceed the number of active workers.

LEGISLATIVE PROPOSALS

The Clinton Administration’s budget for fiscal year 2001 included numerous provisions to encourage the expansion of retirement plan coverage, including under defined benefit plans. These provisions included:

- a simplified defined benefit plan called SMART (Secure Money Annuity or Retirement Trust) for small businesses with 100 or fewer employees;
- a reduced PBGC premium of $5 per participant for the first five years of a small business’s new plan and phase-in of the variable-rate premium over five years for new plans of all sizes;
- expansion of the missing participants clearinghouse to other terminating plans, including multiemployer defined benefit pension plans insured by PBGC, certain other defined benefit pension plans not insured by PBGC, and defined contribution plans;
- simplified rules governing PBGC’s guarantee of benefits for a partial owner of a company and the allocation of plan assets to the benefits of these owner-employees;
- doubling PBGC’s benefit guarantee for multiemployer plans, which has been at the same level since 1980, from the current maximum guarantee of $5,850 to $12,870 (shortly after the year ended, the Congress enacted the increase in the multiemployer guarantee as part of the Consolidated Appropriations Act, 2001—the guarantee increase requires no change in the multiemployer premium rate);
• a tax credit for part of the administrative expenses that a small business incurs when setting up a new plan;
• a tax credit for part of the cost of the contributions a small business makes to a defined benefit or defined contribution plan; and
• permitting accelerated funding of defined benefit plans.

SAFEGUARDING SOLVENCY

Favorable economic conditions enabled PBGC to further strengthen its financial position. Terminations of underfunded plans fell to their lowest level since 1993, contributing to the increasing strength of PBGC's net financial position. Although premium income declined for the fourth straight year, strong returns on both fixed-income and equity investments enabled both insurance programs to report net income for the year. The agency's determined defense of its legal positions led to important outcomes as well, both in negotiated settlements and in court.

INFORMATION SYSTEMS AND SECURITY

PBGC's extensive efforts to prepare its information systems and software for the Year 2000 century-date change produced a seamless transition from 1999 to 2000. All PBGC mission-critical and secondary systems continued to function normally with no Y2K problems.

The agency's primary focus shifted during 2000 to enhancing the security of its existing information systems and data. Testing of the agency's computer systems by PBGC's Inspector General found PBGC's systems secure from penetration through the Internet but identified other vulnerabilities common in complex networks. The agency immediately took corrective actions to address these problems, in the process accelerating initiatives planned for future years. These measures included:
• new, more robust passwords for access to the information systems and additional automated tools for monitoring and testing compliance;
• an annual independent assessment of PBGC's vulnerabilities;
• enhanced controls restricting high-level access to authorized users backed by a strong hardware-based authentication mechanism;
• implementing an intrusion management program to detect and address intrusion attempts;
• establishing and filling the new position of Information Systems Security Officer; and
• enhancing corporate-wide computer security awareness training and procedures for monitoring compliance with security policies.

PBGC also placed a major emphasis on improving its capabilities for conducting its business electronically. The ultimate goal is to provide electronic alternatives to paper forms and records within the next few years. In addition, the agency upgraded its Internet Web site to make the agency's information accessible to users with disabilities.
Both of PBGC's insurance programs posted significant financial gains during 2000, with the single-employer program recording the largest one-year gain in its history. Both programs' gains came mainly from investment income.

For the single-employer program, both fixed-income and equity investments contributed to the final result, producing total investment income of nearly $2.4 billion. However, due largely to companies' reduced risk-based premiums, premium income continued to decline from the record level reached in 1996, falling to $807 million in 2000. Consistent with recent trends, losses from plan terminations continued to decline. The combination of low termination losses and strong returns on investments enabled the single-employer program to record net income of nearly $2.7 billion, increasing the program's net surplus to $9.7 billion. This current surplus provides the insurance program with a cushion against future sizeable losses that are unforeseen and episodic in nature.

The multiemployer program reported net income of $68 million, due almost entirely to investment returns on the program's fixed-income assets. With total assets of $694 million and liabilities totaling $427 million primarily for nonrecoverable future financial assistance, the program had an end-of-year surplus of $267 million. The program's premium income increased slightly to about $24 million.

PBGC's financial statements have received their eighth consecutive unqualified opinion from the agency's auditors. The 2000 audit was again performed by PricewaterhouseCoopers LLP under the direction and oversight of PBGC's Inspector General.

The Joint Financial Management Improvement Program (JFMIP) recognized the accomplishments of Chief Financial Officer N. Anthony Calhoun by presenting him with its annual Donald L. Scantlebury Memorial Award for distinguished leadership in financial management improvement in the public sector. The award cited Mr. Calhoun's "exceptional leadership in improving financial management of the retirement benefits of millions of Americans," noting Mr. Calhoun's championing of innovative financial systems technology and implementation of a system of internal controls that assure the issuance of reliable financial information. The JFMIP is a joint program of the Department of the Treasury, Office of Management and Budget, and Office of Personnel Management that works with all federal agencies to improve financial management practices and policies.

Investment Program.—The Corporation's investable assets consist of premium revenues accounted for in the Revolving Funds and assets from terminated plans and their sponsors accounted for in the Trust Funds. By law, PBGC is required to invest the Revolving Funds in fixed-income securities; current policy is to invest these funds only in Treasury securities. The agency has more discretion in its management of the Trust Funds, which it invests primarily in high-quality equities. The asset allocation is designed to provide sound long-term performance.

PBGC has structured its investment portfolio to improve the agency's financial condition in a prudent manner. The Revolving
Fund assets are invested to earn a competitive return and partially offset changes in its benefit liabilities. The agency's investment in equities provides overall portfolio diversification and a higher long-term expected return, within prudent levels of risk. PBGC uses institutional investment management firms to invest its assets subject to PBGC oversight. PBGC, with the advice of its Advisory Committee, continually reviews its investment strategy to ensure that the agency maintains an investment structure that is consistent with its long-term objectives and responsibilities.

As of September 30, 2000, the value of PBGC's total investments in the single-employer and multiemployer programs, including cash, was approximately $21 billion. The Revolving Fund's value was $12.1 billion and the Trust Fund's value was $8.9 billion. Cash and fixed-income securities represented 61 percent of the total assets invested at the end of the year, as compared to 60 percent at the end of 1999, while the equity allocation remained constant at 39 percent of all investments. A very small portion of the invested portfolio remains in real estate and other financial instruments.

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<th>Investment Profile</th>
<th>September 30,</th>
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<tbody>
<tr>
<td></td>
<td>2000</td>
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<tr>
<td><strong>Fixed-Income Assets</strong></td>
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<td>Average Quality</td>
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<td>Average Maturity (years)</td>
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<td>Duration (years)</td>
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<td>Yield to Maturity (%)</td>
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<td>Average Price/Earnings Ratio</td>
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<td>Dividend Yield (%)</td>
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<td>Beta</td>
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</table>

The current allocation to equities is the maximum currently allowable to PBGC, given legislative restrictions limiting equity investments to the Trust Funds. The increased equity allocation, adopted in 1994 as part of a strategic change in the agency's investment policy, has significantly improved PBGC's overall financial condition, as PBGC's equity assets have substantially outperformed its long-term Treasury portfolio by more than 11 percentage points per year over the past 6 years (21.7% versus 9.9%). This change in policy has made an important contribution to the insurance program's current surplus and to PBGC's long-term financial viability.

Results for fiscal year 2000 were favorable for capital market investments and PBGC's investment program. For the year, PBGC's fixed-income program returned 9.8 percent while its equity program advanced 18.2 percent. PBGC's five-year returns approximated their comparable market indices, meeting the agency's strategic performance goal. For the year, PBGC reported a gain of $1.1 billion from fixed-income investments and a gain of $1.3 billion from equity investments.
### Investment Performance

#### (Annual Rates of Return)

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<tbody>
<tr>
<td>Total Invested Funds</td>
<td>13.2</td>
<td>3.6</td>
<td>12.1</td>
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<tr>
<td>Equities</td>
<td>18.2</td>
<td>24.7</td>
<td>19.9</td>
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<tr>
<td>Fixed-Income</td>
<td>9.8</td>
<td>(7.9)</td>
<td>7.6</td>
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<tr>
<td>Trust Funds</td>
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<td>24.3</td>
<td>19.2</td>
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<tr>
<td>Revolving Funds</td>
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<td>(7.7)</td>
<td>7.5</td>
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<td>Indices</td>
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<td>Wilshire 5000</td>
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<tr>
<td>S&amp;P 500 Stock Index</td>
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<td>21.7</td>
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<tr>
<td>Lehman Brothers Long Treasury Index</td>
<td>9.8</td>
<td>(7.7)</td>
<td>7.5</td>
</tr>
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</table>

**Contract Management.**—Following a review of PBGC's contract management, the U.S. General Accounting Office reported during the year that, although PBGC complied with all legal requirements, the agency's contract management might be improved through better contract procedures and monitoring. The GAO recommended measures that PBGC accepted and began implementing before the year ended. At the same time, PBGC significantly increased the training provided to its Contracting Officer's Technical Representatives (COTRs) and its contract monitors. By the end of the year, the agency had begun developing a COTR certification program to ensure that agency COTRs are and remain qualified for that function.

Of the contracts issued during 2000, PBGC awarded 88 percent through full and open competition. The remainder were sole-source contracts or set aside for minority bids.

### SINGLE-EMPLOYER PROGRAM EXPOSURE

PBGC's “expected claims” are dependent on two factors: the amount of underfunding in the pension plans that PBGC insures (i.e., exposure), and the likelihood that corporate sponsors of these underfunded plans encounter financial distress that results in bankruptcy and plan termination (i.e., the probability of claims).

Over the near term, expected claims result from underfunding in plans sponsored by financially weak firms. PBGC treats a plan sponsor as financially weak based upon factors such as whether the firm has a below-investment-grade bond rating. PBGC calculates the underfunding for plans of these financially weak companies using the best available data, including the annual confidential filings that companies with large underfunded plans are required to make to PBGC under Section 4010 of ERISA.

For purposes of its financial statements, PBGC classifies the underfunding of financially weak companies as “reasonably possible” exposure, as required under accounting principles generally accepted in the United States of America. As of December 31, 1999, as disclosed in the financial statements, PBGC's estimated “reasonably possible” exposure was $5 billion.

Over the longer term, exposure and expected claims are more difficult to quantify either in terms of a single number or a limited range. Claims are sensitive to changes in interest rates and stock returns, overall economic conditions, the development of under-
funding in some large plans, the performance of some particular industries, and the bankruptcy of a few large companies. Large claims from a small number of terminations and volatility characterize the agency's historical claims experience and are likely to affect PBGC's potential future claims experience as well.

**Methodology for Considering Long-Term Claims.**—No single underfunding number or range of numbers—even the reasonably possible estimate—is sufficient to evaluate PBGC's exposure and expected claims over the next ten years. There is too much uncertainty about the future, both with respect to the performance of the economy and the performance of the companies that sponsor insured pension plans.

PBGC uses a stochastic model—the Pension Insurance Modeling System (PIMS)—to evaluate its exposure and expected claims.

PIMS portrays future underfunding under current funding rules as a function of a variety of economic parameters. The model recognizes that all companies have some chance of bankruptcy and that these probabilities can change significantly over time. The model also recognizes the uncertainty in key economic parameters (particularly interest rates and stock returns). The model simulates the flows of claims that could develop under thousands of combinations of economic parameters and bankruptcy rates. (For additional information on PIMS, see PBGC's Pension Insurance Data Book 1998, pages 10–17, which also can be viewed on PBGC's Web site at [www.pbgc.gov/publications/databooks/databk98.pdf](http://www.pbgc.gov/publications/databooks/databk98.pdf))

Under the model, median claims over the next ten years will be about $650 million per year (expressed in today's dollars); that is, half of the scenarios show claims above $650 million per year, and half below. The mean level of claims (that is, the average claim) is much higher, more than $1,050 million per year. The mean is higher because there is a chance under some scenarios that claims could reach very high levels. For example, under the model, there is a ten percent chance that claims could exceed $2.6 billion per year.

PIMS projects PBGC's potential financial position by combining simulated claims with simulated premiums, expenses, and investment returns. The mean outcome is an $11.6 billion surplus in 2010 (in present value terms). However, the model also shows the potential for significant downside outcomes. In particular, there is nearly a 20 percent chance that the agency could return to a deficit in the next ten years and a ten percent chance that the deficit could exceed $12.0 billion in 2010 (in present value terms). These outcomes are most likely if the economy performs poorly, in which case PBGC may experience large claims amounts and investment losses. PBGC is continuing to analyze the best way to manage and reduce the risk of insolvency.

**LOSS PREVENTION**

During the year, PBGC took a significant step toward easing employers' concerns about the Early Warning Program by issuing guidance clarifying the scope of the program's operation. Under the Early Warning Program, PBGC monitors certain companies with underfunded pension plans in order to identify corporate transactions that could jeopardize pensions and to arrange suitable pro-
tions for those pensions and the pension insurance program. Following a comprehensive internal review of the program, which included discussions with employers, pension professionals and others with interest in the program, PBGC adopted new more-restrictive screening criteria for determining when to contact companies about pending transactions. The agency then issued detailed guidance to help plan sponsors and pension professionals anticipate when PBGC is likely to be concerned about a business transaction and understand the types of pension protection PBGC may seek. The new guidance was well-received, and PBGC anticipates that its new screening criteria will result in far fewer contacts with corporate sponsors of pension plans.

During the year, PBGC reached agreements valued at about $66 million with 5 companies. These agreements provided contributions, security, and other protections for the pensions of about 31,000 workers and retirees.

LITIGATION

PBGC continued to face challenges in courts across the country, a number of which could impair the agency’s ability to recover its losses for underfunded plans from the employers responsible for those plans. At the end of the year, PBGC had 81 active cases in state and federal courts and 575 bankruptcy cases.

Major cases in 2000 included:

White Consolidated Industries, Inc.—In a July 1999 ruling, a district court found White liable for the unfunded benefits of six pension plans that White transferred to the Blaw Knox Corporation in 1985. PBGC later took over the plans because they ran out of money or would have been abandoned after Blaw Knox ceased business in 1994. PBGC sought to recover approximately $120 million, plus interest, for the plans' underfunding, alleging that a principal purpose of White's transaction was to evade its pension liabilities. This effort culminated in the district court ruling. White appealed to the Third Circuit Court of Appeals, which affirmed the district court's ruling in June 2000. In July 2000, PBGC and White reached an agreement settling the litigation and White's separate administrative appeal before PBGC challenging the agency's calculation of the unfunded benefit liabilities. Under the settlement, White agreed to resume sponsorship of the six pension plans and pay the plan participants their full plan benefits with a 5 percent increase, plus any benefits PBGC did not pay because of the legal limits on PBGC's guarantee. White also agreed to reimburse PBGC for its costs in paying benefits under the plans as well as its litigation costs. Certain aspects of the agreement are subject to approval by the Internal Revenue Service and the Department of Labor. Should the agreement not go forward for any reason, PBGC will keep the plans. White will then pay the plan participants the value of their unpaid non-guaranteed benefits and pay PBGC $180 million less the amount White pays directly to participants. This agreement is unprecedented in that it is the only time PBGC has conditioned settlement on getting participants benefits they would otherwise not be able to receive.

Copperweld Steel Company.—PBGC continued to pursue bankruptcy claims to recover amounts due PBGC and Copperweld's
three terminated pension plans, which covered about 3,000 workers and retirees. The company’s liquidation trustee contests whether PBGC’s claims for unpaid minimum funding contributions in excess of $1 million are entitled to tax priority, and whether the assumptions PBGC prescribes in its regulations appropriately measure PBGC’s claims for unfunded benefit liabilities. In December 1997, the bankruptcy court ruled for the liquidation trustee’s position on both issues. On PBGC’s appeal, the district court affirmed the bankruptcy court’s adverse decision and, in November 2000, the Sixth Circuit Court of Appeals affirmed the lower court rulings. PBGC is considering whether to seek further review.

Pineiro, Brooks, and Beaumont v. PBGC.—In 1991, PBGC became trustee of three Pan Am pension plans underfunded by $914 million. Three former employees of Pan American World Airways later filed suit asking a district court to replace PBGC with an independent trustee. In 1997, the court initially dismissed virtually all of the allegations as meritless, leaving open only an allegation concerning the timeliness of PBGC’s notices of benefit determination to the Pan Am participants. The plaintiffs filed an amended complaint in January 1998 realleging PBGC delays in issuing benefit determinations as well as most of the dismissed allegations; PBGC responded with a motion to dismiss the amended complaint. In March 2000 the district court issued a new decision that vacated significant parts of its 1997 ruling, allowing several of the plaintiffs’ claims to continue while dismissing others. The court’s decision focused on the technical legal issue of whether PBGC operates as a “trustee” or as a “statutory guarantor” when calculating guaranteed benefits. The district court subsequently permitted PBGC to file an immediate appeal of its ruling and stayed all further proceedings in the case pending that appeal. PBGC’s request to immediately appeal the district court decision was pending before the appellate court at yearend. Despite the exceedingly poor condition of company records and the difficulties caused by Pan Am’s protracted bankruptcy proceedings, PBGC has been paying benefits to Pan Am retirees continuously since taking over the plans. The agency has completed all benefit determinations for the 53,000 former Pan Am workers and retirees.

Raytech Corporation.—In 1986 Raymark Industries, Inc., formerly known as Raybestos-Manhattan, Inc., created Raytech Corporation as a wholly owned subsidiary. In doing so, Raytech acquired Raymark’s profitable assets while leaving Raymark with asbestos-related liabilities and two pension plans that are underfunded by about $19 million. In 1999, while undergoing reorganization in bankruptcy, Raytech filed for a declaration that it was not liable for any minimum funding contributions to the Raymark pension plans after it ceased being a member of Raymark’s controlled group. PBGC filed a counterclaim alleging that the spin-off of Raytech and Raymark was a scheme intended to defraud creditors and asking the court to order Raytech to maintain, administer and fund the plans. In December 1999, the bankruptcy court granted PBGC’s motion for summary judgment and ordered Raytech to take full responsibility for the two pension plans. The court agreed with PBGC that the transactions that separated Raytech from Raymark were intended to defraud Raymark’s creditors and that PBGC was
entitled to relief under fraudulent conveyance law. Raytech's appeal was pending before the district court at yearend.

ANNUAL PERFORMANCE REPORT

PBGC's five-year strategic plan has four broad goals that form the framework of the agency's short- and long-term plans. In 2000, PBGC updated the plan to cover the period 2000–2005, in some cases refining the performance measures to make them more meaningful to customers. The PBGC goals are to:

(1) protect existing defined benefit plans and their participants, thereby encouraging new plans;
(2) provide high quality, responsive services, and accurate and timely payment of benefits to participants;
(3) strengthen financial programs and systems to keep the pension insurance system solvent; and
(4) improve internal management support operations.

The performance measures track specific results that are significant to PBGC's customers and gauge PBGC's solvency and customer service accomplishments. The following table shows the results achieved in 2000 and meets the annual reporting requirement established by the Government Performance and Results Act. More information on PBGC's strategic plan and annual performance plan may be found on PBGC's Web site at www.pbgc.gov/about—pbgc/mission/mission.htm.
### 2000 PBGC Corporate Performance Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Applicable Goal</th>
<th>2000 Milestone</th>
<th>2000 Result</th>
<th>Baseline*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protecting the Interests of Participants:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protect the interests of defined benefit pension plan participants by:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution of bankruptcy actions with companies sponsoring plans</td>
<td>(1) **</td>
<td>82 plans 56,800 participants.</td>
<td>92 plans 226,000 participants (1999)</td>
<td></td>
</tr>
<tr>
<td>Finding and paying benefits to missing participants in plans</td>
<td>(1) **</td>
<td>8,265 participants</td>
<td>1,303 participants (1999)</td>
<td></td>
</tr>
<tr>
<td>Customer Satisfaction:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieve &quot;outstanding&quot; or &quot;above average&quot; ratings (on a five point customer satisfaction scale) for inquiries handled:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From people whose plans we trustee</td>
<td>(2)</td>
<td>74%</td>
<td>71%</td>
<td>79% (1997)</td>
</tr>
<tr>
<td>From pension practitioners/sponsors</td>
<td>(2)</td>
<td>67%</td>
<td>62%</td>
<td>54% (1997)</td>
</tr>
<tr>
<td>Operations:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide reliable estimated benefits to participants that are within 10% of final benefits and are in clear, understandable language.</td>
<td>(2)</td>
<td>88%</td>
<td>94%</td>
<td>84% (1999)</td>
</tr>
<tr>
<td>Reduce from 5–6 years to 4–5 years the average time frame to send benefit determinations to participants in defined benefit plans taken over by PBGC.</td>
<td>(2)</td>
<td>4–5 years</td>
<td>4.9 years</td>
<td>5.95 years (1997)</td>
</tr>
<tr>
<td>Reduce the age of pre-trusteeship inventory to no more than 1 year</td>
<td>(2)</td>
<td>100% 2 years or less.</td>
<td>98% 2 years or less.</td>
<td>98.6% 4 years or less (1998)</td>
</tr>
<tr>
<td>Send the first benefit payment to an eligible person within 3 months of receiving his/her completed application</td>
<td>(2)</td>
<td>88%</td>
<td>91%</td>
<td>83% (1999)</td>
</tr>
<tr>
<td>Financial Management:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collect 95% of pension insurance premiums due</td>
<td>(3)</td>
<td>99%</td>
<td>99%</td>
<td>97% (1997)</td>
</tr>
<tr>
<td>Research and respond within 90 days to requests for premium refunds, waiver of premium penalties, and reconsiderations of PBGC premium decisions.</td>
<td>(3)</td>
<td>99%</td>
<td>99%</td>
<td>90% (1999)</td>
</tr>
<tr>
<td>Approximate comparable 5-year investment indices for PBGC's portfolio performance</td>
<td>(3) **</td>
<td>PBGC Index</td>
<td>(1997) PBGC Index</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Equities 19.9%</td>
<td>Equities 20.5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fixed-Income 7.6%</td>
<td>Fixed-Income 7.5%</td>
<td></td>
</tr>
</tbody>
</table>

*Year in parentheses indicates the year in which the baseline value was set.**

**By their nature, these measures do not lend themselves to setting annual targets or milestones. PBGC measures performance annually based on actual results.
ACHIEVING PERFORMANCE TARGETS

Protecting the Interests of Participants, Thereby Encouraging New Plans:

- Six times more missing participants were located through PBGC's efforts during the year compared to the prior year. This was due in part to an agreement allowing PBGC to regularly search the Social Security Administration data base for names and addresses. Participants thus received millions of dollars in pension benefits they otherwise would have lost.
- PBGC also protects participants' interests by educating participants and pension practitioners about defined benefit plans. PBGC conducted 54 group meetings to inform participants in PBGC-trusteed pension plans about the PBGC guarantee and what they can expect. Similarly, PBGC officials participated in 59 meetings and conferences with pension practitioners to address issues of mutual concern and to get their feedback.

Customer Satisfaction:

- PBGC continues to learn about customer expectations and opinions through satisfaction surveys and focus groups, and has set performance targets for both participants' and practitioners' satisfaction through 2005.
- In 2000, participant satisfaction remained at the same level as the previous year. Retired participants receiving benefits continue to report a higher level of satisfaction with PBGC service than those due a future pension. PBGC has taken steps to improve the accuracy and timeliness of benefit estimates and to communicate earlier and more frequently with future payees. These changes will address a major cause of dissatisfaction.
- 62 percent of pension practitioners rated PBGC's overall service "outstanding" or "above average" in 2000, slightly down from the previous year, but within the margin of error. PBGC's 2000 goal was 67 percent. To address this, after year's end, PBGC changed and simplified its premium regulations to ease the burden for plan administrators: prorated premium payments for short plan years are now allowed; the definition of participant for premium purposes is simpler; and the standard for claiming the variable-rate premium exemption for a fully insured plan is simpler. By consistently meeting its customer service pledge, and making changes based on practitioner feedback, PBGC expects to improve overall satisfaction in 2001.

Operations:

- The principal measure of operations is to "reduce to 3 to 4 years the average time frame to send benefit determinations to participants in defined benefit pension plans taken over by PBGC." Efforts to speed up processing have succeeded. Participants received benefit determinations in 2000 almost one year faster on average than participants in the previous year. As an indication of continued improvement in processing times in the future, the average age of unissued benefit determinations was reduced from 2.3 years to 2 years.
During the year, participants received final benefits within 10 percent of the earlier estimated benefits in 94 percent of the cases. PBGC revised this measure, broadening it to include all participants versus the small number of participants included in the old definition. The new definition is more meaningful to the participant universe.

PBGC further reduced the age of cases awaiting trusteeship. The goal is that no pending case be more than one year old by 2002, reached in annual milestones. At the end of the fiscal year, 98 percent of cases to be trusteeed were two years old or less.

91 percent of eligible participants who completed applications received pension payments from PBGC within three months, a significant improvement over the previous year.

Financial Management:

The premium collection rate is the amount of premiums collected divided by the amount of premiums due. PBGC achieved its 99 percent collection goal.

Practitioners now routinely receive responses to requests for premium refunds, waiver of penalties, and reconsiderations of premium decisions within ninety days 99 percent of the time. Practitioners said this is an important service element, and PBGC responded.

Investment management results are measured against recognized industry indices aggregated over a five-year period. The five-year period smooths out volatility in annual market performance and provides a more realistic, long-term view of investment success. This year, PBGC's performance approximated the indices for equities and fixed-income investments.

PROGRAM EVALUATION

PBGC conducted customer satisfaction surveys of participants in plans trusteeed by PBGC, and of pension practitioners who have dealings with us on premium payment or standard termination matters. Evaluation of the survey responses resulted in improvements in program operations, as discussed earlier in the Annual Report.
ITEM 26—POSTAL SERVICE

PROGRAMS AFFECTING OLDER AMERICANS

CARRIER ALERT PROGRAM

Carrier Alert is a voluntary community service provided by city and rural delivery letter carriers who watch participant’s mailboxes for mail accumulation which might signal illness or injury. Letter carriers report mail accumulations to their supervisors, who then notify a sponsoring agency, through locally developed procedures, for follow-up action. The program completed its 18th year of operation in 2000 and continues to provide a lifeline to thousands of elderly citizens who live alone.

DELIVERY SERVICE POLICY

The Postal Service has a long-standing policy of granting case-by-case exceptions to delivery regulations based upon hardship or special needs. This policy accommodates the special needs of elderly, handicapped, or infirm customers who are unable to obtain mail from a receptacle located some distance from their home. Information on hardship exceptions to delivery receptacles can be obtained from local postmasters.

SERVICES AVAILABLE FROM YOUR RURAL CARRIER

Rural carriers continue to provide their customers with retail services they have come to expect from the rural “post office on wheels.” Retail services provided include registered and certified mail, accepting parcels for mailing, and taking applications for money orders. Rural carriers also provide customers with receipts for such services.

Retail services are available to all customers served by rural carriers but are most beneficial to those individuals who are elderly or have physical limitations that adversely impact their ability to go to the post office for these important services. Rural carriers provide their customers with almost all retail services available from the post office 302 days per year.

PARCEL DELIVERY POLICIES

For postal customers who are unavailable to receive parcels, but who normally are at home, our letter carriers will automatically re-deliver the article the following day. In addition, if the mailer requests, uninsured parcels are left at customer homes or businesses provided there is reasonable protection from weather and theft. Both of these policies make it easier for customers, particularly the
elderly, to receive mail and minimize the need for trips to the post office.

ACCESSIBILITY

The Postal Service is subject to the Architectural Barriers Act of 1968. The resulting standards for the design, construction, and alteration of leased and owned facilities, are published in Postal Service Handbook RE-4, Standards for Facility Accessibility by the Physically Handicapped.

Significant progress continues to be made to increase the accessibility of 36,000 Postal Service facilities. Enhanced facility features such as accessible routes, handrails, ramps and automatic doors benefit physically challenged and elderly customers. In 1999 and 2000, 231 accessibility projects were completed in existing postal facilities at a cost of $8.8 million. Our commitment to barrier-free facilities is apparent by our continued effort toward retrofitting historic facilities. The Postal Service values its elderly customers and feels they will benefit from our efforts to make facilities more accessible.

CONSUMER EDUCATION AND FRAUD PREVENTION

The U.S. Postal Inspection Service endeavors to alert consumers and businesses to various types of postal crimes by attracting media attention to crime trends, publicizing positive law enforcement accomplishments, circulating media releases and hosting crime prevention presentations.

Older citizens and disadvantaged groups are especially dependent on mail delivery for vital purchases, and can be particularly susceptible to fraudulent schemes. Illegal schemes that rely on the use of the mail are limited only by the imagination of con artists. For over 200 years Postal Inspectors have been protecting postal customers from fraudulent schemes involving the U.S. Mail including investment, insurance, health care, telemarketing, loan, and merchandise misrepresentation schemes.

NATIONAL CONSUMER PROTECTION WEEK


In 1999 the NCPW theme was “Know the Rules, Use the Tools,” and focused on educating consumers, particularly seniors, about their rights and empowering them to protect themselves from fraud and abuse in the marketplace. A variety of special events were held across the country and supported by informational Web sites, the distribution of consumer awareness brochures and consumer fairs.

The NCPW theme for 2000 was “Armchair Armor-Shopping Safely from Home,” and was selected because this type of consumer fraud is big business. Marketing and telecommunications advances in the “information age” have given everyone, even con artists, the power to boost the sophistication and reach of a sales pitch. Fraud
promoters now masquerade as national firms, using telemarketing, direct mail, television or other methods to reach potential victims. Efforts by the NCPW partners focused on educating consumers and advising them to contact consumer protection agencies prior to making purchases to avoid becoming a victim. In an effort to reach as many individuals as possible, the Inspection Service procured ad space on the Next Generation Network (NGN), which has monitors located at convenience stores, gas stations, and office buildings in 18 major media markets throughout the country, including 8 of the top 10. Six million people view NGN’s monitors at approximately 5,000 locations each day. The number of E*billboard ads totaled over 21 million for the week, reaching approximately 42 million Americans at 5,228 locations.

DECEPTIVE MAILINGS

Postal Inspectors worked closely with the Senate Permanent Subcommittee on Investigations regarding sweepstakes and deceptive mailings legislation. As a result, the Deceptive Mail Prevention and Enforcement Act was passed and signed into law on December 12, 1999. It became Public Law 106–168, and was effective in April 2000. The new law protects consumers, especially seniors, against deceptive mailings and sweepstakes practices by:

- establishing standards for sweepstakes mailings, skill contests and facsimile checks,
- restricting government look-alike documents, and
- creating a uniform notification system allowing individuals to remove their names and addresses from all major sweepstakes mailing lists at one time.

Additionally, disclosures will make sure that no purchase is necessary to enter a sweepstakes and that a purchase will not improve consumers’ chances of winning a prize. The law also creates strong financial penalties for companies that do not disclose all terms and conditions of a contest.

To make the most effective use of the new statute and protect consumers, the Inspection Service recently established a Deceptive Mail Enforcement Team, composed of Postal Inspectors, Inspector Attorneys and Inspection Service fraud analysts. The team reviews complaints related to promotional mailings to assess their compliance with the Act. As of September 30, 2000, 12 subpoenas have been issued, allowing Inspection Service personnel to develop information on questionable promotions. To date, approximately 57 suspect mailings have been reviewed and found to be in compliance with the law.

PRIZE PROMOTIONS—“PROJECT PRIZE FIGHTER”

Prize promotion fraud continues to target unwary consumers who lose millions of dollars each year to fraudulent promotions. To combat scams of this nature, the Postal Inspection Service joined the Federal Trade Commission, State Attorneys General and other law enforcement agencies in “Project Prize Fighter.” The project focused on bogus prize promoters who preyed on consumers who had previously entered sweepstakes, informing victims they had won a prize, but had to pay fees to get them. None of the victims received a prize, regardless of how much money they mailed to the unscrup
pulous promoters. "Project Prize Fighter" resulted in 24 law enforcement actions against more than 40 defendants in 9 states; the Postal Inspection Service alone brought 10 of the enforcement actions.

LOTTERY PROMOTIONS

Similar to prize promotions, lottery promotions that promise large winnings for little effort also target consumers and are often aimed at senior citizens who are most vulnerable to such scams. In one case, a major international lottery promoter was sentenced in Seattle to six months in prison, three years' probation and ordered to forfeit $12 million. Inspectors seized his assets for restitution to the victims and in partial satisfaction of a prior consent agreement.

WORK-AT-HOME SCHEMES—"OPERATION JOB FRAUD"

Older Americans are often interested in supplementing their income by seeking employment opportunities. Unfortunately, some have limited mobility and are enticed by work-at-home opportunities promising big earning possibilities. To address the continuing problem of fraudulent work-at-home promotions, the Postal Inspection Service and numerous offices of the Better Business Bureau formed "Operation Job Fraud." Operation Job Fraud's mission was three-fold: to alert the public to work-at-home schemes, expose these practices and operators that deceive and rob the public, and help law enforcement in criminal prosecutions.

The task force identified a variety of work-at-home companies, including envelope stuffing, product assembly, medical billing, and mystery shopping. Business opportunities, such as vitamin sales, auto-dialing machines, selling advertising on the Internet, and telemarketing of videotapes, books and seminars were also identified. As the task force gathered results, information was shared with Postal Inspectors to assist in arrests and prosecution. The effort is ongoing.

KNOW FRAUD

In November 1999, during a weekly radio address, President Clinton launched the initial KNOW FRAUD campaign and cited the project as "an excellent example of coordination among federal government's consumer protection agencies." The campaign, said to be the largest consumer protection effort ever undertaken, included a postcard mailing to 120 million American households alerting consumers to the dangers of telemarketing and mail fraud, a national press conference, and more than 100 press conferences in cities across the country. To date, the campaign has generated well over 100,000 consumer inquiries via the established toll-free telephone number and Web site as well as through written inquiries. Partners of the national campaign included the Council of Better Business Bureaus, AARP, Department of Justice, Federal Bureau of Investigation, Federal Trade Commission, National Association of Attorneys General, Securities and Exchange Commission, and United States Postal Inspection Service.

As a result of the KNOW FRAUD initiative, consumers have been educated about unscrupulous telemarketing and mail fraud
promotions and have learned where to receive help and report possible telemarketing and/or mail fraud schemes. In addition to the multi-media approach taken by KNOW FRAUD to get the message to consumers, North American Precis Syndicate (NAPS) reported that 1,276 news articles related to KNOW FRAUD have been printed in 36 states with readership of 93.5 million. Additionally, 845 radio stations ran KNOW FRAUD broadcasts to an audience of 18.5 million.

**FRAUD AND DECEPTION ON THE INTERNET—“GETRICHQUICK.CON”**

In February 2000, Postal Inspection Service representatives were leading participants in the Federal Trade Commission’s (FTC) “GetRichQuick.con” surf project, the largest ever international law enforcement project to fight fraud and deception on the Internet. During the surf, participants from 150 organizations in 28 countries discovered and reported on approximately 1,600 different Web sites making suspect get-rich-quick claims. As a result, warning E-mails were sent to the targeted sites with hyperlinks to the partners' consumer and business education materials.

**IDENTITY THEFT**

In an effort to educate consumers about identity theft, in Fiscal Year 2000, an Inspection Service video news release aired on 132 stations, and was seen by 5.6 million viewers. A print news release was picked up by 144 newspapers that reached 7.3 million readers, and a radio broadcast was aired by 271 stations with a total audience of 8.5 million.

**CONSUMER PROTECTION INITIATIVES COMMITTEE OF THE ATTORNEY GENERAL’S COUNCIL ON WHITE COLLAR CRIME**

In response to President Clinton's request that a long lasting partnership of leading private and government agencies continues, the Department of Justice formed the Consumer Protection Initiatives Committee of the Attorney General’s Council on White Collar Crime. At monthly meetings, agency representatives meet to discuss how to prevent consumer fraud and improve coordination among federal government agencies in planning consumer protection efforts. Joining the Postal Inspection Service are the Federal Trade Commission, Securities and Exchange Commission, Department of Treasury and Food and Drug Administration. Non-governmental organizations include the AARP, Council of Better Business Bureau Foundation, National White Collar Crime Center and North American Securities. National consumer organizations, as well as state and local law enforcement agencies also participate on the committee. This multi-agency committee membership allows for the development of interagency consumer protection initiatives that target enforcement, deterrence and public awareness.

**HEALTH CARE FRAUD**

The National Health Care Anti-Fraud Association honored the U.S. Postal Inspection Service with its 1999 Investigation of the Year award and honorable mention awards for performance in two investigations. "Operation Takeback" was a four-year task force op-
eration that consisted of Florida Division Postal Inspectors, officials from Blue Cross Blue Shield of Florida and other federal, state and local agencies. The task force targeted health care providers that paid illegal rebates, bribes and kickbacks in return for patient referrals. Over $2 million in fines and restitution was ordered by the courts and another $1.77 million was returned to the Medicare Trust Fund. Additionally, the Inspection Service was recognized for its participation in MEDWEB, another Florida Division task force case, involving the illegal sales of Medicare patients’ names, account numbers and prescriptions. To date, 39 convictions have been obtained.

STAMPS BY AUTOMATED TELLER MACHINE (ATM)

Stamps by ATM is a convenient way to purchase stamps at a bank’s automated teller machine. There are currently over 18,000 ATMs nationwide that dispense stamps. Because many ATMs are accessible 24 hours a day, our customers are able to do banking and buy postage stamps at their convenience. A specially designed sheetlet of 18 First-Class stamps is dispensed at the touch of a button. Financial institutions may add a surcharge to the face value of the stamps to cover their processing costs. The cost is debited from the customer’s checking or savings account and treated like a cash withdrawal.

STAMPS BY MAIL

Stamps by Mail is a service that allows customers to purchase stamps in booklets, sheets and coils along with other products such as post cards and stamped envelopes, by ordering through the mail.

The Stamps by Mail program benefits a wide variety of people and is particularly beneficial to elderly or shut-in customers who cannot travel to the post office. Stamps by Mail provides order forms incorporated in self-addressed postage-paid envelopes to customers for their convenience in obtaining products and services without having to visit a Postal Service retail unit. The form is available in lobbies or from the customer’s letter carrier. Once the form is completed it can be returned to the carrier or dropped in a collection box. Orders are normally returned to the customer within 2 or 3 business days.

STAMPS BY PHONE

Stamps by Phone is a convenient program that is intended to target business, professional, and household customers who are willing to pay a service charge for the convenience of ordering by phone and paying by credit card (VISA or Master Card) to avoid trips to the post office. Customers utilizing this service can call a toll-free number (1–800–STAMPS–24), 24 hours a day, 7 days a week, and order from a menu of postal products. There is no minimum purchase amount, and customers receive their orders within 3 to 5 business days.

ALTERNATE POSTAL RETAIL SITES

Alternate postal retail sites include grocery stores and other retail stores that offer stamps for sale through a consignment agree-
ment, and contract Postal Units that offer a wider variety of services. Stamps offered through consignment agreements are sold at no more than face value at retailer checkstands. Contract postal units provide more convenient locations for our customers to mail packages, purchase stamps and postal money orders, send registered mail, and obtain postal services.

In 1998, the Postal Service began testing a partnership with Mail Boxes Etc. (MBE) to sell stamps and postal services at 250 MBE locations throughout the United States. In 2000, the test partnership expanded to 700 MBE locations. By providing services at numerous alternate locations, the Postal Service provides greater access and flexibility for all customers to obtain stamps and other postal services, which generally means less wait time to obtain these retail services. This enables customers to combine their mailing needs and other errands into a single trip to the neighborhood shopping center or grocery store. This is especially convenient for our elderly customers who may have limited access to transportation.

STAMPS VIA THE WORLD WIDE WEB

On November 8, 2000, the Postal Service launched the new Postal Store, an online retail channel. Accessed through our homepage, www.usps.com, The Postal Store offers USPS customers an alternative channel for buying stamps and stamp products without having to visit a physical retail outlet. With just a click of their mouse, customers can browse through “aisles” displaying a variety of stamps, stationery, Pro Cycling gear and phone cards. To provide ease of use, stamps and other products are organized and displayed according to categories and/or stamp release dates. As an added convenience, credit cards are processed and validated at the time orders are placed. Security is enhanced through the application of the Address Verification System, which verifies a customer’s billing address through their credit card company. State-of-the-art order processing and automated fulfillment equipment systems ensure the efficient delivery of orders within 3–5 days.

This convenient, secure, and easy-to-use web site especially benefits customers who, because of special needs, prefer to purchase postal and non-postal products from the comfort of their homes.

STAMPS HIGHLIGHTING AGING ISSUES

On September 7, 2000, the Postal Service honored the memory and work of former U.S. Senator Claude D. Pepper of Florida by issuing a commemorative stamp bearing his image. The stamp, which is part of the Postal Service’s Distinguished Americans stamp series, helped celebrate the life of a man who was known as a champion for the rights of Senior Citizens in his home state of Florida and across the country.
ITEM 27—RAILROAD RETIREMENT BOARD

ANNUAL REPORT ON PROGRAM ACTIVITIES FOR THE ELDERLY FOR THE U.S. SENATE SPECIAL COMMITTEE ON AGING 1999 AND 2000

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 widow(er)s, children, and parents of deceased railroad workers. Qualified railroad retirement beneficiaries are covered by Medicare in the same way as social security beneficiaries.

Under the Railroad Unemployment Insurance Act, the Board pays unemployment benefits to railroad workers who are unemployed but ready, willing and able to work and pays sickness benefits to railroad workers who are unable to work because of illness or injury.

BENEFITS AND BENEFICIARIES

During fiscal year 2000, retirement and survivor benefit payments under the Railroad Retirement Act amounted to nearly $8.3 billion, $46 million more than the prior year. The number of beneficiaries on the retirement-survivor rolls on September 30, 2000, totaled 673,000. The majority (85 percent) were age 65 or older.

At the end of the fiscal year, 309,000 retired employees were being paid regular annuities averaging $1,381 a month. Of these retirees, 138,000 were also being paid supplemental railroad retirement annuities averaging $42 a month. In addition, some 161,000 spouses and divorced spouses of retired employees were receiving monthly spouse benefits averaging $530 and, of the 211,000 survivors on the rolls, 175,000 were aged widow(er)s receiving monthly survivor benefits averaging $826. About 8,000 retired employees were also receiving spouse or survivor benefits based on their spouse's railroad service.
Some 621,000 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 2000. Of these, 607,000 (98 percent) were also enrolled for supplementary medical insurance.

Gross unemployment and sickness benefits paid under the Railroad Unemployment Insurance Act totaled $111.2 million during fiscal year 2000, while net benefits totaled $78.8 million after adjustments for recoveries of benefit payments, some of which were made in prior years. Total gross and net payments decreased by approximately $9.9 million and $9.6 million, respectively, from fiscal year 1999. Unemployment and sickness benefits were paid to 35,000 railroad employees during the fiscal year. However, only about $0.4 million (less than 1 percent) of the benefits went to individuals age 65 or older.

FINANCING

At the end of fiscal year 2000, the balance in the Railroad Retirement Board's accounts was $18.6 billion, registering an increase of $0.6 billion over the previous year, and earnings on investments, including capital gains, totaled $1.2 billion for the year.

The Board's 21st triennial actuarial valuation, submitted to Congress in June 2000, was generally favorable. The valuation concluded that, barring a sudden, unanticipated, large drop in railroad employment, the railroad retirement system will experience no cash-flow problems during the next 35 years. The long-term stability of the system, however, is not assured. Under the current financing structure, actual levels of railroad employment over the coming years will determine whether additional corrective action is necessary.

The Board's 2000 railroad unemployment insurance financial report was also favorable, indicating that even as maximum benefit rates increase 50 percent from $46 to $69 from 1999 to 2010, experience-based contribution rates maintain solvency even under the Board's most pessimistic employment assumption. The report also predicted average employer contribution rates well below the maximum throughout the projection period, but a periodic resumption of the surcharge required to maintain a minimum account balance.

No increases in the tax rates provided under current law were recommended by the Board for the railroad retirement or unemployment insurance systems.

LEGISLATION

Public Law 106-182, enacted April 7, 2000, eased the earnings restrictions affecting social security beneficiaries working after full retirement age. The legislation also applied to annuitants covered by the Railroad Retirement Act.

Under the two-tier railroad retirement system, tier I railroad retirement benefits and vested dual benefits paid by the Board to employees, spouses and survivors, as well as the tier II benefits paid to survivors, are subject to earnings deductions just like social security benefits, if post-retirement earnings exceed certain exempt amounts.
Retroactive to January 1, 2000, the amendments eliminated, for those of full social security retirement age, deductions of $1 in benefits for every $3 of earnings over and indexed earnings limit that previously applied until age 70. Earnings deductions, however, remain in effect for beneficiaries who have not yet attained full retirement age, and this legislation did not eliminate the railroad retirement work restrictions which are not included in the Social Security Act.

OFFICIALS

On May 24, 2000, the Senate confirmed President Clinton's nominations of Management Member Jerome F. Kever and Labor Member V.M. Speakman, Jr., for reappointment to the Board. Cherryl T. Thomas continues to serve as Chair.

Mr. Kever was first appointed to the Board on the recommendation of the Association of American Railroads and the Ameridan Short Line Railroad Association in 1992. He was reappointed to another term of office in 1995. Prior to joining the Board, Mr. Kever served as a financial consultant to private industry and was Vice President and Corporate Controller for the Santa Fe Pacific Corporation. His reappointment was for a term expiring in August 2003.

Mr. Speakman was first appointed to the Board on the recommendation of the Railway Labor Executives' Association in 1992. He was reappointed to another term of office in 1995. Before joining the Board, Mr. Speakman served as President of the Brotherhood of Railroad Signalmen. His reappointment was for a term expiring in August 2004.

SERVICE AND ADMINISTRATIVE IMPROVEMENTS

The Railroad Retirement Board implemented various initiatives during 1999 and 2000 to improve agency operations and provide the best possible service to its customers.

Customer Service.—For fiscal year 2000, the Board's performance versus its customer service standards remained at the same high level when compared to fiscal year 1999 performance.

Performance improved from fiscal year 1999 levels for retirement applications, initial survivor applications, survivor conversions, sickness insurance applications, unemployment and sickness insurance claims, disability decisions and disability payments.

The most marked improvement came in the rendering of disability decisions. For disability applications processed in fiscal year 2000, 63.6 percent of applicants received a decision within 105 days of their filing dates as compared to 50.6 percent in fiscal year 1999; and the average processing time for decisions improved to 94.7 days, as compared to 116 days the previous year. In fiscal year 1998, only 28.1 percent of applicants received a decision within 105 days and the average processing time was 143.9 days.

Only in the handling of lump-sum death benefits, unemployment applications and correspondence were there very slight declines in performance from fiscal year 1999, (0.1 percent, 0.2 percent and 0.1 percent, respectively). Even with these minimal declines in performance, the Board still exceeded its annual performance plan tar-
gets for the handling of lump-sum death benefits and unemployment applications.

New Medicare Carrier Selected.—In April 2000, the Board selected Palmetto Government Benefits Administrators LLC, a subsidiary of BlueCross BlueShield of South Carolina, to process the Medicare Part B medical insurance claims for physicians' services to about 650,000 railroad retirement annuitants. Palmetto GBA took over the existing Medicare claims operations facility of the Board's previous carrier, Uniprise, which had informed the Health Care Financing Administration and the Board that it was withdrawing from the Medicare program as a claims processing contractor.

Railroad retirement beneficiaries are covered by Medicare on the same basis as social security beneficiaries, and the Board, which enrolls, annuitants for Part B medical coverage and collects premiums, also has authority to select a Part B carrier. Carriers for Part A hospital insurance claims are selected by the Health Care Financing Administration, which runs the Medicare program.

New Internet Services.—Beginning November 2000, railroad retirement beneficiaries and railroad employees can access a number of new Internet services through the Railroad Retirement Board's Web site at www.rrb.gov. The services available include requests for:

- Statements of individual railroad service and compensation history
- Replacement Medicare cards
- Duplicate benefit information statements for income tax purposes
- Annuity rate verification letters

Individuals accessing the Board's Web site for these services are asked to complete and submit an on-line form. The agency is utilizing the most secure encryption technology available to ensure all information it receives through the Internet remains confidential and safe from unauthorized access. While these same services are available through the Board's toll-free automated Help Line at 1-800-808-0772, or through any of the agency's 53 field offices nationwide, this marks the first time such transactions have been available through the Internet. AccessRRB, a new section on the Board's Web site, outlines plans for additional services and provides a description of the security features that will be employed. Also included is an Internet Customer Survey to allow visitors to provide feedback on the types of services they would like to see the Board offer over the Internet.

Year 2000 Project.—The Railroad Retirement Board began the year 2000 with all its computer systems operating smoothly and benefit payments being issued without delay. The Board spent an estimated $14 million over a 5-year period to make sure that all its computer programs and systems would handle the rollover to the year 2000 without interruption. This successful project was the largest system development initiative ever undertaken by the agency in terms of scope, impact and visibility.

Data Center.—The Board continued its data center improvement program with new tape storage and handling equipment replacing a variety of aging tape drives that required manual handling and
continual oversight. The new system, which uses a "virtual tape server," has allowed for more efficient data storage, lower operating costs and a permanent reduction in staffing requirements.

Frame Relay Communications.—During fiscal year 1999, the Board completed implementation of high speed communications via frame relay technology. All field and regional offices as well as the agency's Office of Legislative Affairs now have local area networks connected to the virtual local area network at Chicago headquarters. Frame mainframe databases and systems through the network, and access the Internet and in-house Intranet. Agency employees can now provide faster, more complete service to their customers with significantly less telecommunication costs.

Document Imaging.—During fiscal year 1999, the Board completed the first phase of a document imaging initiative to reduce use of paper documents in claims processing operations. This phase replaced an obsolete imaging system servicing the Board's unemployment and sickness benefits system. Initial implementation of this initiative into retirement, survivor and disability benefit operations took place in fiscal year 2000, with additional phases planned through fiscal year 2002.

Document imaging helps move the agency closer to its goal of "one and done" service for customers by eliminating the need to have a folder in hand to service beneficiaries. The agency will save money by eliminating expenses associated with storing and transporting folders between the storage facility and headquarters.

Finally, the system's workflow software package, which allows users to easily control, assign and track pending work assignments, will also help the Board establish new and better interfaces with the Social Security Administration since that agency uses the same workflow software.

OFFICE OF INSPECTOR GENERAL

During fiscal year 2000, the Railroad Retirement Board's Office of Inspector General maintained its efforts to assist management in increasing the efficiency of agency programs. Sixteen audits and reviews issued during the year contained findings concerning internal controls, benefit payment accuracy, financial reporting and program operations. The Office of Inspector General continued to monitor the agency's Investment Committee activities and the security controls for its automated information systems. It requested that the National Security Agency conduct an information systems security assessment. As a result of the review findings, the agency developed plans to address most of the identified weaknesses. The Office of Inspector General also consulted with managers concerning the Document Imaging Implementation Plan to ensure agency compliance with all applicable laws and regulations. Investigative activities resulted in 66 criminal convictions, 35 indictments/informations, 45 civil judgments and approximately $4 million in investigative financial accomplishments.

PUBLIC INFORMATION ACTIVITIES

The Board maintains direct contact with railroad retirement beneficiaries through its field offices located across the country. Field personnel explain benefit rights and responsibilities on an in-
dividual basis, assist railroad employees in applying for benefits and answer any questions related to the benefit programs. The Board also relies on railroad labor groups and employers for assistance in keeping railroad personnel informed about its benefit programs.

At informational conferences sponsored by the Labor Member’s Office of the Board for railroad labor union officials, Board representatives describe and discuss the benefits available under the railroad retirement-survivor, unemployment-sickness and Medicare programs, and the attendees are provided with comprehensive informational materials. Approximately 2000 railroad labor union officials attended 39 informational conferences held in cities throughout the United States during 2000. In addition, railroad labor unions frequently request that a Board representative speak before their meetings, seminars and conventions.

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. During 2000, the Management Member’s Office of the Board sponsored its fourth national employer training seminar as well as 10 seminars for railroad officials. It also conducted pre-retirement counseling seminars attended by railroad employees and their spouses, and benefit update presentations.

The Board’s headquarters is located at 844 North Rush Street, Chicago, Illinois 60611-2092, phone (312) 751-4500; the agency’s Web site is www.rrb.gov. In addition, the Board maintains an Office of Legislative Affairs in Washington, DC as a liaison for dealing with Members of Congress on matters involving the Railroad Retirement and Unemployment Insurance Acts and legislative issues that affect the Board. The Office of Legislative Affairs is located at 1310 G Street, NW, Suite 500, Washington, DC 20005-3004, phone (202) 272-7742.
ITEM 28—SMALL BUSINESS ADMINISTRATION

While SBA continues 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.

The SBA is the sponsoring Federal agency for the Service Corps of Retired Executives (SCORE) program. SCORE is an organization of approximately 11,400 retired individuals who volunteer their time and expertise to provide management, counseling and training to small business owners and people just starting a new business. They have extensive business experience, either as entrepreneurs and business owners or former corporate executives. SCORE counseling is confidential and free of charge and is provided at more than 386 locations in the United States and its territories. E-mail counseling is also available through SCORE's web site at www.score.org.
ITEM 29—SOCIAL SECURITY ADMINISTRATION

PROGRAMS ADMINISTERED BY THE SOCIAL SECURITY ADMINISTRATION, CALENDAR YEAR 1999

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 46 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 calendar year 1999.

I. OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS AND BENEFICIARIES

At the beginning of 1999, about 96 percent of all jobs were covered under the Social Security program. The major groups of work-
ers 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 governments have not elected Social Security coverage.

At the end of December 1999, 44.6 million people were receiving monthly Social Security cash benefits. Of these beneficiaries, 27.8 million were retired workers, 3.3 million were dependents of retired workers, 6.5 million were disabled workers and their dependents, 7.0 million were survivors of deceased workers.

The monthly amount of benefits being paid at the end of December 1999 was $32.6 billion. Of this amount, $23.7 billion was payable to retired workers and their dependents, $4.0 billion was payable to disabled workers and their dependents, and $4.9 billion was payable to survivors.

Retired workers were receiving an average benefit at the end of December 1999 of $804, and disabled workers received an average benefit of $754.

During the 12 months ending December 1999, $386 billion in Social Security cash benefits were paid. Of that total, retired workers and their dependents received $258.9 billion, disabled workers and their dependents received $51.3 billion, and survivors received $75.3 billion.

Monthly Social Security benefits were increased by 1.3 percent for December 1998 (payable beginning January 1999) to reflect a corresponding increase in the Consumer Price Index (CPI).

II. SUPPLEMENTAL SECURITY INCOME BENEFITS AND BENEFICIARIES

In January 1999, SSI payment levels (like Social Security benefit amounts) were automatically adjusted to reflect a 1.3 percent increase in the CPI. From January through December 1999, the maximum monthly Federal SSI payment level for an individual was $500. The maximum monthly benefit for a married couple, both of whom were eligible for SSI, was $751.

As of December 1999, 6.6 million aged, blind, or disabled people received Federal SSI or federally administered State supplementary payments. Of the approximately 6.6 million recipients on the rolls during December 1999, about 2.0 million were aged 65 or older. Of the recipients aged 65 or older, about 711,000 were eligible to receive benefits based on blindness or disability. About 4.5 million recipients were blind or disabled and under age 65. During December 1999, Federal SSI benefits and federally administered State supplementary payments totaling about $2.6 billion were paid.

For calendar year 1999, $30.1 billion in benefits (consisting of $26.8 billion in Federal funds and $3.3 billion in federally administered State supplementary payments) were paid.

III. SPECIAL BENEFITS TO CERTAIN WORLD WAR II VETERANS AND BENEFICIARIES

Under Public Law 106-169, special benefits may be paid to certain World War II veterans. The law applies to veterans who served in the active military, naval, or air services of the United States. It also includes Filipino veterans of World War II who
served in the organized military forces of the Philippines while those forces were in the service of the U.S. Armed Forces.

Qualified veterans will receive a monthly special veterans benefit equal to 75 percent of the current SSI Federal benefit rate less the amount of any recurring pension benefit income for the month. There is no provision for payments to dependents or survivors.

The program began in May 2000; therefore, annual figures for numbers of individuals made eligible and benefits paid are not yet available. However, as of December 1999, 1,400 individuals had been found eligible under this program.

IV. 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.)

In September 1997, SSA negotiated an agreement with DOL under which DOL handles most of SSA's Part B black lung work on a reimbursable basis. Under the agreement, SSA is continuing to take Part B initial applications for black lung benefits and is processing any hearings before administrative law judges. DOL performs the following activities for SSA on a reimbursable basis: 1) processes Part B black lung claims applications and reconsideration's; 2) maintains claims files; 3) processes post-entitlement actions; 4) processes benefit payment adjustments required for each active, suspended, or terminated Part B claim; and 5) prepares and delivers the monthly roll of eligible Part B beneficiaries by magnetic media to the appropriate disbursing center of the Department of Treasury.

As of the end of March 1999, about 106,000 individuals (85,000 aged 65 or older) were receiving $46 million in monthly Part B black lung benefits. These benefits are financed from general revenues. Of these individuals, 15,000 miners were receiving $10 million, 72,000 widows were receiving $34 million, and 19,000 dependents and survivors other than widows were receiving $2 million. During fiscal year (FY) 1999 SSA paid out black lung payments in the amount of $550 million.

Consistent with the general pay increase for Federal employees, excluding locality pay adjustments, black lung benefits payments increased by 3.8 percent effective January 2000. The average monthly payment to a coal miner disabled by black lung disease increased from $469.50 to $487.40. The average monthly benefit for a miner or widow with one dependent increased from $704.30 to $731.00 and with two dependents from $821.60 to $852.80. The maximum monthly benefit payable when there are three or more dependents increased from $939.00 to $974.70.

The conference committee report on FY1998 appropriations specified that the SSA and DOL Inspectors General prepare a joint report assessing the agreement between the two agencies on the handling of Part B black lung claims. The Senate Appropriations Committee Report on FY2000 appropriations notes that DOL and SSA
have agreed to implement a recommendation from the report that the two agencies study the feasibility of transferring the entire Part B program from SSA to DOL. The agencies are directed to report the results of that study to the Committee, when completed, and to incorporate those results in their subsequent appropriation requests.

V. COMMUNICATION AND SERVICES

SSA's public information activities are aimed at more than 44 million Social Security beneficiaries, more than six million SSI recipients, and about 154 million workers currently paying into the system. SSA seeks to ensure that current and future beneficiaries are aware of programs, services, and their rights and responsibilities.

In October 1999, SSA began sending a Social Security Statement to all workers aged 25 and older. Between October 1999 and September 2000, SSA mailed about 133 million Statements—at the rate of more than 500,000 per day. The Statement provides the worker with an estimate of the retirement, disability, and survivors benefit they and their family may be eligible for. It also lists the worker's earnings recorded in Social Security records.

To help publicize the Statement, SSA released a public service campaign in October 1999. It included television, radio and print media and garnered more than $9 million in advertising space. A new public service campaign, released in November 2000, talks about the importance of the Statement, as well as inform workers that they should not count on Social Security as their sole source of retirement income.

The agency also produces a wide range of publications on all Social Security programs. More than 100 consumer booklets and fact sheets keep the public informed about programs and policies affecting them. Many publications also are available in Spanish, and SSA is developing more informational materials in other languages. Many of the publications are available on the Internet at SSA's web site, http://www.ssa.gov.

VI. SUMMARY OF LEGISLATION THAT AFFECTS SSA, 1999

P.L. 106–69 (H.R. 2084), Department of Transportation and Related Agencies Appropriations Act 2000, signed on October 9, 1999

- Provides funding for necessary expenses for the National Transportation Safety Board. It repeals Section 355, Section 656(b) of division C of the Omnibus Consolidated Appropriations Act of 1997, which required Social Security numbers on drivers' licenses.

P.L. 106–169 (H.R. 3443), The Foster Care Independence Act of 1999, signed on December 14, 1999

- Establishes the new title VIII under the Social Security Act and entitles certain SSI-eligible World War II veterans to a benefit payable under this new title. Includes provisions affecting the treatment of SSI resources in countable resources for assets held in trust, imposes penalties for the disposal of resources at less than fair market value, and imposes new non-
payment penalties for false or misleading statements used to establish benefit eligibility. SSI overpayment provisions include increased liability of representative payees for overpayments to deceased recipients, recovery of overpayments of SSI benefits from lump sum SSI benefit payments, and extends to the SSI program all of the debt collection authorities currently available for the collection of overpayments under the OASDI program. Includes a requirement that SSA provide State prisoner information to Federal and federally assisted benefit programs. Includes several systems-based approaches to controlling fraud, e.g., computer matches among Federal and State programs and a provision granting SSA greater access to the financial records of applicants and beneficiaries. Requires SSA to complete a study of denial of SSI benefits for family farmers and to submit this report to Congress.

P.L. 106–170 (H.R. 1180), The Ticket to Work and Work Incentives Improvement Act of 1999, signed on December 17, 1999

- Directs the SSA Commissioner to establish a Ticket to Work and Self-Sufficiency Program under which a disabled beneficiary may use a ticket issued by the Commissioner to obtain at SSA expense, employment and vocational rehabilitation services or other support services, pursuant to an appropriate individual work plan, with services provided by Employment Network, paid under either an outcome or an outcome-milestone payment system, or by established State VR agencies. Establishes a Work Incentive Advisory Panel and a Work Incentives Outreach program and authorizes the Commissioner to make payments to protection and advocacy systems established in each State. Eliminates work activity as a basis for conducting continuing disability reviews for individuals entitled to disability benefits for at least 2 years, establishes an expedited reinstatement process for former beneficiaries whose benefits were terminated due to work, and directs the Commissioner to conduct demonstration projects (such as $1-for-$2 benefit offset program) to test the effects of possible national program modifications on beneficiary behavior. Extends the incentive payment provisions in effect for SSI prisoners to OASDI, and authorizeds the Commissioner of Social Security to provide, on a reimbursable basis, this reported information to any agency administering a Federal or federally assisted cash, food, or medical assistance program for the purpose of determining program eligibility.
ITEM 30—DEPARTMENT OF VETERANS AFFAIRS

I. INTRODUCTION

The Department of Veterans Affairs has the potential responsibility for a beneficiary population of more than 25 million veterans. The median age of veterans is approximately 58 years old compared to a median age of approximately 34 years old for the general U.S. population. Over thirty-six percent (or more than 9 million) of the veteran population is age 65 and older. By the year 2005, over four-and-a-half 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 healthcare services. The number of physician visits, short-term hospital stays, and number of days in the hospital, as well as need for long-term care services, all increase as the patient moves from the fifth to seventh decade of life.

VA has developed a wide range of services to provide care in a variety of institutional, non-institutional, and community settings to ensure that the physical, psychiatric and socioeconomic needs of the patient are met. Special projects, a variety of innovative, medically-proven programs and individual VA facility initiatives have been developed and tested that can be used for veteran patients and adapted for use by the general population.

VA operates the largest healthcare system in the Nation, encompassing 172 hospitals, 132 nursing home care units, 40 domiciliaries, and over 600 outpatient clinics. VA also contracts for care in non-VA hospitals and in community nursing homes, provides fee-for-service visits by non-VA physicians and dentists for outpatient treatment, and supports care in 93 State Veterans Homes in 43 States. As part of a broader VA and non-VA network, affiliation agreements exist between virtually all VA healthcare facilities and nearly 1,000 medical, dental, and associated health schools. This affiliation program with academic health centers results in approximately 91,000 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 non-institutional extended care programs. The dual purpose is to facilitate independent living and to keep the patient in a community setting by making available the appropriate supportive medical services. These programs include Home-Based Primary Care, Community Residential Care, Adult Day Health Care, Psychiatric Day Treatment and Mental Hygiene Clinics, and Homemaker/Home Health Aide Services.

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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. VA continues efforts to improve the outcomes of care for elderly patients with complex problems by supporting Geriatric Research, Education and Clinical Centers and specialized clinical services such as Geriatric Evaluation and Management Programs.

II. VETERANS HEALTH ADMINISTRATION

A. OFFICE OF PATIENT CARE SERVICES

The Office of Patient Care Services comprises thirteen strategic healthcare groups. Each of these functional groups has contributed significantly to VA’s efforts on behalf of older veterans.

Primary and Ambulatory Care Strategic Healthcare Group (SHG)

The Office of Primary and Ambulatory Care and the Office of Geriatrics and Extended Care continue to maximize collaboration in transforming the veterans healthcare system from a bed-based, hospital inpatient system to one rooted in ambulatory care.

Geriatric Primary Care Education Program

The Employee Education System, Northport Center, sponsored a national conference for the purpose of providing an integrated Geriatric Primary Care Education Program that would allow each VHA Network to develop and implement a Geriatric Primary Care model. The emphasis was on continuity of care, care management, and assessment/triage, based on an interdisciplinary approach. The conference also provided a forum for discussion of a variety of successful VA and non-VA Geriatric Primary Care models of care, and attempted to link the models to FY99 Performance Measures.

Conference participants included a multidisciplinary team composed of a geriatrician and various primary care providers (physician, physician assistant, nurse practitioner, clinical nurse specialist and social worker) from each Network. In addition, the Northport Center purchased Geriatric Primary Care pocket guides and pocket pals for all conference participants and for each VA facility.

The Employee Education System, Northport Center, will continue to coordinate the activities of VHA’s National Primary and Ambulatory Care Education. The Northport Center, in collaboration with Primary and Ambulatory Care, Geriatric Care and Mental Health is planning to present a Strategic Integration Conference.

Dentistry

Oral/dental care for the geriatric patient involves the restoration of the dentition and the elimination of pain and suffering attributable to oral disease. Microorganisms originating in the mouth
have been identified as the causative agents for life-threatening infections of the heart, brain, lung, kidney, spine, and joints. There is growing evidence, much of it deriving from longitudinal studies at several VA facilities, that chronic periodontal (gum) disease plays a role in causing heart attacks and stroke.

Oral cancer is a disabling and disfiguring disease that primarily affects middle-aged and older adults. Ninety-five percent of cases occur in those over age 40. Tobacco, alcohol, and advanced age are important risk factors in the development of this disease. Through a long-standing program of oral screening examinations, VA dentists have been able to expeditiously detect incipient oral cancers in veterans. Such interventions minimize mortality rates and the need for ablative surgery, which often results in severe disfigurement and functional difficulties in eating, speaking, and swallowing.

It is important for older veterans to be able to masticate a variety of foods so that daily maintenance of caloric and nutritive intake, as well as convalescence after surgery, chemotherapy, or other significant radical interventions, is expedited. Elimination of the causes of oral pain and replacement of missing oral structures both work to enhance the amount and number of choices of foods that can be eaten. Interpersonal skills, which are highly dependent upon physical appearance, and effective communication are enhanced by improving the patient's appearance and by properly aligning and restoring anterior teeth to maintain clarity of speech.

Destruction of tissues due to dental decay and the periodontal diseases is chronic and, in the elderly, usually asymptomatic. For this reason, public and private healthcare payers may perceive oral healthcare directed at dental and periodontal diseases as a low priority or even a luxury. In older patients, dental and periodontal diseases are often aggravated by coexistent medical problems; the oral disease in turn contributes to systemic illness, and in this way drives up healthcare costs. The relatively minor expense associated with preventive dentistry thus represents a net saving in overall health costs. Preventive modalities can 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.

Most VA facilities have a Geriatric Evaluation and Management (GEM) Program. The goals for all disciplines involved in geriatrics—to maximize function and to foster independence—are reflected in dentistry's goals for elderly veterans.

Patients are rehabilitated more rapidly with properly staged and coordinated care. To that end, Dental Services contribute to the interdisciplinary team effort by conducting admission oral assessments, collaborating on treatment planning, providing specialty consultations and needed care, and preparing summaries of oral care protocols to be maintained after discharge. The VA Program Guide, "Oral Health Guidelines for Long-Term Care Patients," developed by the Offices of Patient Care Services, the Office of Dentistry, and the Office of Geriatrics and Extended Care, continues to serve as the primary handbook for management of the geriatric oral health efforts. It describes the goals, implementation and mon-
 VA dentistry is an undisputed leader in geriatric oral healthcare training. GEMs and nursing homes serve as training sites for all of the existing advanced formal training programs in geriatric dentistry in the United States. VA-trained geriatric dentists have appointments on a majority of the dental school faculties in the United States. More than one fourth of all hospital-based general dentistry post-graduate education takes place in VA medical centers, where the residents devote much of their educational efforts to the clinical management of older veterans.

The impact of VA programs in geriatric dentistry is not limited to VA's healthcare system, but extends to a broader level. VA dentistry is represented on National Institute of Dental Research reviews, a U.S. Surgeon General's workshop on oral health promotion and disease prevention, the development of the first Surgeon General's Report on Oral Health, and on review panels for programs in medical and dental geriatric education funded by the Department of Health and Human Services, Health Resources and Services Administration.

VA dentists are and have been long involved at the highest levels of leadership in the professional organizations (American Society for Geriatric Dentistry, American Association of Hospital Dentists, Federation of Special Care Organizations in Dentistry, American College of Prosthodontists, American Association for Dental Research, Gerontological Society of America) most heavily concerned with oral care issues for older adults. The American Association of Dental Schools (AADS) has an ongoing Geriatric Education Project that has developed guidelines for teaching concepts in gerontology and geriatrics to dental and dental hygiene students, and VA dentists have been noteworthy contributors to these efforts to define geriatric educational objectives and identify source materials for dental faculty members.

VA dentists have been leaders and active participants in recent projects involving health services and basic research relevant to the older adult. One investigator has developed measures to assess the relationship between oral health and overall quality of life in older patients. Longitudinal studies of older veterans in Massachusetts and Michigan have yielded a wealth of knowledge on the relationships between age, systemic disease, oral diseases, and diet. VA researchers have surveyed VA dental services to determine the effectiveness of smoking cessation interventions; others have investigated the education of both dental and non-dental health providers with respect to oral cancer risk factors and screening.

Multicenter longitudinal clinical studies through VA have examined the Efficacy of metal, ceramic, and ceramo-metal crowns. Another VA cooperative study has amassed the largest database in the world on the emerging alternative to toothlessness, osseointegrated implants, and the factors that predict their successful implementation. VA clinical studies on preventive strategies and materials in oral cancer patients have set the standards for management of such patients internationally. Finally, research, in collaboration with NIH, is ongoing to discover biological markers for the detection of oral cancer.
In summary, VA dentistry and the Office of Dentistry continue to support efforts that will benefit older veterans in the three general areas that define the mission of the Department. First, the provision to elderly veterans of quality oral healthcare, of both preventive and restorative character, is recognized by and practiced within VA as an important and cost-effective component of total health maintenance. Second, education in geriatric oral health is critical on many levels, and will continue to be a VA focus directed at veterans; VA dental staff and residents; the dental profession and dental education communities; and non-dental providers such as nurses, physicians, and family members. Third, VA dental research has enhanced and will continue to broaden our understanding of oral disease, its relationship to general health, and its treatment in older adults.

Acute Care Strategic Health Care Group (SHG)

The Acute Care Strategic Health Care Group (ACSHG) serves the elderly veteran in a variety of ways. In FY1999, 54 percent of the patients on inpatient medical services and 47 percent on the inpatient surgical services were over 65. This age group accounted for 58 percent of Intensive Care Unit (ICU) days and 50 percent of Outpatient Care (OPC) surgery. The ACSHG continues to serve as the primary source of physicians trained in medical specialties for the care of all veterans, including the elderly. Elderly patients tend to have more complex medical problems and require more frequent hospitalizations than other age groups. It is necessary that acute care services continue to be available and adequately staffed to meet these demands. This is particularly true in medical specialty areas such as cardiology, pulmonology, endocrinology, rheumatology, oncology and the surgical specialty areas of urology, cardiothoracic, vascular, and orthopedic surgery. Most medical problems afflicting the geriatric patient can be handled by Primary Care physicians on a general medicine ward. However, there is also a need for areas such as Geriatric Medicine within the acute hospital setting to provide the specialized care needed by the complex geriatric patient. These Geriatric Medicine Sections not only emphasize clinical care, but also coordinate research and education efforts related to geriatrics. The implementation of Primary Care within Acute and Ambulatory Care has facilitated a smoother transition for the elderly patient from outpatient to inpatient care as the need arises.

Geriatrics and Extended Care Strategic Healthcare Group (SHG)

Geriatrics and Extended Care has developed an extensive continuum of clinical services including specialized and primary geriatric care, residential rehabilitation, community-based long-term care, and nursing home care. The shared purpose of all geriatrics and extended care programs is to prevent or lessen the burden of disability on older, frail, chronically ill patients and their families/caregivers, and to maximize each patient’s functional independence. The following is a description of VA’s geriatrics and extended care programs and activities within each.
VA Nursing Home Care

VA nursing home care units (NHCUs), which are based at VA facilities, provide skilled nursing care and related medical services. Patients in NHCUs may require shorter or longer periods of care and rehabilitation services to attain and/or maintain optimal functioning. An interdisciplinary approach to care is utilized in order to meet the multiple physical, social, psychological and spiritual needs of patients. In Fiscal Year 1999, more than 46,000 veterans were treated in VA's 132 NHCUs. The average daily census of patients provided care on these units was 12,653.

Plans are underway for systemwide implementation of the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) in VA NHCUs. The RAI/MDS is a valid and reliable standardized multidisciplinary assessment database and treatment planning process. The RAI/MDS has been in use in community nursing homes since 1990 when it was mandated by Health Care Finance Administration (HCFA) as a provision of the Omnibus Reconciliation Act of 1987.

Implementation of the RAI/MDS will enhance care provided nursing home patients. The MDS gathers comprehensive functional status information on residents admitted to nursing homes. The interaction of the elements of the MDS triggers problem areas that are highlighted to facilitate the development of individualized treatment plans. The interaction of elements of the MDS also determines Resource Utilization Groups (RUGs). RUGs are used for identifying case mix and determining resource allocation to meet the needs of patients served. The RUGs can additionally serve as indicators of outcomes of care delivered. Finally, and perhaps, most importantly, the MDS will generate information regarding the quality of care patients receive. VA is providing interdisciplinary NHCU staff educational programs in the use of the RAI/MDS and automation required to support this initiative.

Community Nursing Home Care

This is a community-based contract program for veterans who require skilled nursing care when making a transition from a hospital setting to the community. Veterans who have been hospitalized in a VA facility for treatment, primarily for a service-connected condition, may be placed at VA expense in community facilities for as long as they need nursing home care. Other veterans may be eligible for community placement at VA expense for a period not to exceed six months. Selection of nursing homes for VA contracts requires the prior assessment of participating facilities to ensure quality services are offered. Follow-up visits are made to veterans by staff from VA medical centers to monitor patient programs and quality of care. In Fiscal Year 1999, more than 28,900 veterans were treated and the average daily census of veterans in these homes was 4,537.

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-oriented programs has provided a better quality of care and life for veterans who require prolonged domiciliary care and has prepared an increasing number of veterans for return to independent or semi-independent community living.

Special attention is being given to older veterans in domiciliaries with a goal of keeping them active and productive as well as integrated into the community. The older veterans are encouraged to utilize senior centers and other resources in the community where the domiciliary is located. Patients at several domiciliaries are involved in senior center activities as part of VA's community integration program. Other specialized programs in which older veterans are involved include Foster Grandparents, Handyman Assistance to senior citizens in the community, and Adopt-A-Vet.

In fiscal year 1999, 24,161 veterans were treated in 40 VA domiciliaries resulting in an average daily census of 5,235. Of these numbers, nearly 5,000 veterans, with an average daily census of more than 1,500, were admitted to the domiciliaries for specialized care for homelessness. The average age of this latter group was 43.7 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 93 state homes in 43 states. Currently, a total of 24,154 state home beds are authorized by VA to provide hospital, nursing home, and domiciliary care. VA's relationship to state veterans homes is based upon two grant programs. The per diem grant program enables VA to assist the states in providing care to eligible veterans who require domiciliary, nursing home or hospital care. The other VA grant program provides up to 65 percent federal funding to states to assist in the cost of construction or acquisition of new domiciliary and nursing home care facilities, or the expansion, remodeling, or alteration of existing facilities.

In fiscal year 1999, state veterans homes provided care to 6,032 veterans in domiciliaries and 21,220 veterans in nursing homes. The average daily census of veteran patients was 3,680 for domiciliary care and 15,014 for nursing home care.

Hospice and Palliative Care

VA has developed programs that provide pain management, symptom control, and other medical services to terminally ill veterans, as well as bereavement counseling and respite care to their families. The hospice/palliative concept of care is incorporated into VA facility approaches to the care of the terminally ill. All VA fa-
Facilities have appointed a hospice consultation team, which is responsible for planning, developing, and implementing the hospice and palliative care program.

**Home-Based Primary 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 home-based interdisciplinary treatment team. The team prescribes the needed medical, nursing, social, rehabilitation, and dietetic regimens, and provides training to family members and the patient in supportive care.

Seventy-eight VA medical centers are providing home-based primary care (HBPC) services. In fiscal year 1999, home care was provided by VA health professionals to an average daily census of 6,828 patients, treating a total of 13,880 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 14 ADHC centers in Fiscal Year 1999 with an average daily attendance of 462 patients. VA also continued a program of contracting for ADHC services in 83 medical centers. The average daily attendance in contract programs was 809 in Fiscal Year 1999.

**Community Residential Care/Assisted Living**

The Community Residential Care/Assisted Living program provides residential care, including room, board, personal care, and general healthcare 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 or friends) to provide the needed care. All homes are inspected by a multidisciplinary team prior to incorporation of the home into the VA program and annually thereafter. Care is provided in private homes that have been selected by VA, and is at the veteran's own expense. Veterans receive monthly follow-up visits from VA health care professionals. In fiscal year 1999, an average daily census of 7,964 veterans was maintained in this program, utilizing approximately 2,100 homes.

**Homemaker/Home Health Aide (H/HHA)**

VA provided homemaker/home health aide services for veterans needing nursing home care. These services are offered in the community by public and private agencies under a system of case management provided directly by VA staff. One hundred and eighteen VAMCs purchased H/HHA services in Fiscal Year 1999 with an average daily census of 8,141.
Geriatric Evaluation and Management

The Geriatric Evaluation and Management (GEM) Program includes inpatient units, outpatient clinics, and consultation services. A GEM Unit is usually a functionally different group of beds (ranging typically in number from 10 to 25 beds) on a medical service or an intermediate care unit of the hospital where an interdisciplinary healthcare team performs comprehensive, multidimensional evaluations on a targeted group of elderly patients who will most likely benefit from these services. The GEM unit serves to improve the diagnosis, treatment, rehabilitation, and discharge planning of older patients who have functional impairments, multiple acute and chronic diseases, and/or psychosocial problems. GEM clinics provide similar comprehensive care for geriatric patients not in need of hospitalization as well as follow-up care for older patients to prevent their unnecessary institutionalization. A GEM program also provides geriatric training and research opportunities for physicians and other health care professionals in VA facilities. In 1999, there were 121 GEM Programs.

Respite Care

Respite care is a program designed to relieve the spouse or other caregiver from the burden of caring for a chronically disabled veteran at home. This is done by admitting the veteran to a VA hospital or nursing home for planned, brief periods of care. The long-range benefit of this program is that it enables the veteran to live at home with a higher quality of life than would be possible in an institutional setting. It may also provide the veteran with needed treatment during the period of care in a VA facility, thus maintaining or improving functional status and prolonging the veteran's capacity to remain at home in the community. Nearly all VA facilities have a respite care program. While they range in size, each program typically provides care to approximately five veterans on any given day.

An earlier formal evaluation of the program found a high level of satisfaction with the Respite Care Program by family caregivers. The evaluation also found a high level of enthusiasm for the program by medical center staff delivering the care.

Alzheimer's Disease and Other Dementias

VA's program for veterans with Alzheimer's disease and other dementias is decentralized throughout the medical care system, with coordination and direction provided by the Geriatrics and Extended Care Strategic Group in VA Headquarters. Veterans with these diagnoses participate in all aspects of the healthcare system.

In order to advance knowledge about the care for veterans with dementia, VA investigators conduct basic biomedical, applied clinical, health services, and rehabilitation research, much of which occurs at VA's Geriatric Research, Education and Clinical Centers (GRECCs), and which is supported through the VA Office of Research and Development as well as extramural sources. In Fiscal Year 1999, VA investigators were involved in 266 funded research projects on Alzheimer's disease and other dementias.
Continuing education for staff is provided through training classes sponsored by GRECCs and VA's continuing education field units. In addition, VHA has disseminated a variety of dementia patient care educational materials in the form of publications and videotapes to all VA medical centers, some of which are available to the general public through inter-library loan.

In Fiscal Year 1999, staff at the Minneapolis GRECC continued work on a professional caregiver version of Alzheimer's Caregiving Strategies, a multimedia computer program (CD-ROM) that VA previously produced for education and training of family caregivers for patients with dementia. This interactive program provides basic information on Alzheimer's disease; guidelines with examples for assessing the functional capacity, or stage, of dementia; and strategies for dementia care that are appropriate at each stage. The Minneapolis GRECC also produced a four-part satellite video conference series on the diagnosis and treatment of Alzheimer's disease.

Also in Fiscal Year 1999, a field-based work group completed a VA clinical guideline on Pharmacological Management of Cognitive Changes in Alzheimer's Disease.

Another major activity in Fiscal Year 1999 was VA's continued participation, through its Upstate New York Healthcare Network, in a national demonstration project on Alzheimer's disease and managed care. This project, "Chronic Care Networks for Alzheimer's Disease," is being co-sponsored by the Alzheimer's Association and the National Chronic Care Consortium. With funding from the Robert Wood Johnson Foundation and other sources, the implementation phase of the project is now underway.

As part of a project examining ways to improve home- and community-based end of life care for persons with advanced dementia, a national survey of caregivers was conducted in Fiscal Year 1999. With additional funding from the national Alzheimer's Association, this ongoing Dementia End of Life Care project is now developing instruments to measure key outcomes of this type of care. Principal investigators for this project are at the GRECC in Bedford, Massachusetts.

Geriatric Research, Education, and Clinical Centers

Geriatric Research, Education and Clinical Centers (GRECCs) are designed to enhance VA's capability to develop state-of-the-art care for the elderly through research, training and education, and evaluation of alternative models of geriatric care. First established by VA in 1975, the GRECCs continue to serve an important role in further developing the capability of the VA healthcare system to provide cost-effective and appropriate care to older veterans.

GRECCs have established many interrelationships with other programs to avoid fragmentation and duplication of efforts. Important examples include the GRECC's coordination with VA's Health Services Research and Development Field Programs and other research programs within VA and at affiliated health science centers; coordination with VA Employee Education Centers and Cooperative Health Manpower Education Programs, as well as with Geriatric Education Centers at affiliated universities; and coordination with clinical programs and quality improvement efforts at each host VA
facility and throughout the VA networks in which each GRECC is located.

In Fiscal Year 1999, GRECCs continued to make a number of contributions to the field of aging and care of the elderly. Some examples of these contributions are: further research on the Alzheimer's gene discovered by researchers at the GRECC in Seattle, Washington; the dissemination of a CD-ROM for family caregivers of Alzheimer's patients (developed at the Minneapolis GRECC); and an evaluation by the Sepulveda, California, GRECC of an interdisciplinary model of geriatric primary care for elderly patients.

- Researchers at the West Los Angeles, California, GRECC are studying how a special bicycle exercise program affects muscle strength and movement speed in patients with strokes. Results to date show improved knee muscle strength in both legs with most subjects also having greater walking speed and improved stability on one leg. Results indicate that the recumbent bicycle is a safe and inexpensive tool to improve or maintain muscle strength necessary for walking in patients who have had strokes.

- At the Madison, Wisconsin, GRECC, investigators are examining tongue strength and swallowing in the elderly. Previous research has shown that tongue strength decreases with age and appears to be associated with diminished tongue muscle mass, slower swallowing, and higher incidence of choking on liquids. A new exercise program to strengthen tongue muscle has increased strength and speed of swallowing and has eliminated choking in the elderly people who have participated to date.

- At the Durham, NC, GRECC, investigators recently completed a five-year, randomized, clinical trial that compared two exercise programs among community-dwelling elders: spinal-flexibility plus aerobic exercise versus aerobic-only exercise. Both groups improved significantly on the primary measures of impairment, movement of the spine and the body's ability to use oxygen. Participants in both groups also reported significant improvements in overall health, total number of symptoms reported, and the effect of symptoms on functional limitations.

- Ann Arbor, MI, GRECC, researchers have studied immune function and survival in mice treated daily with the male hormone, dihydroepiandosterone (DHEA). Their results demonstrate that lifelong consumption of DHEA does not extend the life span of experimental animals. Mice given DHEA also showed no improvement in their immune function when tested late in middle age. These data provide no support for the popular idea that exposure to DHEA is likely to lead to dramatic improvements in immunity or disease resistance in the aging human population.

- Bedford, MA, GRECC researchers have studied the effectiveness of antibiotic therapy in advanced dementia. In their work, they consider the burden of treatment as well as its potential for effectiveness. Bedford researchers have demonstrated that antibiotics are no more effective than palliative care in preventing death from infection in persons with ad-
advanced dementia. Results indicate that the use of antibiotics in advanced dementia has very limited benefit, while producing significant burden for patients due to stressful, invasive diagnostic procedures as well as side effects from the antibiotic therapy. Therefore, these researchers recommend a "high-touch," palliative treatment strategy when planning end of life care for these patients.

- At the Miami, FL, GRECC, investigators evaluated the effectiveness of research-based interventions in preventing falls in a hospital setting. Structured education on fall prevention was initiated for nursing staff in all units. The fall rate two years after the intervention was significantly lower. The patients who fell were identified to be at risk and had a history of falls. The most common site for falls was at bedside. Most falls occurred during walking, climbing over the siderails, or accidentally rolling out of bed. The investigators concluded that a research-based fall prevention program is effective in reducing falls.

- Bedford, MA, GRECC researchers have developed "Bright Eyes," an innovative, group treatment program providing sensory stimulation experiences to patients with advanced Alzheimer's disease. The goal is to combat the effects of sensory deprivation while promoting engagement and socialization. The sensory cues are organized around a specific theme and are selected to represent familiar experiences for the veterans, such as going to a baseball game. Because persons with Alzheimer's disease are often unable to initiate activity, the "Bright Eyes" program provides an important opportunity for patients to participate in meaningful activity.

During 1998, VHA solicited proposals from VA facilities and networks for establishing new GRECCs. In FY1999, 2 new GRECCs were designated at the Cleveland VA and Pittsburgh VA facilities, bringing the total number of GRECCs to 18. A solicitation to expand the program further was also initiated in 1999.

Mental Health Strategic Healthcare Group (SHG)

Although the reported prevalence of mental illness among the elderly varies, conservative estimates for those age 65 years or older include a minimum of 5 percent with Alzheimer's disease or other dementias and an additional 15 to 30 percent with other disabling psychiatric illnesses. If we use the 30 percent estimate, 2.3 to 2.7 million veterans can be expected to need psychogeriatric care at any given time during the first two decades of the next century. Mental Health Services throughout VA have continued to provide care to older veterans through both clinic and other community-based programs and a growing continuum of residential care, acute, subacute, and long-term hospital programs in each of the 22 Veterans Integrated Service Networks (VISNs). Close collaboration with Geriatric and Extended Care Services at the medical centers is strongly recommended. Some of the specific activities in Fiscal Year 1999 are noted below:
New Mental Health Program Guidelines

The VHA Program Guide (1103.22) called Integrated Psychogeriatric Patient Care published March 26, 1996, was updated and condensed as a chapter in a new publication, Mental Health Program Guidelines for the New Veterans Health Administration (1103.3). Both program guides are recommended as a resource for clinicians serving elderly veterans and non-veterans alike.

UPBEAT (Unified Psychogeriatric Biopsychosocial Evaluation and Treatment)

UPBEAT, a controlled demonstration project at 9 VA facilities costing $2 million annually, is exploring clinical and economic outcomes as a result of screening elderly patients in acute VA medical and surgical hospital settings for depression, anxiety, and substance abuse. Following an interdisciplinary psychogeriatric team evaluation and treatment plan, care coordinators follow patients with positive symptoms for a two-year period. With only a year until the project is completed, preliminary results of 887 patients show statistically significant (p=0.029) savings of 3.66 days per patient for UPBEAT care in the first year of enrollment (as compared to 935 “usual care” patients)—an estimated savings of over $3.4 million. Eight VA medical centers outside of the demonstration project are also interested in adopting the UPBEAT intervention.

Aging, Mental Health, Substance Abuse, and Primary Care Program

The Veterans Health Administration, through its offices of Mental Health, Geriatrics and Extended Care, and Primary and Ambulatory Care, has established an interagency Memorandum of Agreement with the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) and Bureau of Primary Health Care (BPHC) of Health Resources and Services Administration (HRSA). This agreement is intended to support a cross-cutting initiative to determine if there are statistically significant differences over a full range of access, clinical functional, and cost variables between primary care clinics that are referring elderly patients to specialty mental health or substance abuse (MH/SA) services outside the primary care setting and those that are providing such services in an integrated fashion within the primary care setting. It will also address improving the knowledge base of primary health care providers to recognize MH/SA problems in older adults. During this year, six VA and five non-VA sites have agreed to participate by developing the necessary clinical resources and rigorous research protocols.

Physical Medicine and Rehabilitation Strategic Healthcare Group (SHG)

Physical Medicine and Rehabilitation services strive to provide all referred older veterans with comprehensive assessment, treatment and follow-up care for psychosocial and/or physical disability affecting functional independence and quality of life. The older veteran’s abilities in the areas of self-care, mobility, endurance, cog-
Therapists utilize physical agents, therapeutic modalities, exercise, the prescription of adaptive equipment and provide treatment to enhance function in activities of daily living, vocational/avocational activities, to facilitate the veteran's ability to remain in the most independent life setting. Rehabilitation personnel provide education to the veteran and family members about adjustment to a disability or physical and social limitations and instruct them in techniques to maintain independence despite disability.

There are approximately 65 comprehensive inpatient medical rehabilitation programs (both acute and subacute) within the Veterans Health Administration (VHA). There has been some shifting of acute rehabilitation beds to less resource intensive subacute beds. The subacute rehabilitation setting affords VHA the ability to provide less intense rehabilitation services for the older veteran, aimed at promoting an individual's integration back into the community. On both acute and subacute rehabilitation units, physicians, usually board certified physiatrists, lead interdisciplinary teams of professionals to focus on outcomes of functional restoration, clinical stabilization, or avoidance of acute hospitalization and medical complications.

A uniform assessment tool, the Functional Independence Measure (FIM), is being 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 data base called the Uniform Data System for Medical Rehabilitation (UDS/mr) monitors outcomes of care and increases the accuracy of developing predictors and ideal methods of treatment for the older veteran with various diagnoses. Through a national contract with UDS/mr, facilities with rehabilitation programs provide data and receive outcome reports as part of a national and international UDS/mr data bank. Use of the FIM as a functional assessment tool is available to all VA medical centers through connectivity to the Functional Status and Outcomes Database (FSOD) for Rehabilitation housed at the VA Austin Automation Center, Austin, TX. The FSOD allows tracking of rehabilitation outcomes across the full continuum of care based upon a severity of illness index, the Function Related Groups.

Rehabilitation therapists are leading and participating in innovative treatment, clinical education, staff development and research. Rehabilitation professionals work within Home-based Primary Care Programs, 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 (GRECCs), and Hospice Care Programs. Applying principles of health education and fitness, rehabilitation staff develop and provide programs aimed at promoting health and wellness for the aging veteran.

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, VA has put emphasis on the training of
the mature driver. Classroom education, updates in laws and de-
offensive driving techniques are supported with behind-the-wheel
evaluation by trained specialists.

RECREATION THERAPY

Provided that adequate preventive and support services are
made available, older individuals can enjoy full and satisfying lives.
Studies have shown that isolation leads to depression, and depres-
sion is the most common mental disorder affecting 20 percent of
persons aged 65 and older. Also, the highest suicide rate in Amer-
ica is among persons aged 50 and over.
The Department of Veterans Affairs (VA) recreation therapists
are an integral part of interdisciplinary teams in the treatment of
illnesses in the elderly. Whether the patient is an inpatient, out-
patient, residential or independent living, therapeutic recreation
services focus on restoring or maintaining optimum independent
living and quality of life. Recreation therapists:
• promote physical health through therapeutic exercises and
gross motor activities;
• enhance mental functioning through the use of reality ori-
entation, sensory stimulation, remotivation therapy and chal-
lenging therapeutic activities;
• use behavioral approaches to help older persons replace
maladaptive behaviors with effective functional skills; and
• provide leisure skill training programs within the patients’
range of abilities and facilitate community integration through
the use of existing resources.
The Department of Veterans Affairs is actively involved in a
partnership with the Very Special Arts Organization. In 1974, Very
Special Arts was founded by Jean Kennedy Smith as an affiliate
of The John F. Kennedy Center for the Performing Arts. The VA/
VSA Art Program was developed to provide VA medical center pa-
tients with quality arts experiences through workshops, art
residencies and community-based activities. The program encour-
ges patients’ artistic talents, and strengthens independent living
and communications skills through creative writing, dance, drama,
music, and the visual arts. A revised artist-in-residence brochure
that highlights the program was recently distributed to all Veter-
ans Health Administration medical centers.
Since 1983, VA’s Recreation Therapy Service has held the Na-
tional Veterans Golden Age Games (NVGAGs) for the benefit of
veterans age 55 and older. Sports and recreation are vital compo-
nents of rehabilitative medicine within VA medical facilities, where
recreation therapy plays an important role in the lives of older pa-
tients.
The NVGAGs serve as a showcase for the preventive and thera-
peutic medical value that sports and recreation provide in the lives
of all older Americans. Participants compete in a variety of events
that include but are not limited to, swimming, tennis, shuffleboard,
horseshoes, croquet, bowling, and bicycle races. The NVGAGs are
co-sponsored by VA and the Veterans of Foreign Wars of the
United States. Numerous corporate sponsors provide financial sup-
port, and hundreds of local volunteers provide on-site assistance
each year.
The 1999 NVGAGs were hosted by the VA Healthcare Network Upstate New York. The 2000 program will be hosted by the VA Eastern Kansas Healthcare System during the week of September 4-9, in Topeka, KS.

**Nursing Strategic Healthcare Group (SHG)**

Nursing Service, in support of VHA's reorganization and "Journey of Change," continues to rank care of the elderly veteran as a major priority. Nurses at every level of the organization are committed to leadership in the clinical, administrative, research, and educational components of gerontological nursing. Powerful societal forces in both the federal government and the private sector require even greater collaborative teamwork as nursing strives to integrate advances in technology and information management, and participates in the transition from inpatient to outpatient healthcare within the managed care model.

Nurses continue to participate in preventive care and health promotion initiative, to preserve both the veterans' and their significant others' independence. Team approaches to improving the health status of aging veterans have fostered optimum levels of self-care, improved productivity, and enhanced quality of life. Health screening, education, primary care and referral of elderly veterans are critical functions necessary to evaluate healthcare needs and properly place the veteran in the most appropriate level of care. This may range from the environment of personal care in the home as the least restrictive setting to nursing home care as the most restrictive environment. Nurses have facilitated interdisciplinary leadership to create and strengthen programs to help keep patients in their homes as long as possible. These include Adult Day Care Programs, Home-Based Primary Care, and Case Management to coordinate multiple health services. Nurses in wellness clinics, mobile units and other ambulatory care settings provide supervision, screening and health educational programs to assist veterans and their significant others in fostering and maintaining healthy lifestyles.

Effective utilization of advanced practice nurses (APN) in the provision of health care services is a critical component of VHA's mission to provide primary care in a seamless system across a continuum of care. This continuum of care for aging veterans includes primary care, acute care, long-term care, rehabilitative care and mental healthcare. Nurses are a vital part of interdisciplinary teams that coordinate and provide care in settings such as Geriatric Evaluation and Management Programs (GEMs), ambulatory care, acute care, long-term care, mobile care units, and community agencies. Gerontological advanced practice nurses provide primary care and continuity of care as clinical care managers, coordinators of care, and case managers. Through sustained patient partnerships, APNs provide healthcare for aging patients in diverse settings, minimizing illness and disabilities and focusing on health promotion, disease prevention and health maintenance.

Primary care may be provided to aging veterans by a physician or a nurse practitioner primary care provider and followed by a care team including psychiatry, psychology, social work, rehabilitative medicine and others. Primary care services are based on the
long-term care needs of aging patients including those with multiple and chronic medical problems, functional disabilities, cognitive impairments and weakened social support systems. Services are provided across the continuum from health promotion and disease prevention to screening for community services including hospice care evaluation.

Nurses facilitate the restoration of functional abilities of veterans with chronic illnesses and disabilities. Programs for the physically disabled and cognitively impaired are administered by nurses and advanced practice nurses in settings representing ambulatory care, inpatient care and home care. Treatment programs and rehabilitation teams are goal-directed with physical and psychosocial reconditioning or retraining of patients. Patient and family teaching are a major part of each program.

Family/significant others have a key role in providing support to veterans. Both are assisted in learning and in maintaining appropriate patient/caregiver rights and responsibilities. VA nurses contribute to planning, implementing and evaluating services for veterans in the community-at-large.

Committed to leadership in education, VA nurses provide creative learning experiences for both undergraduate and graduate nursing students. Nursing education initiatives including “distance learning” are being developed to provide skills and competencies necessary to function in primary and managed care settings. Students are able to work and study with VA nurses who have clinical and administrative expertise in aging and long-term care. These include nurses in various organizational and leadership roles. Nurses have responded to the growing emphasis upon end-of-life issues by providing training and local programs for palliative care, including hospice programs. Pain management in the elderly has been identified as a major problem and will be part of the National Pain Management Strategy. These collaborative experiences promote a culture and image of an agency that is committed to quality care and quality of life for aging veterans.

To assist facilities in meeting performance measures, nurses have been involved in developing creative alternatives to acute inpatient care. This includes chronic ventilator programs, which extend into nursing home and even home settings. There is also increased emphasis upon defining VA Nursing Home Care Unit (NHCU) programs as transitional and rehabilitative, providing a realistic discharge option for patients continuing to require nursing intervention and who were previously confined to acute wards. VA NHCU programs continue to demonstrate a significant restraint reduction. Decreased restraint usage is attributed to interdisciplinary re-assessment of the patient’s treatment. Each patient/resident has a comprehensive interdisciplinary plan of care, which facilitates reduced restraint usage. Resident outcomes include a decrease in the number of falls and injuries with an increase in residents’ alertness, happiness, muscle strength, independence and pride. Nurses and other members of the interdisciplinary team are proud of these clinical outcomes and VA NHCU programs success in reducing the use of chemical and physical restraints in care of the elderly. Such an environment enhances resident behaviors in independence, decision making and socialization.
Multi-arts programs have been developed including Tai Chi, Dance, Art Appreciation, Hands on Art, Sign Language and Creative Writing. Patient outcomes include an increase in mobility and functions and an increase in spontaneity and happiness as measured by standardized instruments.

Committed to research, VA nurses continue to change and re-shape clinical nursing practices. Nursing research is improving care delivery and health promotion in the following areas:

- Alternatives to Institutional Care;
- Wound Care and Effectiveness of Treatment Regimens;
- Risk Assessment for Falls;
- Restraint Minimalization and Interdisciplinary Assessment Tool Effectiveness;
- Patient Education, Health Promotion and Maintenance;
- National Minimum Data Set Implementation;
- Clinical Pathways; and,
- Assessment of Pain/Implementation of Pain as the 5th Vital Sign.

Timely application of research findings to clinical care in all practice settings will improve the quality of care and quality of life to aging veterans. Quality of life is an essential component for evaluating the effects of nursing care in both research and clinical practice. Research by nurses as a discipline and in collaboration with other members of the healthcare team continues to focus on specific patient care outcomes including quality of life, assessment of pain, effectiveness of care interventions, cost effectiveness, and patient satisfaction.

Pharmacy and Benefits Management Strategic Healthcare Group (SHG)

The Under Secretary for Health established the Pharmacy Benefits Management (PBM) Service line in FY1996 to provide a focus within the Veterans Health Administration (VHA) concerning the appropriate use of pharmaceuticals in the healthcare of veterans. A secondary goal was to decrease the overall cost of healthcare through achievement of the PBM's primary goal. As VHA has transitioned from an emphasis on inpatient care to ambulatory/primary care, pharmaceutical utilization has increased dramatically and will continue to do so.

One of the key organizational elements of VHA's PBM is its group of field-based physicians called the Medical Advisory Panel (MAP). The MAP provides leadership and guidance to the PBM in addressing the four functions of the PBM. These functions are: (1) to enhance the efficiency and effectiveness of the drug use process; (2) to enhance the distribution systems for pharmaceuticals used in both the inpatient and outpatient settings; (3) to bring consistently best pharmaceutical practices into the VA healthcare system; and (4) to maintain and enhance VA's drug pricing capabilities.

The PBM serves a qualitative and quantitative role in addressing the needs of older veterans. In a patient population that frequently has co-morbidities and multiple drug therapies, the actions of pharmacists to improve the drug use process are essential in realizing the goal of the appropriate use of pharmaceuticals. To date, eleven Pharmacologic Management Guidelines, sixteen Drug Class Re-
views, five Clinical Practice Guidelines, and nine Criteria for Use documents have been developed and promulgated for use in the VA healthcare system. Many areas of interest and merit in addressing the health conditions of elderly patients are included in the published drug treatment guidelines; they include depression, congestive heart failure, benign prostatic hyperplasia, Alzheimer’s disease, Erectile Dysfunction, and Criteria for Use for COX-2 Inhibitors. In addition, to improve the use of drugs in elderly patients, VA is implementing a screening tool in VISTA (formerly known as the Decentralized Hospital Computer Program) to identify patients receiving medications known to require close monitoring in elderly patients. Facilities will use this tool to individually tailor the patient’s drug therapy.

During FY1998 and FY1999, dramatic increases in the utilization of pharmaceuticals and the dollars expended on pharmaceuticals occurred across VHA. Through the use of effective contracting strategies tied to the development of disease management guidelines, the ability of VHA to provide quality medical care at an affordable price was achieved. Members of Congress, members of veterans service organizations, and individual patients generated considerable interest in VA’s National Formulary and related processes. Initiatives in applied research regarding formulary decisions and in medication data management began in 1998. These efforts are crucial to the continued evolution and future value of the PBM to VHA’s mission.

Allied Clinical Services Strategic Healthcare Group (SHG)

NUTRITION AND FOOD SERVICE

A new Interdisciplinary Task Group was established to develop Nutrition Performance Measures that identify nutrition indicators for patients at risk for malnutrition. These performance measures will provide a nutrition profile of acute care, chronic and elderly long-term veteran patients.

SOCIAL WORK SERVICE

Meeting the biopsychosocial healthcare needs of an aging population of veterans and the needs of 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 healthcare environment, as well as cost-effective and efficient in addressing the social components of healthcare, has led to a re-examination of social work priorities and their relevance to VA’s healthcare mission, with special reference to the needs of chronically ill, frail elderly veterans. Without a support network of family, friends, and community health and social services, healthcare gains would be lost and VHA acute care resources would be over-burdened. Frequently, it is 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 and Adult Day Health Care is evidence of the importance of non-institutionalized support networks in maintaining the veteran in the community. Social workers continue to coordinate discharge plan-
ning and to serve as the focal point of contact between the VA medical center and the veteran patient, family members, and the larger community health and social services network. The veteran and family members have, in many respects, become the "unit of care" for social work intervention. It is this veteran 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 healthcare team and as a key player in the provision of healthcare 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 care for the elderly is provided in the home by family, neighbors and others. The family, ordinarily the veteran's spouse, is the key decision-maker concerning health insurance issues, access to health resources and community support services.

As VHA transitions from an acute care to a primary care/community interactive healthcare 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 published Social Work Practice Guidelines, Number 2: Social Work Case Management, in September 13, 1995, and Case Management Outcomes and Measures: A Social Work Source Book, in August 1997. These standards are used as a starting point and part of the educational process that takes place at each VA facility as we move into interdisciplinary clinical paths and practice guidelines. 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 healthcare 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 veterans' healthcare needs and those of their caregivers. During 2000, and beyond, VHA, and particularly 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 in healthcare in terms of its absolute relevance to successful healthcare outcomes. In a revitalized and reconfigured VA healthcare system with expanded entitlement for long-term care service, issues of coordination, access, cost, and appropriateness of VA and community services will be determined not only by the needs of the veterans, but also by the experience and expertise of the providers.

Diagnostic Services Strategic Healthcare Group (SHG)

The clinical services of Pathology and Laboratory Medicine, Radiology, and Nuclear Medicine constitute the Diagnostic Services Group. Each of these clinical services provides direct services to
veteran patients and to clinician-led teams in ambulatory/primary care, acute care, mental health, geriatrics and long-term care, and rehabilitation medicine.

Diagnostic Services staff are educated on special care of the elderly. Pathology and Laboratory staff, for example, receive special training on phlebotomy with the elderly. In addition, normal values of various laboratory tests may be different in the elderly. These differences are incorporated into each VA facility's reference on normal ranges for tests.

Prosthetic and Sensory Aids Strategic Healthcare Group (SHG)

The mission of the Prosthetic and Sensory Aids Service (PSAS) Strategic Healthcare Group is to provide specialized, quality patient care by furnishing appropriate prosthetic equipment, sensory aids and devices in the most economical and timely manner in accordance with authorizing laws, regulations and policies. PSAS serves as the pharmacy for assistive aids and PSAS prosthetic representatives serve as case managers for the prosthetic equipment needs of the disabled veteran.

Currently, the majority of geriatric veteran patients treated in VHA's primary care clinics receive some type of prosthetic appliance. Prosthetic and Sensory Aids Service (PSAS) furnishes such appliances as eyeglasses, canes, crutches, wheelchairs, hearing aids, orthopedic shoes, arch supports, artificial limbs, and home oxygen equipment. PSAS also arranges for training and instructions on the use of these prosthetic appliances.

PSAS employees simplify the geriatric patients' communication difficulties with private home care durable medical equipment companies. They arrange for delivery and training on a variety of devices such as hospital beds, patient lifts, and environmental control appliances that the geriatric patient would have considerable difficulty in arranging themselves. Vendors have to have in-depth prescription and unique needs of the patients explained to them by PSAS employees prior to delivery, installation and instructions.

PSAS employees are also a vital link between the local VAMC clinic teams and geriatric veteran patients in developing the prescription needs of patients with catastrophic disabilities. The knowledge of appliances and componentry available in the private sector and VA sources is used to complete the prosthetic appliance prescription in the manner that meets the veterans prescription needs as well as maximizing the VA resources at hand.

Telemedicine Strategic Healthcare Group (SHG)

The Telemedicine Strategic Healthcare Group has the mission of furthering the innovative use of information and communications technologies to provide and support healthcare for veterans across distance and time barriers. VHA has played a leadership role in telemedicine, which involves the use of different communication technologies to transmit diagnostic and therapeutic information across significant distances. Telemedicine is expected to play an increasingly important role in improving healthcare for veterans by providing greater access to care, continuity and timeliness of care, reduction in travel time, and connectivity between providers and patients at remote locations.
Clinicians throughout VHA in many clinical specialties have used different telemedicine technologies to improve access, coordination and continuity of care for veterans. The Telemedicine Strategic Healthcare Group will continue to evaluate and recommend strategies to improve the capabilities for new information technologies to assist clinicians in bringing down the barriers of distance and time and, thereby, enhance the support of healthcare delivery to the older veteran.

**Spinal Cord Injury/Disorders Strategic Healthcare Group (SHG)**

The Spinal Cord Injury and Disorders (SCI&D) Strategic Healthcare Group (SHG) provides primary, specialty, and rehabilitation care for veterans with spinal cord injuries and disorders. Due to health care interventions and improved methods of long-term management, veterans with SCI&D are living longer. The average current age of veterans with SCI has been estimated to be twelve years older than the average current age in the general SCI population. Over twenty percent of the general SCI population is over the age of 61, and since the veteran geriatric population is proportionately larger than the general population, this percentage is also significantly larger. A recent program review, noted that twenty-eight percent of veterans offered initial VHA rehabilitation for new SCI onset are over the age of sixty-five while only nine percent are over the age of sixty-five in other modes of SCI&D care. There have been increases in the incidence of aging-related spinal cord problems and increasing survival rates for older persons with SCI in addition to basic demographic changes. Major clinical issues related to aging with a spinal cord injury being addressed in VHA include recurrent pressure ulcers, degenerative processes related to overuse syndromes, long-term urinary tract and gastrointestinal tract complications, cardiovascular changes and silent ischemia, pulmonary complications, assisted living, home care services, and the psychological and social impact of losing caregiver support.

With over thirty-six percent of the total veteran population being 65 years old or older (compared with thirteen percent of the general population), long-term care is a critical issue for America’s veterans. VA is intensifying its strategy development for providing long-term care for elderly veterans. VISN 8, with the support of regional Paralyzed Veterans of America (PVA) chapters, is taking steps to assure high-quality institutional and non-institutional long-term care to paralyzed veterans enrolled in Network 8. The VISN8/PVA Long-Term Care Working Group has established estimates of need among Network 8 paralyzed veterans across all elements of long-term care, and identified additional VA and State of Florida resources that can serve these needs. The group recognizes unmet needs in Puerto Rico and is working to find ways to address those needs. The VISN8/PVA Long-Term Care Working Group is a positive model for constructive partnership. The SCI&D SHG is also working collaboratively with a veterans service organization on policies regarding follow-up care for veterans with spinal injury and disorders who use community nursing homes. Certain SCI Centers have significant long-term care components to their missions and goals.
Research on aging and SCI&D is a high priority in VA. The SCI Quality Enhancement Research Initiative has several concept papers and research initiatives pertinent to issues of aging with a disability. Service directed research on SCI and surgical risk may address aging as a moderating variable, while aging issues could also be addressed in response to a Request for Applications (RFA) regarding pressure ulcer prevention and management. The important scientific and clinical knowledge gaps identified by consumers and providers related to the unique issues of aging with an SCI injury are being summarized from work with regional focus groups. Research on SCI preventive medicine and health promotion issues may also have findings related to aging. The SCI Quality Enhancement Research Initiative (QUERI) has also identified a sub-committee to address aging, disability, and long-term care research issues. Over the next three years, solicitations will be developed regarding aging and clinical areas for which additional research is needed. Both the Rehabilitation Research Center at the Houston VAMC and the Geriatric Research, Education, and Clinical Center (GRECC) at the Brockton/West Roxbury VA are focusing research on aging with a spinal cord injury.

Forensic Medicine Strategic Healthcare Group (SHG)

Forensic Medicine SHG operates to coordinate the interface between law and medicine in VHA. Within this context, Forensic Medicine is involved in VHA support to Veterans Benefits Administration (VBA) claims processing activities. This primarily involves Headquarters coordination for compensation and pension examinations in support of veterans’ claims for benefits. These examinations are required by VBA to enable the adjudication of most disability claims. Although not specifically focused on aging veterans, the work of this SHG, particularly in the compensation and pension process, directly affects benefits to elderly veterans, surviving spouses and dependents.

B. OFFICE OF RESEARCH AND DEVELOPMENT

Because of the often unique and difficult health problems of the elderly, VA is engaged in a vigorous research effort that approaches aging from a number of directions reflecting the multi-faceted nature of aging.

The commitment to research on aging veterans is demonstrated by the fact that the Office of Research and Development has established aging as one of nine Designated Research Areas (DRA) under which virtually all VA Research and Development programs and projects fall. For clarity, a DRA is defined as an area of research in which VA has a particularly strong strategic interest because of the prevalence of conditions within the VA patient population, the uniqueness of a specific patient population and its disease burden to the VA system or the importance of the question to healthcare delivery within VA. Clearly, veteran aging and its associated problems fall within this definition. VA research that is considered to fall primarily within the Aging DRA includes:

- Normal age-related changes in the body’s structure and function;
• Aging syndromes, such as frailty, immobility, falls, cognitive impairment;
• Compound problems and co-morbidities, such as dementia and hip fractures;
• Care of elderly veterans; and,
• End-of-life issues hospice care, “quality of dying”, and similar areas.

Below are highlights of recent advances in research on aging veterans from each of the Office of Research and Development's programs: Medical Research, Health Services Research and Development, Co-operative Studies, and Rehabilitation Research and Development.

MEDICAL RESEARCH SERVICE OVERVIEW

Medical Research Service (MRS) administers VA biomedical research focussed on the etiology, pathogenesis, diagnosis, and treatment of diseases affecting veterans. Aging research continues to be a priority area within MRS. The studies comprising the aging research portfolio examine many aspects of the wide spectrum of changes that occur during normal aging as well as syndromes associated specifically with the elderly, e.g., dementia, osteoporosis, etc.

MRS administers scientific research via several mechanisms intended to support the most scientifically meritorious work by investigators. Investigator-initiated proposals submitted to the MRS Merit Review program are peer-reviewed prior to funding; the funded programs form the backbone of our biomedical research. (See studies described below.) Additionally, MRS supports young investigators through several mechanisms, including a new training program initiative, the Associate Investigator (AI) program. Scientists may then elect to submit to the Career Development or the Merit Review Entry Program, each of which provides research support in a mentoring environment as the applicants progress toward independent research careers. These early awards are considered crucial to our efforts to attract and retain investigators interested in working in geriatric research.

In addition to individual awards, MRS established the Research Enhancement Award Program (REAP) during this fiscal year to promote and support groups of VA investigators studying medical areas of importance to the veteran population. The REAP program enables collaborating researchers to integrate basic science and clinical research approaches with understanding and treatment of these conditions. The goals of the REAP are to train new investigators, develop new and innovative research approaches to medical problems, and foster collaboration among investigators working in common areas. More than half of the funded REAPs are studying problems related to aging, including:

• pathogenesis, prevention and treatment of bone disease;
• molecular mechanisms of lung host defense;
• chronic obstructive pulmonary disease;
• defense mechanisms in colonic epithelia;
• diagnosis and management of dementing disorders;
• pathogenesis and treatment of cerebral ischemia;
• neurogenetics and neuroendocrinology of dementia;
• cellular activation in prostate cancer;
• mechanisms of neuronal degeneration;
• cardiac remodeling and arrhythmogenesis; and
• basic mechanisms of cardiac hypertrophy and failure.

Previously established research centers, where scientists are working collaboratively on a specific medical condition, continue to be supported by MRS. Research centers with components related to aging include:
• alcoholic liver disease;
• schizophrenia; and
• diabetes.

MRS also supports the Geriatric Research Education and Clinical Care (GRECC) program by funding the pilot projects in the GRECCs that have been peer-reviewed and determined to be scientifically meritorious. Ongoing pilot project work includes:
• a study of the factors that may increase the risk of post-stroke depression, and similarities and differences between post-stroke depression and depression in neurologically normal geriatric patients;
• the epidemiology of resistant pathogens in residents admitted to an acute care facility from long-term care facilities;
• examination of the post-infarction recovery of elderly patients; and
• comparison of two models of mental health and alcohol abuse service delivery to determine effective strategies for older veterans.

Merit Review Programs

MRS currently supports over 100 research projects related to aging. Listed below are the objectives of some of the programs that received funding during this fiscal year.

NORMAL AGING PROCESSES

• Determine if difficulties in performing tasks of daily living by older adults may be related to the oxygen deficit that occurs when older subjects are physically active.
• Examine whether transplants integrate with the host and provide functional recovery in aged as well as middle-aged and young subjects.
• Examine the relationship between age-dependent alterations in oxidative DNA damage and the increased vulnerability of dopaminergic neurons to toxins, early senescence, and cell death.
• Determine the factors that may explain why certain infections (e.g., sepsis) are more damaging in aged patients compared to younger patients.
• Understand how human aging alters lipid-mediated gene expression in the immune system, which may provide insight into age-related problems in immunologic defense mechanisms.
• Examine night-time incontinence in older males via a pilot test of a treatment based on hormonal therapy.
• Understand the role of the Werner Syndrome gene to elucidate the basic sequence of aging events, as well as obtain clues for therapeutic intervention in some of the common geriatric disorders.
STROKE
• Obtain new information concerning the role of neurite growth regulating factors in brain connectivity and recovery following stroke in the aged central nervous system.

MENTAL HEALTH
• Examine the benefit of treating alcohol dependence in older adults who are receiving treatment for major depression where subjects will be randomly assigned to receive either naltrexone or placebo in addition to sertraline and compliance enhancement therapy.

SCHIZOPHRENIA
• Study the contribution of certain brain neurotransmitters (glutamate and GABA) to schizophrenia and determine if they differentially are related to cognitive deficits in elderly schizophrenics.

CANCER
• Determine how older oncology patients are at increased risk for cardiotoxicity from anthracyclines used to treat different cancers.
• Increase the understanding of the regulation of certain enzymes, matrix metalloproteases (MMP), in neoplastic prostate growth, especially in relation to tumor grade in specimens from patients and in the induction or repression of tumor metastasis. These studies should determine if certain MMPs would be good candidates as bioindicators in future studies predicting the latent or aggressive nature of prostate tumors.

OBESITY
• Determine if sequence variances in a gene (lipoprotein lipase) affects the amount of weight loss and metabolic responses during a hypocaloric diet treatment for obesity.
• Determine how age-related changes in muscle may be responsible for the decrements in energy expenditure and thus contribute to obesity.

ANOREXIA
• As older people ingest less food than do younger, they are at risk of developing severe malnutrition in the presence of a disease. Study will examine reasons for the physiological anorexia of aging.

NEURODEGENERATIVE DISORDERS
• Determine if treatment with estrogen enhances cognition and skills of independent living for postmenopausal women with Alzheimer's disease.
• Determine whether overcoming insulin resistance by administering insulin intravenously enhances cognitive performance in patient with Alzheimer's.
• Examine the basic mechanisms underlying the interactions between glutamate neurotoxicity and the inflammatory second-messenger system.

• Examine whether progressive neuronal loss may be related to environmental factors and genetically determined susceptibility, and determine if there are intermediate declines that might be identified before a full-blown Parkinson's Disease is diagnosed.

• Examine the pathology of Alzheimer's disease through a murine slice culture study of the mechanisms of amyloid B protein deposition.

ALCOHOLISM

• Determine if aging and alcohol dependence involve similar stresses on neurochemical transmission.

• Examine the benefit of treating alcohol dependence in older adults who are receiving treatment for major depression.

OSTEOPOROSIS

• Understand the underlying pathology for the changes in parathyroid gland function that occurs with aging and its impact on bone and mineral metabolism in the elderly.

• Enhance current knowledge of the cellular and molecular basis of osteoarthritis.

HEALTH SERVICES RESEARCH AND DEVELOPMENT (HSR&D)

Research supported by the Health Services Research and Development Service (HSR&D) is designed to enhance veterans’ health and functional status and the quality of care provided to elderly veterans. HSR&D researchers focus on identifying effective and cost effective strategies for the organization and delivery of health services and for optimizing patient- and system-level outcomes. They employ the expertise and perspectives of clinicians, social scientists, and managers to advance the field of health services research and answer practical questions that are important both inside and outside VA. Elderly veterans and their special health care needs have always been a major focus of HSR&D activity.

Through its various programs, HSR&D supports both research that is (1) pertinent to aging, and (2) research that addresses unique aspects of aging. In the first case, a large proportion of HSR&D projects active in FY1999 addressed health care for chronic diseases and conditions that are especially common in the elderly. For example, in the Investigator-Initiated Research (IIR) program, 12 projects focused on treatment and outcomes for cardiac disease, including hypertension, coronary artery disease, acute myocardial infarction, chronic lung disease, and stroke. Six IIR projects focused on prostate cancer, emphasizing patient preferences for treatment and quality of life. Additional IIR projects as well as projects funded under other HSR&D programs, addressed health care for cancer, depression, diabetes, osteoarthritis, pressure ulcers, and other conditions for which elderly veterans seek or receive care. In this research, HSR&D investigators are examining access to care, clinical decision-making, health care costs, utiliza-
tion patterns, and a wide range of patient outcomes, including quality of life and functional status. Several of these projects address racial and ethnic variations in health care utilization and seek explanations for observed disparities.

This report emphasizes HSR&D research activity in areas unique to aging, as defined in the Designated Research Area. Presently, this includes research related to:

- Aging syndromes, such as frailty, immobility, falls, cognitive impairment;
- Care of elderly veterans; and
- End-of-life issues.

A. HSR&D INVESTIGATOR-INITIATED RESEARCH (IIR)

HSR&D's IIR program supports research projects proposed and carried out by investigators at VA medical centers throughout the Nation. This includes projects proposed in response to special solicitations initiated in VA Headquarters. All proposals undergo rigorous peer review to assure scientific/technical merit and importance to VA. IIR projects range in duration from one to four years.

In FY1999, HSR&D supported 12 continuing IIRs and initiated 6 new IIRs with a specific focus on aging. (Asterisk identifies projects scheduled for completion during FY1999.) These address the following:

AGING SYNDROMES:

- the effect of clinical guidelines on pressure ulcer care in nursing homes (Berlowitz);
- trial of a physical restoration intervention to reduce falls in the frail elderly; (devito)*; and
- assessment of physical health status in older adults using Item Response Theory (McHorney IIR 95-033).

NEW

- effectiveness of health education to improve well-being and reduce health care utilization and costs for frail elderly outpatients (Engelhardt).

Care of Elderly:

- decline in functional status as a quality indicator for long-term care (Rosen);
- a system for case-finding and referral of elderly veterans in primary care (Rubenstein);
- the effect of patient- and system-level factors on the use of VA and non-VA health services among elderly veterans (Morgan);
- patient outcomes and treatment preferences for prostate cancer (2 projects) (Bennett*, Clark); and
- process, structure and outcomes of post-stroke rehabilitation care (Duncan).
NEW

- patient decision-making regarding hormone replacement therapy (Schapira);
- assessment of pressure ulcers via telemedicine (Lowery); and
- validation of a Spanish translation of a cognitive assessment tool (Morgan-de Vito).

End-of-Life Issues:

- attributes of the quality of dying, from the perspective of patients, family members, and providers (Tulsky)*; and
- an intervention to encourage comprehensive advance care planning (Pearlman)*.

NEW

- study of terminally ill older persons, their families and physicians, to better understand preferences and communication issues at the end of life (Fried); and
- the needs and concerns of patients with advanced cancer (Schiller).

B. Nursing Research Managed by HSR&D

In 1995, VA's Research and Development Office, in collaboration with the Nursing Strategic Healthcare Group, implemented a program to encourage new research on nursing topics and to expand the pool of nurse investigators in VA. The Nursing Research Initiative (NRI) invites proposals for health services research, medical research and rehabilitation research. Of the 19 projects funded under this initiative to date, several focus on treatment or management of conditions that occur most frequently in the elderly (e.g., heart failure, COPD).

NRI research that addresses aspects of the Aging DRA includes one new project and nine ongoing projects, as follows:

Aging Syndromes:

- Gait and balance training to reduce falls and fear of falls (Galindo-Ciocon)
- Measure of risk of developing a pressure ulcer (Wilson)

Care of Elderly:

- Nurse managed clinic for dementia patients and family caregivers (Maddox)
- Effect of activity on sleep in cognitively-impaired veterans (Richards)
- Informal caregivers of veterans with dementia (Clipp)
- Managing resistance to care in patients with Alzheimers Disease (Hurley)
- Pain management and behavioral outcomes in dementia (Buffum)
- Nurse counseling for physical activity in primary care patients (Dubbert)
dementia outcomes assessment module (Cody)

*End-of-Life Issues:*
- Use of pain resource nurses to improve outcomes of cancer pain (Hagan)

**C. SERVICE-DIRECTED RESEARCH (SDR)**

This is a centrally-directed program of health services research carried out by VA field staff, VHA Headquarters staff, and/or contractors engaged to analyze specific problems. Projects include program evaluations, information syntheses, feasibility studies, new initiatives and other research projects responsive to specific needs identified by Congress, other federal agencies, or Department of Veterans Affairs executives and managers.

Ongoing HSR&D Service-Directed Research (SDR) projects focus on issues relevant to aging veterans. These projects include a study of patient preferences in advanced metastatic prostate cancer and costs, quality of life and functional outcomes of veterans treated for multiple sclerosis. A study to improve the quality of ambulatory care focuses on six health care conditions important to elderly veterans (angina, obstructive lung disease, depression, diabetes, hypertension, and problem drinking).

Five continuing HSR&D projects related to women's health are expected to benefit aging female veterans. These projects address issues of access to VA care; rehabilitation concerns of women with spinal cord injuries; depression, surgical risks and outcomes; alcohol prevalence, screening and self-help; and gender differences in compensation and pension claims for PTSD.

During FY1999, researchers completed two SDRs related to aging veterans. One study focused on the clinical management of veterans with stroke. A second study developed and tested measures of health-related quality of life applicable to veterans.

**D. QUALITY ENHANCEMENT RESEARCH INITIATIVE (QUERI)**

HSR&D is leading the new Quality Enhancement Research Initiative (QUERI) launched in FY1998 by the Office of Research and Development to create and implement a national system to translate research discoveries, innovations and proven clinical strategies into patient care. QUERI is a comprehensive, data-driven, outcomes-based quality improvement program promoting excellence in outpatient, inpatient, and long-term care. This initiative currently focuses on eight specific clinical conditions: mental health, substance abuse, diabetes, chronic heart failure, ischemic heart disease, stroke, spinal cord injury, and HIV/AIDS. While these conditions are not uniquely related to aging, all are important in elderly veterans and account for a major component of their health care use.

In FY1999, as part of QUERI, HSR&D initiated two projects focused on diabetes care; five projects on ischemic heart disease, and one project on mental health. Additional aging-related QUERI research is anticipated in FY2000 and beyond.
E. MANAGEMENT DECISION AND RESEARCH CENTER (MDRC)

HSR&D’s Management Decision and Research Center (MDRC) translates research into practice by bringing technology assessment, management consultation, and research findings to managers, policymakers and clinicians within and outside of VA. For example, MDRC’s Information Dissemination Program (IDP) has created a wide variety of products utilizing both print and electronic mechanisms to disseminate important research information. Communication media include televideo broadcasts, R&D’s webpage and fax on demand system, and various print publications such as a series of primers, Management Briefs, and a biannual newsletter. Another IDP publication is VA Practice Matters, which summarizes the results of important research within VA and promotes its application by describing the potential impact and possible implementation strategies and resources. In FY1999, one issue of Practice Matters focused on Primary Stroke Prevention, a topic of importance in elderly veterans.

Also in 1999, MDRC’s Technology Assessment Program produced two evaluations on topics relevant to elderly patients: shared decision-making programs for patients with prostate cancer, and the use of stereotactic pallidotomy for treatment of Parkinson’s disease. Other relevant assessments currently underway include evaluations of brachytherapy (a radiation therapy) for prostate cancer; systematic reviews of impotence therapies; minimally invasive treatment options for abdominal aortic aneurysms; and an update on the assessment of the use of positron emission tomography as a diagnostic test for cancer and Alzheimer’s disease. The Technology Assessment Program has also produced (released in January, 1999) a systematic review of treatments for erectile dysfunction, a common complaint among elderly males. Currently underway is another systematic review, requested by VA’s Rehabilitation Strategic Health Care Group, assessing a new computerized lower limb prosthesis. Leg amputation is a relatively frequent complication of vascular disease in the elderly, whose difficulty learning to walk with a prosthesis may be reduced by technologic improvements.

In addition, MDRC’s Management Consultation Program initiated an evaluation of a demonstration hospice program at the request of the VHA Medical Sharing Office and the VA Palo Alto Health Care System (HCS) and in collaboration with VA’s Office of Geriatrics and Extended Care. Under new VA sharing authority, the Palo Alto HCS is expanding its inpatient hospice beds to serve additional veterans and, for the first time, non-veterans referred under contracts with community hospice agencies. The evaluation is designed to determine whether the revenues from non-veterans cover the costs of caring for them and to assure that preference for veterans and quality of care are maintained in the service. This project will be completed in FY2002.

F. HSR&D CENTERS OF EXCELLENCE

HSR&D’s Centers of Excellence conduct research and support the integration of research and practice. Each Center develops its own research agenda, is hosted by a collaborating VA Medical Center
and maintains affiliations with community institutes and schools of public health, university health administration programs, and research institutes to support its goals and objectives. Of the eleven ongoing HSR&D Centers, seven are conducting aging research in addition to the work highlighted above (IIRs, SDRs, and QUERI).

The Northwest Center for Outcomes Research in Older Adults in Seattle, Washington, is a collaboration of VA Puget Sound Health Care System and the Portland VA Medical Center. Major community institutions supporting Center research are the University of Washington School of Public Health and Community Medicine and the Kaiser Permanente Center for Health Research in Portland. Research focuses on three areas: (1) primary and specialty care management of chronic disease; (2) preservation of independence in older adults; and (3) evaluation of alternative systems of health care delivery. In FY1999, VA researchers at the Seattle Center were involved in 117 individual projects. Illustrative research on aging addresses: Chronic diseases that are common among the elderly, including heart disease, depression, urinary tract infections and diabetes; identification and treatment of hearing impairment (Yueh); predictors of better outcomes of community residential care (Hedrick); and effectiveness of rehabilitation services (Evans).

The Midwest Center for Health Services and Policy Research, in Hines, Illinois, is a joint program of Hines VA Hospital, North Chicago VA Medical Center and the Chicago VA Health Care System. The Center currently maintains academic affiliations with all of the major universities in the Chicago area and has an established program of research in long-term care and geriatrics, as well as other aspects of health services research. Examples of research at Hines include projects focused on assisted living (Guihan), risk factors for femorodistal bypass surgery or amputation (Fineglass, Cowper), and the effects of exercise on aerobic capacity and quality of life in heart failure patients (Collins). In addition, HSR&D researchers at the new VA Information Resource Center (VIREC) are working to merge VA data with Medicare data. This project (Hynes) is a collaboration of VA's Office of Policy and Planning and the Health Care Financing Administration. The merged data will be a valuable resource for studying care of the elderly within and outside VA.

The Center for Health Services Research in Primary Care at the Durham, North Carolina VAMC emphasizes projects that enhance the delivery, quality and efficiency of primary care provided to veterans. The Center's academic affiliations with Duke University and the University of North Carolina at Chapel Hill support a variety of research collaborations. Of the 79 research projects underway in FY1999, many specifically address age-related conditions seen in primary care and other aspects of health care for elderly veterans. Ongoing research at the Durham Center includes projects focused on defining best practices for patients with stroke (Oddone) and diabetes (Edelman); understanding the influence of race on access to care; and examining the utility of telemedicine in diagnosing dermatologic lesions (Whited).

The Center for Health Quality, Outcomes and Economic Research based in Bedford, Massachusetts, emphasizes research related to improving the quality of health care for elderly veterans.
Ongoing projects focus on quality of long-term care (Rosen), veterans' hospice care (Hickey), and other issues in end-of-life care. Other studies focus on care for particular conditions that are very common in elderly veterans, including hypertension (Berlowitz), diabetes, osteoporosis (Miller), prostate disease (Boehmer); and oral health (Jones).

The HSR&D Center for Practice Management and Outcomes Research in Ann Arbor, Michigan, emphasizes outcomes research and studies to improve the quality of clinical practice. The Center is affiliated with the University of Michigan Hospitals, Medical School and School of Public Health. Additionally, this Center is fully integrated with VA's Serious Mental Illness Treatment Research and Evaluation Center (SMITREC), a special evaluation and research field program of the Mental Health and Behavioral Sciences Strategic Healthcare Group (at VA Headquarters). Aging research at the Ann Arbor Center addresses quality improvement; costs and quality of diabetes care; prostate cancer treatment (Wei); and mental health issues relevant to older veterans (Kales).

The Sepulveda, California, HSR&D Center for the Study of Healthcare Provider Behavior has affiliates at the West Los Angeles campuses of the VA Greater Los Angeles Healthcare System and the San Diego VA Healthcare System and collaborates with two non-VA institutions—the University of California (campuses at Los Angeles and San Diego) and the RAND Health Program. The Center seeks to build a knowledge base that will help researchers, policy makers, and health care managers design, implement and evaluate policies and programs to improve health outcomes. During FY1999, investigators at Sepulveda conducted over 80 research projects at VA and non-VA locations. Research relevant to aging addresses variations in VA primary care delivery and the implications for facility performance (Yano); improving care for depression (Rubenstein); and provider adherence to smoking cessation guidelines (Sherman). Additionally, an evaluation of intervention strategies to improve prevention activities among elderly veterans was completed in 1999 (Shekelle).

The Center for Chronic Disease Outcomes Research at Minneapolis, MN, has a broad-based research portfolio, with programs in prevention, treatment outcomes, quality of care, and gender issues. HSR&D research underway at Minneapolis includes an assessment of physician knowledge, attitudes, and practices regarding adult immunization (Nichol); an evaluation of the determinants of osteoporotic fractures in men (Ensrud); and a study of the effectiveness of an organizational strategy to increase provider compliance with smoking cessation guidelines (Joseph).

Cooperative Studies Program FY99 Aging Research Activities

The Cooperative Studies Program (CSP) is a component of the Office of Research and Development and supports multi-center clinical studies where multiple VA medical centers study collectively a selected medical problem. The Cooperative Studies Program (CSP) is comprised of four Coordinating Centers (CSPCCs), a Clinical Research Pharmacy, and three Epidemiological Research and Information Centers (ERICs). The CSP exists to provide credible, con-
sistent, and effective answers to major scientific questions that determine evidence-based medical practice in VA and in the country.

Outcomes of specialized care for elderly patients evaluated

The proportion of veterans over age 65 will increase from 26 percent in 1990 to 46 percent in 2020. VA must be prepared to serve the needs of this growing population. A large, multi-outcome study will determine whether specialized inpatient and outpatient units are the best way for VA to care for elderly patients. The impact of this study will extend far beyond VA, as millions of older Americans come under managed care. No other study is likely to provide the conclusive evidence needed to guide policy in this critical area.

Seizures

New-onset epilepsy occurs among 45,000 to 50,000 elderly people every year. These patients are especially vulnerable to side effects from drug treatments and often have other conditions for which they take medication. This study will compare the effects of two drugs recently approved for the treatment of seizures, gabapentin and lamotrigine, with a standard drug, carbamazepine, in elderly patients. Identification of a more effective drug for elderly people would allow these patients to live better, more seizure-free lives with fewer side effects.

Cholesterol Reduction in the Elderly

The objective of this study is to determine the extent to which various lipid parameters predict the risk of coronary heart disease among those 65 years or older, compared with younger individuals. Better estimates of risk associated with lipid abnormalities, as well as the risks, benefits, and costs of cholesterol reduction in the elderly, will aid in the refinement of guidelines targeted for the aging US population.

Major trial launched to test new vaccine against shingles

Shingles in older people is extremely painful and disabling. There is no effective treatment (lasting more than a month) for people who suffer from shingles; nor is there an effective method to prevent shingles. This study will test a promising new vaccine to prevent shingles and reduce its severity and complications. The randomized, controlled trial will enroll 35,000 older veterans for a minimum of three years. If the vaccine proves successful, it will supply a safe and cost-effective means for reducing the severe impact of shingles and its complications on the health of older veterans.

Heart Disease—COURAGE Trial

Heart disease affects more than 7 million people in the US and is the leading cause of death among Americans. The COURAGE study is a large-scale, multi-center, randomized controlled trial comparing the effectiveness of angioplasty with medical therapy to medical therapy alone in treating patients with coronary heart disease.
Heart Failure—WATCH Study

Congestive heart failure remains an important clinical problem for the elderly. This study will compare the effectiveness of three antibiotic therapies (warfarin, aspirin, and clopidigrel) in patients with congestive heart failure. This international study will involve 4,500 patients across 150 medical centers among VA, non-VA US hospitals as well as centers in the UK and Canada.

Prostate Cancer—PIVOT

Prostate cancer is the most common cancer among men and second leading cause of death in men. The management of localized prostate cancer in older men has generated considerable debate due to risks and potential benefits associated with different treatment options. Research shows that patients' treatment preferences vary significantly, depending on the risk associated with surgery, their life expectancy, their symptoms and tolerance for their symptoms.

Important questions remain concerning long-term outcomes for prostate cancer treatment. VA, in collaboration with the National Cancer Institute (NCI) and the Agency for Health Care Policy and Research (AHCPR), is addressing these questions through a landmark study that compares the two most widely used treatment methods: radical prostatectomy, in which the prostate is surgically removed, and expected management or "watchful waiting," in which only the disease symptoms are treated. The Prostate Cancer Intervention Versus Observation Trial (PIVOT) is a 15-year, randomized study involving 2,000 men.

Prostate Cancer—SELECT Study

VA has entered collaborations with the NCI and the Southwest Oncology Group to study the effects of Vitamin E and Selenium in the primary prevention of prostate cancer. The proposed Selenium Vitamin E Cancer Prevention Trial (SELECT) is a randomized, double-blind, placebo controlled, factorial design trial among 30,000 healthy men without prostate cancer.

Prostate Cancer—Racial Differences

Another study on prostate cancer will look at the racial differences in the incidence and mortality of the disease. Among African Americans, the incidence and mortality from prostate cancer is highest. This research will provide insight into genetic-environmental interactions that initiate and promote prostatic neoplasia, as well as address whether there are differences in patterns of care that impact morbidity and survival.

Colorectal Cancer

The relative five-year survival for colorectal cancer is approximately 40 percent among veterans, substantially lower than the general population of 61.7 percent (colon) and 59.3 percent (rectum). Colorectal cancer is preventable through screening, and, if diagnosed in an early stage, is curable.

This is the first study to examine factors that may explain the worse prognosis for veterans with colorectal cancer. If modifiable factors such as physician and patient delay in diagnosis, or poverty
explain the increased mortality among veterans, educational programs and interventions that improve the process of care associated with screening and diagnosis can be instituted.

*Positron Emission Tomography (PET) to Detect Solitary Lung Nodules*

Accurate non-invasive identification of cancerous lung tumors may expedite the removal of potentially surgically curable cancerous lesions and minimize the number of benign masses and surgically incurable lung cancers for which chest surgery is done. This study is evaluating the utility of PET in differentiating benign from cancerous tumors in patients with solitary lung nodules. It is anticipated that PET will be more accurate than chest x-ray and CAT scan.

*Influenza Virus Infection in Patients with Chronic Obstructive Pulmonary Disease*

Influenza infections are a source of significant morbidity among patients with underlying respiratory illnesses such as chronic obstructive pulmonary disease (COPD). COPD is a common health problem among patients in the VA health care system. The primary question is whether or not co-administration of live, cold-adapted influenza virus vaccine (CAIV-T) with intra-muscular inactivated influenza virus vaccine (TVV) is more efficacious in preventing natural, wild-type influenza virus infection than inactivated influenza virus vaccine given intra-muscularly (TVV) alone in patients with COPD.

**RESEARCH CONSORTIA AND PARTNERSHIPS**

*Alzheimer’s Disease VA Consortium*

Alzheimer’s Disease (AD) is the third most expensive chronic disease to treat following cancer and heart disease. It is estimated that by the year 2000, there will be 600,000 veterans with severe dementia.

The principal goal of this consortium is to take advantage of existing VA resources to address important issues in the management of AD and other progressive dementias. The main objectives of the consortium are: (1) to identify VA medical facilities with substantial numbers of patients suffering from AD and related progressive dementias that possess the infrastructure, interest and expertise to conduct informative clinical trials; (2) to identify and prioritize areas of investigation that should be pursued in consultation with other research organizations (e.g., NIH Consortium, Reagan Institute, Harmonization Group); (3) to implement a number of clinical trials in VA facilities which are prepared to embark on these studies; (4) to develop promising clinical trials in collaboration with pharmaceutical and biotech industries; and (5) to integrate results of these studies into the practice of VA physicians.

*VA Clinical Oncology Research Network (VACORNET)*

The VA Clinical Oncology Network (VACORNET) is a group of VA clinician investigators interested in oncology research and multi-site trials. The mission of the VA CORNET is to:
• promote oncology research relevant to the health of veterans;
• promote oncology research with pharmaceutical companies, especially multi-site trials, and promote investigator-initiated research;
• foster communication among oncology researchers;
• develop an infrastructure to support national studies;
• encourage supportive care trials; and
• offer assistance to VA investigators who need multiple sites to answer a clinical research question.

VA Cardiology Consortium

The VA Cooperative Studies Program has considerable experience with cardiovascular clinical trials. The distributed nature of scientific expertise in VA is both an advantage and a barrier to involvement with this area of research. To ensure that VA patients have access to the latest innovations in care and that study design is responsive to the needs of VA, it is desirable to facilitate the collaboration between VA cardiologists and the principal sponsors of cardiology research. This initiative will develop a process for expediting the involvement of VAMCs in such cardiology trials.

VA/National Institutes of Health (NIH), National Institute on Aging (NIA)

In collaboration with the National Institute on Aging, CSP seeks to conduct a series of multi-site, randomized clinical trials to enhance VA's efforts to treat its rapidly growing population of elderly veterans. These studies include investigations of osteoporosis in men, focusing on fracture prevention; androgen replacement therapy in men; preoperative interventions for older patients undergoing non-cardiac surgery; approaches to cardiovascular surgery in older patients; and treatment for diastolic dysfunction for patients with coronary heart failure and normal systolic function. CSP also may conduct studies in long-term care settings, including ways to prevent lower respiratory infections and catheter-related urinary tract infections in nursing home units.

Other research projects may focus on ways to improve chronic disease management; the use of alternative treatment approaches for patients with potentially terminal illnesses; and the management of behavioral disturbances among patients institutionalized with Alzheimer's disease. CSP will also study the impact of nutritional interventions in vulnerable geriatric populations; the effectiveness of a variety of interventions in treating fall-related fractures; and the appropriateness, cost-effectiveness, and incidence of adverse effects of prescription drugs for geriatric patients.

VA and the National Parkinson Foundation

VA and the National Parkinson Foundation, Inc. (NPF) have joined forces to seek a cure and improve treatments for Parkinson's disease. The Alliance to Cure Parkinson's disease between VA and NPF has launched a variety of activities. They include: a series of symposia highlighting state-of-the-art research for scientists and policy makers; educational programs for VA medical personnel that are focused on advances in the understanding and treatment of
Parkinson's; information products for public dissemination on VA's research and treatment programs in Parkinson's; continuing medical education training for VA clinicians who treat patients with Parkinson's; and jointly-funded research initiatives to expand the medical community's understanding of the causes, mechanisms, and treatment of this disease.

VA/National Institutes of Health, National Heart Lung & Blood Institute (NHLBI)

VA, in collaboration with the NHLBI and Intercardia Incorporation, is conducting a major study entitled, “Beta-blocker Evaluation of Survival Trial (BEST),” to determine whether beta-blockers extend the lives of patients with chronic heart failure. The implications of this trial, involving 2,800 patients with moderate to severe congestive heart failure, are substantial. In addition to prolonging patients' lives, researchers conservatively predict that successful use of these drugs will save the VA system approximately $9.4 million annually.

Rehabilitation Research and Development

Over 9 million of the veteran population is now over 65 years of age. As the veteran population continues to age, most veterans will experience more medical complications from multiple illnesses and new disabilities including loss of hearing and vision which further limits their function, mobility, and quality of life. In addition to their physical limitations, many elderly veterans are further isolated as a result of living in remote rural areas or far from medical facilities. Due to increasing disability and poor vision, many veterans are unable to drive and lack the support systems needed to obtain adequate health care. Maximizing remaining function and enabling aging veterans to stay healthy in their own home environment are critical goals.

Rehabilitation Research and Development (Rehab R&D) Service is one of four services within the VA Office of Research and Development that is forging ahead to provide quality research resulting in new knowledge leading to improved health care delivery services for veterans. Rehabilitation research, new interventions, development of new technology, and adaptation of existing technology, all offer a wider range of options and opportunities to the growing population of aging veterans with disabilities. Rehab R&D initiatives are designed to monitor, prevent, and provide treatment interventions through the use of cutting edge technology which would allow aging veterans to have an improved quality of life in their own home.

The ultimate goals of (Rehab R&D) Service include achievement of actual functional return, compensatory therapies to maximize remaining function and to mitigate secondary conditions, corolling cutting edge technologies to compensate for lost function, and fostering better ways for living with disability. This is especially important for the aging population. To this end, over 200 VA researchers have dedicated themselves in a comprehensive effort to advance the health care needs of veterans with disabilities.

Nine Rehabilitation R&D Centers located at VA facilities around the country function to attract the best and brightest minds from
academia, industry, and medicine to VA to study specific aspects of aging and disability research, as well as to work together as a national network. Here, investigators renew half a century of commitment to seeking solutions to rehabilitation's most challenging research problems. Moreover, in looking toward a new generation of researchers, a research career development program has been initiated to mentor doctoral-level rehabilitation clinical professionals. These men and women will help guide the future of rehabilitation research and development.

In order to disseminate research results, the Rehab R & D Service has committed to publishing its efforts, through outlets such as a bi-monthly peer-reviewed journal, an annual reporting of progress in rehabilitation research throughout the world, clinical monographs, and data sheets. Each of these activities stimulates new research ideas and keeps clinicians and consumers on the cutting edge of new ideas in disability management. The Journal of Rehabilitation Research and Development has a long history of disseminating research results related to prosthetic and rehabilitative care. Although largely oriented towards engineering and assistive technology, the Journal has made an impact on the general rehabilitation research community. To increase dissemination and cut mailing and publication costs, in 1999, the Journal and progress reports became available on the Internet.

NEW INITIATIVES

VA Rehabilitation Research and Development Centers

In July of 1999, the VA Rehabilitation Research and Development Service added three new R&D Centers to its portfolio. The newest of the now nine Centers focus on Cognitive and Motor Impairment Rehabilitation (including Alzheimer's and stroke) (Gainesville, FL), Restoration of Function in SCI and Multiple Sclerosis (West Haven, CT), and Wheelchair and Related Technology (Pittsburgh, PA). This group complements the six established Centers in Geriatric Rehabilitation (Atlanta, GA), Aural Rehabilitation (Portland, OR), Prosthetics and Consequences of Amputation (Seattle, WA), Mobility (Palo Alto, CA), and Aging with a Disability (Houston, TX). It is anticipated that these Centers will sponsor research and attract funding from many sources to advance knowledge in these important areas. In addition, Centers mentor young investigators thus, building capacity for future research. These initiatives will provide a new knowledge base for clinicians as they work to rehabilitate and maximize remaining function of elderly veterans.

VA R&D Technology Transfer

To further maximize technology transfer productivity, the Director of Rehab R&D Service has been recently charged with assessing, coordinating and maximizing technology transfer activities and opportunities within VA. Technology Transfer efforts within Rehab R&D have traditionally been focused on evaluating prototypes of developed assistive technology. These evaluations are helpful in furthering the commercialization of developed devices, but not enough to assure that promising prototypes reach the commercial
market. In addition, rehabilitation research results not only in new technology, but also in therapies, practices and new knowledge. These results must be translated into clinical care. Availability of an individually prescribed wheelchair, new and improved hearing aids, and new visual adaptive devices are all-important in increasing the aging veteran's quality of life. Advances in these areas frequently benefit the general non-veteran aging population as well.

In FY98 and FY99 Rehab R&D expanded its scope of technology transfer activities to include pursuing patents and developing the capacity for conducting clinical trials. A workshop was presented at the June 1999 VA Rehabilitation Clinical Symposium in Houston to introduce clinicians to opportunities for translating research findings into practice that results in improved patient care.

**Multiple Sclerosis: A Step Forward**

Multiple sclerosis (MS) attacks the nervous system creating multiple disabilities, from paralysis to impaired vision, and sometimes blindness. Veterans with MS are predominantly male and older than the typical MS patient. Due to its patient population and its research capacity in the areas of disability prevalent in the MS patient community, VA is in a unique position to advance research. For example, ongoing research funded by Rehabilitation Research and Development will impact MS care. Rehabilitation research in dysphasia, physical therapies, dementia, audiology and vision also applies to some or all of this patient population.

In February of 1999, Rehabilitation Research and Development, in collaboration with the National MS Society, Eastern Paralyzed Veterans of America, and Paralyzed Veterans of America, organized a research agenda setting symposium to usher in the beginning of a new focus on applying rehabilitation disciplines to treating and alleviating the symptoms of multiple sclerosis. The proceedings of the symposium were published in September 1999. A collaborative effort to study the sensory impairments (speech, vision, and hearing) affected by MS is currently underway. Other issues to be addressed immediately include coordinating the several registries already in existence, encouraging more “cross talk” and collaboration between disciplines and, ultimately, finding ways to translate research results into accepted clinical protocol.

In FY99, Rehabilitation Research and Development issued a program announcement to guide the rehabilitation field in submitting appropriate proposals in response to this need. Funding for these proposals will begin in FY2000.

**NeuroRehabilitation**

NeuroRehabilitation is a young and exciting science on the cusp of therapeutic breakthroughs which promise to return useful function. For instance, in stroke therapies, patients are often taught adaptive strategies to compensate for paralyzed muscles. However, it has been shown in rat models that forced use of affected areas can actually return useful function to those areas. Research in NeuroRehabilitation stands to benefit many veteran populations with neurologic disorders, including those with spinal cord injuries, multiple sclerosis, Parkinson' disease, or consequences of stroke.
Capitalizing on these opportunities requires coordinating the intersection of basic and applied sciences, a step already taken this year through the development of a NeuroRehabilitation scientific review panel with expertise from both areas.

"Elder Technology"

"Elder Technology" is an application of existing creative technologies and development of new technologies which help overcome the impairment and disabilities associated with aging (i.e., loss of memory, vision, hearing and mobility). "Elder Technology" is a stated priority of the White House Office of Science and Technology Policy. The growing population of older adults will change many aspects of health care. One change will be an increase in the number of people who experience a disabling condition as a result of aging and, consequently, need to use some form of assistive technology. During inpatient rehabilitation, an adult receives an average of eight devices to use at home for dressing, mobility, seating, bathing, grooming, and feeding. Safety monitoring devices for geriatric patients are helping to heal an industry beset by liability costs due to falls and accidents. These problems are not limited to just slipping on floors and tumbling or sneaking out of bed.

Telerehabilitation

Telerehabilitation is an emerging health care delivery tool that uses electronic information and communications technologies to provide and support health care when distance separates the participants. Because of many unresolved questions, there is a need for specific evidence of efficacy/therapeutic, diagnostic impact/cost analysis, and the development of baseline data in many areas of telerehabilitation. Issues of diagnostic/therapeutic efficacy, privacy and security of information transmission, clinical standards and guidelines for practice, technical interoperability of systems and technology, and human resource planning all must be addressed. Statistically significant outcome studies on the effectiveness of telerehabilitation as compared to conventional rehabilitation service delivery models are required.

Neuro-Rehabilitation Robotic Systems

Conventional rehabilitation for sensorimotor impairment includes physical and occupational therapy programs. These require labor intensive individualized exercises with a therapist. Typical exercise activities include manual manipulations of the patient’s limb, either as the patient remains passive or actively assists with the movement. As an alternative clinical intervention, robotic technology may assist the therapist in the rehabilitation of neurological impaired patients.

In April of FY99, Rehab R&D issued three RFPs calling for proposals to: 1) evaluate new and emerging “elder technologies;” 2) conduct studies which systematically and scientifically evaluate existing telerehabilitation applications and/propose demonstration projects for new applications; and 3) evaluate and develop innovative robotic systems for therapeutic application after the onset of neurologic disorders such as multiple sclerosis (MS), stroke, and
traumatic brain injury (TBI). It is anticipated that these studies will be designed to use robotics as training aids, assisting patients to regain the ability to become ambulatory.

In addition to the above initiatives, Rehab R&D Service conducts an on-going investigator-initiated peer review research program. A wide spectrum of research activities includes studies on amputation, spinal cord injury, vision impairment, hearing loss, and other disabilities associated with aging.

Examples of approved studies in 1999 with relevance to impairments that are commonly associated with aging are:

**Stroke**

Stroke is the leading cause of disability among the aging population. Stroke disability persists for life and limits the function and quality of life of stroke survivors. They have significant deficits in building blocks of function, which include strength, balance, and endurance.

*Restoration of Gait in Acute Stroke Patients Using Functional Neuromuscular Stimulation (FNS)*

Conventional rehabilitation post stroke is inadequate to restore safe, independent gait for many stroke patients. The purpose of this study is to determine the efficacy of Functional Neuromuscular Stimulation with implanted electrodes in improving lower extremity motor recovery and gait pattern of acute stroke patients. Preliminary results indicate that patients tolerate the procedure and treatment well. Gains have been noted in impairment and disability measures.

*Coordination of Hemiparetic Movement after Post-Stroke Rehabilitation*

This study will supplement a NIH-funded, randomized clinical trial to evaluate a post-stroke exercise program designed to increase, balance, strength, and endurance of aging veterans. Investigators have developed a therapeutic exercise program that targets functional recovery of aging persons with acute stroke. Pilot data suggest that the intervention improved lower extremity motor recovery and gait velocity following stroke.

*Development of a Quality of Life Instrument for Stroke Survivors*

With recent changes in conflicting approaches of medical and social models of health, the development of new models have yielded to a more integrated biopsychosocial approach in which the measurements of health outcomes have been extended beyond the traditional indicators of mortality and morbidity, to include measures of the consequences of health conditions on daily activities and quality of life. Most generic functional disability and health-related quality of life measures used in rehabilitation and long-term care settings, fail to adequately assess the consequences of communication impairments on daily activity. This study is designed to develop a population-specific quality-of-life-assessment instrument to measure quality of life in stroke survivors whose constructs are
theoretically linked to all relevant domains of functioning, their disorders, and interventions.

**Portable Monitoring of Physical Activity and Depression in Stroke (Telemedicine)**

Physical inactivity worsens cardiovascular risk and can be promulgated by perceived fatigue, as well as depression and including prevalent post-stroke factors linked to poorer activities of daily living (ADL). The study tests the validity and reliability of integrated physiological and kinematic personal status monitoring as outcome measures of community-based physical activity. This study involves testing the validity of using telemedicine instrumentation to accurately monitor the activity levels of this at-high-risk population in the home environment, and to intervene early to encourage adequate levels of physical activity to prevent further deterioration and institutionalization.

**VA Stroke Rehabilitation Outcomes: Barriers to Efficient Performance (Outcomes Study)**

This investigation will study barriers to the delivery of rehabilitation services to VA stroke patients and their effects on rehabilitation outcomes. Significant barrier-outcome associations have been found in several patient groups or health delivery systems: cancer treatment, diabetes control, continuum of care, outpatient and short-stay surgeries, pharmacotherapy compliance, depression, early thrombolytic treatment, spinal pain, and preventive care. Clinicians from multiple disciplines are being surveyed to obtain a composite estimate of barriers to the provision of rehabilitation services. The barriers database will be merged with an existing VA structural database containing a comprehensive array of physical and organizational variables describing the entire Physical Medicine and Rehabilitation Services (PM&RS).

**Video-Based Functional Performance and Assessment Following Stroke (Telemedicine)**

For people who have hemiplegia as a result of stroke, a critical safety-related retraining area for physical functions is wheelchair transfers. To incorporate the relatively unsupervised home care into the rehabilitation process, clinicians require a better means to assess functional gains and provide effective training tools. To fill these two needs, the goal of this project is to develop a personalized training and clinical assessment instrument based on the Video-Based F-PAT (Functional Performance Assessment and Training), which relies on the manipulation of digitized videoclips. An Occupational Therapist will be trained to create the personalized videotapes distributed to patients who undergo acute rehabilitation at the VA Comprehensive Rehabilitation Center and are discharged to their homes or a sub-acute facility. The effectiveness of the personalized training videotapes and the video-based assessment methodology will be evaluated.
Parkinson’s Disease

Parkinson’s disease is one of the most common serious neurological disorders. This disease stems from a loss of dopaminergic neurons in the substantia nigra of the midbrain; this deficit produces a complex disorder of motor function including symptoms of both underactivity (hypokinesia) and overactivity (tremor and rigidity). Clinical depression occurs in up to 50 percent of all Parkinson’s patients.

Transcranial Magnetic Stimulation for Depression in Parkinson’s Disease

Transcranial magnetic brain stimulation appears to be an effective treatment for refractory depression, can replicate the beneficial effects of electroconvulsive therapy more easily and safely, and, with less risk. It may thereby improve both mood and motor performance of patients with Parkinson’s disease. The objective of this project is to explore and develop safer, more effective methods for treatment of Parkinson’s disease and depression, and to improve the utility of transcranial magnetic stimulation as an alternative therapeutic modality.

Motion or Velocity Encoder for Monitoring Essential or Neurological Tremor (Movement)

This study involves the development of software for commercially available palm computers (PDAs) that allows for easy and user-friendly capture of handwriting and of graphical drawings, tracings and tracking in a clinical setting from individuals with Parkinsonian and other neurological tremors or spasms. The captured images can be analyzed to yield various indices of spatial performance and temporal performance that previous investigators have suggested may be potentially valid metrics for quantifying neurological tremor or spasm, and that might change in response to therapeutic intervention. This device is designed to help quantify the effect of pharmacological regimens or evaluate other possible interventions. This device will provide a tool to clinicians to more easily and accurately quantify outcome measures.

Auditory and Visual Impairments

Disabilities in these functional areas increase as the aging process continues and the aging veteran experiences increasing isolation.

Measurement and Prediction of Outcomes of Amplification

The long-term goal of this project is to develop methods whereby clinicians can predict both the benefit and the satisfaction those individual hearing-impaired patients will derive from amplification in daily life.
Evaluation of Treatment Methods for Clinically Significant Tinnitus

Tinnitus is a growing auditory problem among the aging veteran population. In this study, investigators are evaluating two different approaches to the alleviation of tinnitus symptoms by comparing changes from baseline performance on the Tinnitus Severity Index. An unbiased evaluation of competing methodologies is being conducted.

The design is one in which pairs of prospective subjects are randomly assigned to one or two treatment groups. Changes in group performance will be compared for selected measures. Tinnitus is one of several studies being conducted at the Rehab R&D Center of Aural Rehabilitation in Portland, Oregon.

A Measurement of the Efficacy of an Adult Aural Rehabilitation Program

This study will evaluate the effectiveness of providing a hearing aid together with adjunctive aural rehabilitation therapy as compared to providing a hearing aid without aural rehabilitation. An aural rehabilitation program will be evaluated in terms of the improvement in quality of life as measured by disease specific and generic instruments. Differential treatment effects will be evaluated immediately after intervention and at six months and one year post-intervention. The cost-effectiveness of the approach will be evaluated using the Hearing Quality Adjusted Life Years Index.

Veterans with Cataracts: Visual Disability in Nighttime Driving

In this project, investigators propose to evaluate how glare disability associated with various stages of cataract affects veterans' ability to read traffic control devices (TCDs) during nighttime driving. Four groups of veterans with differing stages of cataract will be tested using 1) clinical visual psychophysical measures believed to be sensitive to the effects of glare disability, and 2) engineering-based field experiments to measure subjects' performance in detecting and reading common TCDs. The primary outcome of this study will be a better understanding of veterans with cataract and the disability they experience in nighttime driving under glare conditions. Expected secondary outcomes include improvements in TCD design and more functionally-based classification systems for designating cataracts as "visually significant."

Predictors of Driving Performance and Successful Mobility Rehabilitation in Patients with Medical Eye Conditions

In this study, investigators have collected a large amount of data that demonstrates the significant effects of vision loss on driving and mobility. Glaucoma and diabetic retinopathy are two diseases that are most common among aging veterans. Both diseases can potentially result in significant peripheral visual field loss, sometimes coupled with decreased visual acuity. They also have serious consequences for driving and mobility. Based on this data, predictive models of automotive driving performance and accidents for patients with retinal diseases will be developed. Based on the spe-
cific visual disease, individual predictive models of driving rehabilitation curriculums will be developed as well as training patients to use low-vision aids to improve driving and mobility.

*The Impact of Blind Rehabilitation on Quality of Life in Visually Impaired Veterans*

The VA health care delivery system is currently experiencing many changes as it is being reshaped to provide more efficient and effective services. Assessing the impact that blind rehabilitation has on the quality of life of those receiving it is a way of evaluating the effectiveness of this service that the VA provides. Quality of life factors will be compared before and after rehabilitation for both veterans and their caregivers. Quality of life measures, because they are broadly based, easy to administer, and assess the whole individual may provide the best means of achieving this goal.

*Nutrition and Oropharyngeal Swallowing*

The compromised physiologic, mental, and socioeconomic status of many in the growing aging population in general, and aging veterans in particular, raises the real possibility of malnutrition which, if left unchecked, can quickly become a precursor to greater disability. It is extremely difficult and expensive to treat once progressed, but it can also be preventable and modifiable.

*Nutrition & Clinical Status of Disabled Older Veterans in Long-Term Care*

The primary objective of this study is to identify physiologic problems accompanying nutritional deficiencies manifested by elderly patients receiving rehabilitation services in extended care over time. Data collected will be used to develop an operational definition of "malnutrition." The resulting hypothesis statements will be used in future intervention studies to address this problem. This is one of several other projects on aging currently in progress at the Houston Rehab R&D Center on Aging with A Disability.

*Oropharyngeal Swallowing Function in Normal Adults*

Appraisal of abnormal swallowing (dysphagia) includes separating the stages of swallowing into clearly defined anatomic regions and reporting the time it takes for a bolus to travel from one anatomic region to the next. Unfortunately, few normative data on these duration measures for bolus sizes employed in typical modified barium swallow examinations are available. Data that are available were collected on bolus sizes that are too small for clinical use or include only one consistency. Thus, differentiating normal from abnormal duration measures is not possible for the majority of clinical patients. The proposed study is designed to develop normal values means, ranges, and standard deviations for 11 measures of swallowing duration. Availability of normative data will assist clinicians in determining the presence of a swallowing disorder, specifying severity, focusing treatment, and measuring outcome.
Chronic Obstructive Pulmonary Disease (COPD)

COPD is one of the most common chronic illnesses in the adult population and is the second leading cause of Social Security disability payments. This condition is prevalent among aging veterans with a history of smoking.

Effectiveness of a Home-Based Pulmonary Rehabilitation Program (Telemedicine)

The objective of this project is to determine whether a newly designed home-based pulmonary rehabilitation program is as effective as a more traditional, outpatient, hospital-based program. The underlying goal is to improve the care of veterans with chronic lung disease. Such a home-based program will meet the needs of the rural veteran population and can be readily adapted systemwide. If effective, such a program will increase access to care with more efficient use of resources. Demonstration of the effects of such a program should have implications for the dissemination of pulmonary rehabilitation programs to smaller VA facilities that do not now have the specialists required in traditional, hospital-based rehabilitation programs.

Home-Based Pulmonary Rehabilitation via a Telecommunications System

This study is evaluating a computer-based telecommunications system designed to promote moderate physical activity for pulmonary rehabilitation as an alternative to traditional inpatient or outpatient pulmonary rehabilitation. This Telephone-Linked Computer-based Pulmonary Rehabilitation system (TLC-PR) has many advantages such as: 1) it does not require specialized facilities to administer as the COPD patient can use it at home; 2) it is very low cost; 3) the intervention can be sustained for an indefinite period; and 4) it can be easily disseminated widely as it is transmitted over the telephone. Due to expected lower initial level of fitness, and prior observations that the elderly make more extensive use of other TLC systems, the benefits of TLC-PR may be greatest in elderly veterans.

Dementia

People with dementia comprise a significant part of the total population of older veterans, many of whom are patients in VA nursing homes.

Development and Evaluation of an Activity Monitor for People with Dementia

The objective of this project is to develop and evaluate a wearable activity monitor for older veterans with dementia that will be given to clinicians to use as a means of remotely monitoring patient compliance with prescribed exercise regimens. This monitor will also provide expended energy and range of motion measures, which can be used to quantify improvements in performance and function.
Behavioral and Functional Problems in Dementia Patients with Sensory Loss

This study describes functional and behavioral problems of demented nursing home patients with sensory impairments and analyzes the relationships among cognition, vision, hearing, functional status, and behavioral disturbance. Interventions with the potential to reduce excess disability in self-care functioning and dementia-related behavioral disturbance will be identified. Long-term study results will be used to focus controlled intervention studies. This project is one among several other studies relating to aging, falls, exercise and dementia that are in progress at Rehab R&D Atlanta Geriatric Rehabilitation Center.

Diabetes and Peripheral Neuropathy Falls

Adult onset diabetes is becoming increasingly widespread as the population ages. This is especially true among aging veterans. Patients with peripheral neuropathy experience increased incidences of slips and falls due to decreased somatic sensation as well as decreased motor responses.

Threshold Detection of Postural Control in Diabetic Neuropathy and Aging

This is one of a few studies that focus on how somatic sensory dysfunction contributes to slips and falls among aging veterans. The focus of this study is to compare the acceleration threshold sensitivity differences between persons with diabetic neuropathy and age-matched adult controls. The results will be compared with results from a previous study on young adults. The outcome will be a test consisting of a set of supra-threshold stimuli that can be used to check specific populations for balance deficits without the need for a more complicated device presently in use. This study may assist in developing more effective evaluations and therapies for persons with diabetic and other neuropathies.

Pressure/Motion Feedback To Protect Skin of Sensorimotor Impaired Elders

The objective of this study is to test the hypothesis that a wearable motion analysis and pressure feedback system will help prevent skin breakdown in elderly individuals who need to monitor soft tissue pressure. The integration of motion and pressure sensing will allow for the monitoring of patient compliance with therapeutic pressure-relief regimens. This integrated system will interact with other measurement devices, provide real-time sensory feedback (visual, tactile, auditory) to the user, communicate patient status to a remote clinician, and recognize if it is unused or incorrectly used when the patient is not complying with instructions. Specific parameters will be recorded for each participant.
Orthopedic Footwear CAD/CAM System for Diabetic Pedal Ulceration

This project involves using the latest technology in the automated design and manufacturing of custom orthopedic footwear for diabetic patients.

C. OFFICE OF ACADEMIC AFFILIATIONS

All short- and long-range plans for the Veterans Health Administration (VHA) that address the healthcare needs of the Nation's growing population of elderly veterans include health professional training activities supported by the Office of Academic Affiliations (OAA). Clinical experiences with geriatric patients are an integral part of healthcare education for approximately 91,000 VHA health trainees, including 31,012 resident physicians and fellows, 18,771 medical students, and 42,048 nursing and associated health students. Each year these residents and students train in VA medical centers as part of affiliation agreements between VA and nearly 1,000 health professional schools, colleges, and university health science centers. Recognizing the challenges presented by the increasing size of the aging veteran population, VHA continues to promote, coordinate, and support geriatric education and training activities for physicians, dentists, nurses and other associated health professional trainees.

GERIATRIC MEDICINE

The demand for physicians with special training in geriatrics and gerontology continues because of the rapidly growing numbers of elderly veterans and aging Americans. The VA healthcare system offers clinical, rehabilitation, and follow-up patient care services as well as education, research, and interdisciplinary programs that constitute the support elements required for the training of physicians in geriatric medicine. This special training has been accomplished through the Physician Fellowship Program in Geriatrics from Fiscal Years (FY) 1978 to 1989 and through specialty residency training since FY1990. In FY1999, VA supported 169.8 physicians receiving advanced education in geriatric medicine and 28 physicians receiving advanced education in geriatric psychiatry. VA also supported 6 physicians pursuing post-residency fellowship education in geriatric neurology.

The Accreditation Council for Graduate Medical Education (ACGME) approved geriatric medicine as an area of special competence in September 1987. 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 VAMC may conduct training in geriatrics provided that an ACGME accredited program is in place.

Over the past five years, VHA has restructured its medical residency portfolio and as a result, geriatric medicine positions have increased. In the fall of 1995, the Under Secretary for Health appointed an expert committee, the Residency Realignment Review Committee (RRRC), to advise him about recommended changes
needed to ensure that VHA's graduate medical education programs meet present and future healthcare needs of both VA and the Nation. The RRRC recommended that VHA restructure its 8,900 medical resident positions and increase the percentage in primary care from 38 percent to 48 percent. This realignment of VHA's graduate medical education portfolio will continue VHA's progress in training a greater proportion of generalist physicians while protecting specialties particularly germane to special VHA programs. Geriatric medicine is one of the primary care disciplines that has experienced growth as a result of residency realignment. Geriatric medicine resident positions increased from 104 positions in Academic Year (AY) 1995-1996 to 169.8 in AY 1999-2000. That is a 61 percent increase.

GERIATRIC DENTISTRY

In July 1982, a two-year Postdoctoral Fellowship in Geriatric Dentistry began at five medical centers affiliated with schools of dentistry. The goals of this program were similar to those described for the physician fellowship program in geriatrics. In FY1993, the number of training sites increased to six for a final three-year cycle. As of June 1994, 52 geriatric dentistry fellows had completed their special training. The Postdoctoral Fellowship in Geriatric Dentistry changed in 1994 to the VA Dental Research Fellowship to expand research training for dentists.

The Postdoctoral Fellowship in Geriatric Dentistry proved to be an excellent recruitment source for dentists uniquely trained in the care of the elderly. Graduates have assumed leadership positions in geriatric dentistry at academic institutions, enhanced patient care and other geriatric initiatives in VA facilities, and contributed to geriatric efforts in affiliated health centers and the community. Nationally, former fellows have made significant contributions to the professional literature and are actively involved in geriatric dental research.

Since the change in the Postdoctoral Fellowship in Geriatric Dentistry to the VA Dental Research Fellowships, OAA has initiated individual awards in dental research. Candidates from any VAMC with the appropriate resources may now compete for postdoctoral dental research fellowships.

NURSING AND ASSOCIATED HEALTH PROFESSIONS

Based on its large number of elderly patients, VA offers all affiliated students clinical opportunities in the care of the elderly. VA also has special programs that focus on geriatrics.

INTERPROFESSIONAL TEAM TRAINING AND DEVELOPMENT PROGRAM

The Interprofessional Team Training and Development Program (ITT&D) is a nationwide, systematic educational program that is designed to include didactic and clinical instruction for VA facility practitioners and affiliated students from three or more health professions such as medicine, nursing, psychology, social work, pharmacy, and occupational and physical therapy. The goal of ITT&D is to develop a cadre of health practitioners with the knowledge and competencies required to provide interprofessional team care to
meet the wide spectrum of healthcare and service needs for veterans, to provide leadership in interprofessional team delivery and training to other VAMCs, and to provide role models for affiliated students in medical and associated health disciplines. Training includes the teaching of staff and students in selected priority areas of VA healthcare, e.g., geriatrics, ambulatory care, management, and nutrition; 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.

The ITT&D, which began in 1978, is based at 12 VAMCs: Birmingham, AL; Buffalo, NY; Coatesville, PA; Little Rock, AR; Madison, WI; Memphis, TN; Palo Alto, CA; Portland, OR; Salt Lake City, UT; Sepulveda, CA; Tampa, FL; and Tucson, AZ. During FY1999, 177 students from a variety of healthcare disciplines received funding support at the 12 ITT&D 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 specialty 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 needs in the VA priority areas of geriatrics, rehabilitation, psychiatric/mental health, primary care, medical-surgical 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 and nurse practitioner students for their clinical practice at VAMCs affiliated with the academic institutions at which the students are enrolled. During FY1999, VA supported 499 master's level advanced practice nurse student positions.

VA PREDOCTORAL NURSE FELLOWSHIP PROGRAM

Gerontological nursing has been a nursing specialty since the mid-1960s. Doctoral level nurse gerontologists are prepared for advanced clinical practice, teaching, research, administration, and policy formulation in adult development and aging.

In FY1985, VA initiated a two-year nurse fellowship program for registered nurses who were doctoral candidates and who had dissertations focused on clinical research in geriatrics/gerontology. The first competitive review for fellows was conducted in 1986. One nurse fellow was selected for the FY1986 funding cycle. Since that time, two nurse fellowship positions have been available for selection at approved VAMC sites each fiscal year. In FY1994, the program was changed to the VA Predoctoral Nurse Fellowship Program to include all clinical areas relevant to the care of veterans.
GERIATRIC EXPANSION PROGRAM AND THE GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTERS (GRECC)

A special priority for geriatric education and training is recognized in the allocation of associated health training positions and funding support to VAMCs hosting GRECCs and to VAMCs (non-ITT&D sites) offering specific educational and clinical programs for the care of older veterans. In FY1999, a total of 176 associated health students received funding support in the following disciplines: Social Work, Psychology, Audiology/Speech Pathology, Clinical Pharmacy, Advanced Practice Nursing, Dietetics, and Occupational Therapy.

GEROPSYCHOLOGY POSTDOCTORAL FELLOWSHIP

In FY1993, OAA began a one-year Geropsychology Postdoctoral Fellowship Program. The purpose of the program is to develop a cadre of highly trained geropsychologists who will contribute to the care of the elderly both within and outside VA. This pool of individuals should provide an excellent source of recruitment for future VA psychologists.

One fellow is selected annually at each of the following ten VAMCs: Brockton, MA; Cleveland, OH; Gainesville, FL; Houston, TX; Knoxville, IA; Little Rock, AR; Milwaukee, WI; Palo Alto, CA; Portland, OR; and San Antonio, TX. These VAMCs have strong, geriatric-focused programs and accredited psychology internship programs.

In summary, through its fellowship, residency, and associated health training VA continues to make outstanding contributions to the Nation's health professions workforce and to foster excellence and leadership in the care of elderly veterans.

D. OFFICE OF EMPLOYEE EDUCATION

In support of VA's mission to provide health care to the aging veteran population, education and training opportunities are offered to enhance the skills of medical center employees in the area of geriatrics. The Office of Employee Education through the Employee Education System (EES) works with medical centers, Veterans Integrated Service Networks (VISNs), and Headquarters' program officials to develop educational activities that respond to the needs of healthcare personnel throughout VHA. Funding is provided to the VISNs to support employee education at the local level, to the GRECCs for educational programming, and to program offices for national or systemwide activities.

With assistance from the EES, approximately 40 single medical center programs were conducted during fiscal year 1999. A number of multi-facility and VISN-wide programs were also presented during this time. Topics included Advances in Geriatrics, Quality of Life and the Elderly, Assessment and Treatment of Geriatric Mental Disorders, Geriatric Periodontics, Essentials of Geriatric Nursing, New Concepts: Diagnosis and Treatment of Alzheimer's, Falls in the Elderly, Aging in Men and Women: Current Health Care Issues, and Pharmacology in the Elderly. National or systemwide activities included Domiciliary Clinical Care Conference and programs on Primary Care for the Elderly, and Improving Care at the
End of Life. A national satellite conference on Assessment and Treatment of Geriatric Mental Disorders was broadcast to all VA medical centers.

A major effort during the fiscal year was the ongoing implementation of the Resident Assessment Instrument/Minimum Data Set project. Other emphasis was placed on developing faculty to expand the end of life and palliative care initiative and developing strategies for further implementation.

GRECCs utilized their funding to present training programs on subjects such as Religion/Spirituality and Health; Nutritional Syndromes in the Elderly; Falls and Function; Critical Clinical Issues in the Care of the Older Adult: Bone and Joint Disorders in the Elderly; End of Life Decision Making; Advances in Geriatrics; Aging in Women/Aging in Men; and Promoting Quality of Life for Persons with Advanced Dementia. All GRECCs presented activities that were attended by VA staff as well as providers from universities and the private sector.

E. CHIEF INFORMATION OFFICE

HEALTH INFORMATION RESOURCES SERVICE

The widespread education and training activities in geriatrics have generated systemwide requirements for information throughout VA. Local library services continue to perform hundreds of online searches on databases such as MEDLINE and other bibliographic databases, and continue to add books, journals, and audiovisuals on topics related to geriatrics and aging.

The VHA Satellite Television network carried eleven live broadcasts targeted to providers who work with aged patients. The topics included Stroke Prevention; Pharmacologic Management of Cognitive Changes in Alzheimer’s Disease; Practical Approaches for the Care of Patients with Alzheimer’s; Cox-2 Drugs in the Treatment of Rheumatoid and Osteoarthritis; Erectile Dysfunction in the Elderly Male; Pharmacological Advances in Secondary Stroke Prevention; Excellence in VA Home Care; Osteoporosis; Pharmacologic Advances in the Treatment of Alzheimer’s Disease; and VA Homecare: A New Approach to Advanced Heart Failure.

Additionally, five videos were purchased and distributed systemwide.

III. VETERANS BENEFITS ADMINISTRATION

A. COMPENSATION AND PENSION

Disability and survivor benefits such as pension, compensation, and dependency and indemnity compensation administered by the Veterans Benefits Administration (VBA) provide all, or part, of the income for 1,567,692 persons age 65 or older. This total includes 1,156,080 veterans; 400,717 spouses; 9,761 mothers; and 1,134 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 acknowledgment of the need for economic security of the Nation's oldest veterans. The current amount added to the basic pension rate is $2,037 as of December 1, 1999.

B. OUTREACH

VBA Regional Office personnel maintain an active liaison with local nursing homes, senior citizen homes, and senior citizen centers in an effort to ensure that older veterans and their dependents understand and have access to VA benefits and services.

This liaison is enhanced by VA's Fiduciary Program. VBA Regional Office staff provide oversight in the management of VA benefits paid on behalf of incompetent beneficiaries. Many of these beneficiaries are elderly and have been found to be mentally incapable of handling their financial affairs. This oversight includes appointment and supervision of suitable payees, as well as routine personal visits with the beneficiaries to ensure that their needs are being met.

Generally, regional office staff visit these facilities as needed or when requested by the service providers. VA pamphlets and application forms are provided to the facility management and social work staff during visits and through frequent use of regular mailings. State and Area Agencies on the Aging have been identified and are provided pamphlets and other materials about VA benefits and services through visits, workshops and pre-arranged training sessions. Senior citizen seminars are conducted for nursing home operations staff and other service providers that assist and provide service to elderly patients. Regional office staff regularly participate in senior citizens fairs and information events, thereby visiting and participating in events where the audience is primarily elderly citizens. VBA staff also visit places where senior citizens congregate such as malls, churches, and special luncheons or breakfasts to advise veterans of their benefit entitlements. Regional office outreach coordinators continue to serve on local and state task forces and represent VA as members of special groups that deal extensively with the problems of the elderly.