DRAFT

POSITION PAPER ON GERIATRIC SOCIAL WORK EDUCATION

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Executive Summary/Recommendations:

The National Association of Deans and Directors of Schools of Social Work, along with the New York Academy of Medicine, have undertaken a national strategy to foster resource development to advance social work expertise in working with older adults. Funding from the John A. Hartford Foundation has underwritten this work.

There is a pressing need for training social workers in aging issues. Public sector funding is needed for social work education in gerontology. Educationally relevant service dollars are needed to support strategic initiatives to educate social workers to work with older adults. We seek to explore multiple sources of federal funding to support student stipends, traineeships, loan deferment opportunities, and for resources to strengthen university-community partnerships necessary to provide appropriate education. These public funding initiatives will involve Medicaid and the Centers for Medicare and Medicaid Services, Veteran Affairs, Health Services Research & Development, Administration on Aging, Agency for Healthcare Research and Quality, Area Health Education Centers, National Institute on Aging, Substance Abuse & Mental Health Service Administration, National Institute of Health, and Bureau of Health Professions, Health Resources and Service Administration and the Department of Labor. We urge the development of new public-private partnerships to increase the number of geriatrically trained social workers to improve outcomes for the aging and their families. Specifically recommended are strategies which:

- Expand geriatric funding through the federal sources, along with private foundations, in order to develop best practice models, policies and procedures, which will increase competencies and efficiencies in geriatric social work education and practice.
- Enhance the geriatric sensitive social work education programs that are currently being funded by John A. Hartford
- Maximize incentives for social work students to pursue careers in geriatric social work through curriculum development, training and employment opportunities, and salary compensation.
- Support schools and departments of social work in their building and expansion of specializations in geriatric social work

- Educate the marketplace on the benefits of geriatric social work education and training

- Identify and disseminate model programs (e.g. curriculum and faculty development programs developed by the John A. Hartford Foundation and CSWE)

- Coordinate state and local funding sources around geriatric social work education and training

- Partner with other geriatric education/training professional advocacy organizations (e.g. pharmacists, nursing, physicians, direct care worker organizations)

- Improve research and data collection on the impact of geriatric social workers on care outcomes for the elderly, their quality of life, cost-effectiveness of services

- Address regulatory barriers (e.g. what it means to be a trained social worker in different settings: aging service agency, nursing home, assisted living facility, hospitals, etc.)

- Develop core-competencies (by setting) based upon a results oriented model that could be replicated nationally

Aging and Demographic Trends

America is aging and this growth in the elderly population is well documented. Between 1980 and 2000, the population over age 65 grew by 36%; the number of people 85 and older has doubled and the number of people over 100 has tripled (Administration on Aging, 2000a). Life expectancy in the United States continues to be extended from age 47 in 1890 to age 75.5 in 1993 (Rouche, 1996). This is attributable in part to advances in pharmaceutical therapies and biomedical breakthroughs.

In the next 20 years the population over 65 is expected to grow by 53% (Dill, 2001). Fastest growing of all is the frailest group, those aged 85 and over, whose numbers are expected to triple to 8.8 million by 2030 (U.S. Bureau of the Census, 1996).

The rapid and breathtaking growth of older populations is accompanied by another profound emerging demographic trend. The composition of the American family is changing. As the aging population is growing in the U.S., younger populations are shrinking. According to the U.S. Census Bureau, by 2025, the number of people age sixty to sixty-nine will be expanding at a faster rate than the number of people age 20 to 29 (Centers for Medicare and Medicaid Services, 2002).

This specter of rising numbers of aging populations, who are also living longer, against the backdrop of shrinking numbers of family caregivers, creates what Drucker

(2001) calls the most dominant aspect of the "Next Society". These compounding demographics will "challenge our nation's financial and human resources and enrich traditional notions of old age. They will require more elder qualified health professionals and force our nation to reshape and improve health care delivery to meet the needs of the elderly" (John A. Hartford Foundation, 2002).

These transformational demographic changes will accentuate the gaps in health care, transportation, housing, and social support needs for the aging. This compels the expansion of aging competent professionals who are able to navigate and expedite a highly sophisticated, complex, health care and social service system.

The "Next Society" will demand more efficient systems of care designed to meet the needs of an aging population with disabilities. While hospitalization is increasingly effective in serving those with acute and severe health care needs, those with chronic health disabilities require alternative, less costly and intrusive healthcare systems.

The Olmstead Decision of 1999 requires a system of healthcare that is less institutional and intrusive. The Supreme Court ruled that unjustified institutionalization of people with disabilities is illegal. This act has accelerated the need for assisted living, home or community based health care services, and supports for the elderly (U. S. Department of Health and Human Services, 2002).

When asking social workers about the need for geriatric training, 62% of NASW members indicate that gerontological knowledge is required in their positions (Peterson & Wendt, 1990). More than one third of NASW members work in health care settings where older adults constitute nearly half of their clients (Peterson & Wendt, 1990).

Aging is a quality of life challenge for our nation

- Currently, serious gaps already exist which compromise society's ability to preserve the independence and quality of life for older adults. Needed are affordable, supportive housing, adequate transportation that maintains personal autonomy, wellness programs that enhance the quality of life, integrated services in rural areas, protective services that include temporary emergency shelters, respite care for caregivers, specialized services for disadvantaged minorities (Scharlach, et al., 2000).

- The elderly, especially those with disabilities, require health care services that are flexible and tailored to meet individual needs (Liu, Manton, & Aragon, 2000). Older adults with cardio-vascular disease, mental illnesses, tuberculosis, HIV infection, and other chronic diseases, involve complicated medication schedules that require monitoring, treatment compliance, and specialized intervention models that link these persons to interrelated systems of care. Coordinated, tailored healthcare creates more enhanced quality of life for the aging and their families and lowers costs for government reimbursement programs such as Medicare and Medicaid (Grimier and Gorey, 1998).

- ❖ Timely interventions result in higher quality of life and lower utilization of medical resources in the future (New York Academy of Medicine, 2000). Promoting health and preventing disease among targeted populations such as the elderly, have proven more cost-effective by as much as a factor of ten than prevention initiatives with the general public (Russell, 1993).

***Aging is a long-term care challenge*:**

- ❖ The chronically ill are aging, which has immense financial and workforce implications for our health care system. Chronic illnesses such as diabetes and heart disease affect more than 45% of Americans and account for three quarters of health care expenditures (Hoffman, Rice, & Sung, 1996). Most of the leading causes of morbidity and mortality are now related to chronic diseases (Pawlson, 1994).

- ❖ America's health care and financing systems were designed to address the acute health needs of a society that experienced an explosion of births following World War II (Shortell, Gillies, & Devers, 1995). Managing healthcare outside of acute settings will require an informed, highly trained, and well-developed work force that is competent in age related, chronic, health care management. Research indicates that home and community based programs save money (Liu, Manton & Aragon, 2000).

- ❖ Managed care has accelerated the numbers of aging being discharged earlier from hospitals (Centers for Medicare and Medicaid Services, 2002). When the elderly are discharged from hospitals 'quicker and sicker,' they require more complex and extensive long-term care at home by a host of community care providers (Liu, Manton, & Aragon, 2000).

Aging is a poverty challenge:

- ❖ Many elderly fall below poverty lines and subsequently rely upon Medicaid for their health and mental health care (Matthews, 2000). Accompanying these trends are the rising numbers of elderly Americans without supplemental health insurance, with the poorest of Americans most likely to be uninsured.

- ❖ Elderly persons living in poverty require the management of innovative, cost effective care that maximizes limited resources. Twenty three per cent of the population over 65 comprises Medicaid beneficiaries (Centers for Medicare and Medicaid Services, 2002).

Aging is an intergenerational family support challenge:

- ❖ Family members still provide the vast majority of all eldercare (Administration on Aging, 2000)**.** Historically, much of this care giving has been performed by women, who work to preserve the independence and well being of older parents and relatives while caring for them in frail health (Johnson & Sasso, 2000). The monetary value of time devoted to informal care giving for the elderly in 1997 was estimated at 196

million dollars (Arno, Levine & Memmott, 1999). The number of family members caring for an elderly person more than tripled from 7 million to 22.4 million from 1986 to 1997 (American Association of Retired Persons, 2001). Rather than just being sandwiched in between both dependent children and dependent parents, family caregivers, *especially women*, may be called on to perform multiple care giving roles across two or three generations of "young-old (65+) and "old-old" (85+) relatives, while employed outside of the home.

- Aging is also a cross-generational care giving challenge. In 1997, 3.9 million children were living in homes maintained by grandparents (Bryson & Casper, 1999)

Employment of Social Workers in Geriatric Settings:

The "Next Society" will require a competent and cost-effective workforce with more professionals and paraprofessionals assuming traditional family roles and assisting family members in caring for the elderly than in the past (Administration on Aging, 2001). Social workers will be needed to respond to these challenges.

Social workers safeguard and enhance the quality of life for an aging population:

- Social workers are trained to work with older adults and provide supports and capacity building for family caregivers. Social workers help the aging and their families navigate their way through complex and seemingly impenetrable systems to access needed services (New York Academy of Medicine, 2000).

- Social workers are equipped to monitor effectiveness and appropriateness of health and social services to ensure cost effectiveness (Scharlach, et al., 2000). This strategic work can promote considerable savings in Medicare, Medicaid and out of pocket health care costs. (Beless, 2002).

***Social workers are well trained in case management*:**

- Case management is defined under Section 1915 (g)(2) of the Social Security Act (SSA) as "services that will assist individuals, eligible under the plan, in ongoing access to needed medical, social, educational, and other services. Case management services are often used to foster the transitioning of a person from institutional care to a more integrated setting or to help maintain a person in the community (U.S. Department of Health & Human Services, 1999)." This has the potential of lowering costs for government programs (Beless, 2002).

- Social workers provide medical case management, remove barriers to service, foster collaboration and coordination among professionals, and mobilize services to address gaps in care. Social work case management encompasses more psychosocial, environmental, and ethical considerations than that of other professions (Scharlach, et

al., 2000). This has immense potential for financial savings for the elderly and government programs (Grimier & Gorey, 1998).

- ❖ Social workers provide targeted case management (TCM) defined in Section 1915 (g) of the Social Security Act: "TCM facilitates transition to community services from an institution in order to enable the person to gain access to medical, social, educational and other services (U. S. Department Health & Human Services, 1999)."

- ❖ The elderly receive case management services while still institutionalized, which include advocacy, supportive services and quality of care issues. Social workers serve in this capacity as administrative case managers, a necessary and cost efficient component of the state plan for service delivery (U. S. Department of Health & Human Services, 1999).

- ❖ Managed care requires brief treatment and solution-focused health and mental health interventions. Social workers are adept at intensive and targeted case management responding to the challenges of managed care and the specialized needs of the aging. These are hallmarks of social work approaches (New York Academy of Medicine, 2000).

- ❖ Social work is critical in increasing health care supports and service delivery efficiencies that lower the risk for more costly inpatient and residential care for the elderly (American Association of Retired Persons, 2001). Such efforts reduce duplicated efforts, unnecessary costs and costly re-hospitalization (Scharlach, et al., 2000).

***Social workers are competent service providers for the poor*:**

- ❖ The social work profession has historically served poor, diverse, vulnerable populations, and those without health insurance. Social workers are the largest group of service providers for people who are poor, especially those living in isolated rural areas and inner city populations. Social workers are the backbone for service delivery to Medicaid populations (Berkman et. al., 1996). Often, these populations have inequitable access to services and supports.

- ❖ Social workers are adept at service coordination and the mobilization of tailored approaches to meet the needs of diverse populations of the aging (Council on Social Work Education, 2001).

- ❖ Social workers are especially trained to navigate the Medicaid system and to expedite optimal care in addressing disabilities associated with chronic illness. Along with this, social workers are adept at inter-professional, collaborative practice and managing complex, ethical dilemmas inherent in the care of the elderly, especially those who are poor (Scharlach, et al., 2000).

- The disproportionate morbidity rate for persons of low socioeconomic status with certain diseases accelerates the need for social workers who are responsive to the unique needs of the poor and vulnerable (Council on Social Work Education, 2001).

Social workers are effective in providing meaningful roles and opportunities for the aging

- Social workers foster equitable access to career opportunities and support the elderly who are entering second careers after retirement

- Social workers tap into the abundance of talents, skills and wisdom that the elderly offer as mentors, volunteers and role models.

Social workers are skilled in addressing intergenerational family needs:

- Social workers identify untapped resources in family or social support systems, linking formal and informal health care and related services to the family system.

- Collaborating with other health care professionals, social workers are ready to meet the intergenerational health care needs of the "Next Society" by:

  - Serving as 'navigators' and 'expeditors' enabling older adults and their families to understand and move among the bewildering array of available health and social services (Gerontological Society of America, 2001).

  - Working to create a continuum of care in housing, transportation, and geriatric case management in urban, suburban and rural environments

  - Addressing the needs of culturally, ethnically and racially diverse families and being culturally competent in service delivery and case management

  - Providing optimal mental health, substance abuse treatments and health supports for the elderly and their families

  - Fostering safety and preventing neglect, self-neglect and abuse among the elderly

  - Promoting care in the least restrictive environment including in-home medical and end of life care

  - Linking the role of nutrition, exercise, and self-care in successful aging

  - Creating technology based services for the aging and their caregivers

Research on the Effectiveness of Social Workers in Geriatric Settings

Social workers demonstrate cost-effective interventions and improved outcomes in serving the aging and their families (Scharlach, et al., 2000; Grinier & Gorey, 1998;Gorey, 1996). Professional social workers are poised to be leaders in medical case management, family capacity building, in delivering home and neighborhood-based services, and coordinating disparate services.

Barriers to Training, Educating and Employing Geriatric Social Workers

Currently the need for trained social workers is projected to grow at a higher rate than for other many other professions. In the next ten years the projected need for social workers will require a 30% increase in our graduates (U.S. Department of Labor, 2002). Since 1995, Schools of Social Work are graduating about 15,000 MSWs and 12,000 BSWs each year (Council on Social Work Education, 2001). This rate has not changed significantly since 1995. Thus, absent a major workforce development campaign and educational resources to support the required 30% increase in graduates, the shortages in geriatric social workers will be especially acute as well as costly.

Three main barriers and obstacles have been identified in attracting students to geriatric social work: inadequately trained faculty, lack of geriatric infused curricula, and financial incentives. When these barriers are creatively and competently addressed, student interest rises (Lubben, et. al., 1992).

- *Academic Barriers*:

Social work educators report that geriatric education programs are loosing interested students and faculty due to a lack of grant support for aging related programs (Dawson & Santos, 2000). They also cite fiscal restraints as a major barrier to recruitment of faculty experts in aging and a barrier to the development and offering of new courses (Damron-Rodriquez et al., 1997).

The majority of BSW and MSW educational programs provide little or no direct infused gerontology content (Scharlach et al., 2000). Only 2.7% (938) of the nearly 35,000 students pursuing social work degrees select an aging concentration (Lennon, 1999).

Schools and Departments of Social work have few full time geriatric social work trainees in field practica. Lack of trainee funding for first year MSW placements is the primary reason (Dawson & Santos, 2000).

- *Financial Barriers:*

Financial support for curricular enhancements, education and training have been significantly limited due to budget cutbacks. For example, an important source of stipends for training was the Administration on Aging, which distributed nearly $80 million between 1966 and 1984 to 185 colleges to support the development of aging curricula and training (Peterson, 1987).

Strategies for Future Action

Creating and maintaining an efficient and effective workforce that will serve older adults is an immediate responsibility for schools of social work, government programs, private funders and community partners. The workforce shortage will be acute if the public and private sectors do not respond in a timely manner. The following strategies will be needed in order to achieve these goals:

- Supporting schools and departments of social work in their building and expansion of specializations in geriatric social work
- Educating the marketplace on the benefits of geriatric social work education and training
- Identifying and disseminating model programs (e.g. curriculum and faculty development programs developed by the John A. Hartford Foundation and CSWE)
- Coordinating state and local funding sources around geriatric social work education and training
- Partnering with other geriatric education/training professional advocacy organizations (e.g. pharmacists, nursing, physicians, direct care worker organizations)
- Improving research and data collection on the impact of geriatric social workers on care outcomes for the elderly, their quality of life, cost-effectiveness of services
- Addressing regulatory barriers (e.g. what it means to be a trained social worker in different settings: aging service agency, nursing home, assisted living facility, hospitals, etc.)
- Developing core-competencies (by setting) based upon a results oriented model that could be replicated nationally
- Building partnerships between public and private sources

Private Sector Initiatives

Dramatic beginning efforts have been made to address the gap in gerontoloical social workers. Through funds from the John A. Hartford Foundation, historic investments have been made in social work education. This includes the preparation of social workers for geriatric social work leadership roles and the facilitation of competencies for graduate and undergraduate level social work students to work with the aging and their families. Over 24 million dollars have been expended from the John A. Hartford Foundation to launch this capacity building investment. Hearst Foundation endowments of over $ 2,500,000 in geriatric social work education along with $30 million from other private sources have helped to reinforce this workforce development initiative. These private sector funds have shown that social work students do pursue careers in geriatric social work when incentives, training and educational supports are made available.

The John A. Hartford Foundation (www.jhartfound.org) has been able to reach over seventy schools and departments of social work with funds to advance relevant curricula and to provide stipends for students in over eleven schools. This private sector investment has demonstrated a profound readiness to invest in schools and departments of social work to focus resources and student interest in geriatric social work. The time has come to ensure that workforce development resources are maximized to address the most vulnerable elders and their families.

Public Sector Resources

I. Medicaid and Geriatric Social Work Education

An estimated 3 billion dollars are spent annually for graduate medical education (GME) through Medicare/Medicaid funding (Henderson, 2000). States have discretionary authority on how this money is spent, with the current bulk of the funds going to educate physicians (Henderson, 2000). A study conducted for the New York Academy of Medicine and the NADD Gerontological Task Force revealed that few of these funds are going to allied health professions and none are going for social work education (Behrman, 2002). Currently Medicare/Medicaid funding for physician education is channeled through teaching hospitals, and less frequently to educational institutions. States like Utah are examining ways to expand medical education funding through Medicare/Medicaid to include nurses and social workers (Behrman, 2002).

Medicare/Medicaid funds used for training and educating professional healthcare workers advance and improve the care and treatment of Medicaid patients (Henderson, 2000). Clearly the goals of geriatric social work fit squarely with the goals of Medicaid funded services, education and training.

Linking Workforce Development with Medicaid:

Payments for social work education can be awarded in support of case management and targeted case management for Medicaid populations. Medicaid payments can also be made which address the following specific public policy objectives:

- In the provision of primary health care in the communities
- Addressing the need for an adequate distribution of health professionals in all geographic areas across the state
- For specialists, where shortages or problems of health care access for Medicaid populations exist
- In the treatment of specific patient groups. For example:
    - ✓ Disabled adults (almost half of Medicaid spending)
    - ✓ Elderly (Medicaid pays for 2/3 of all nursing home care)
    - ✓ Grandparents raising children in home care
    - ✓ Medicaid eligible elderly and their families with mental health, substance abuse and related health care needs

Strategies:

Schools/departments of social work are encouraged to work with representatives of county, state and federal regions to advance a Medicaid financing strategy. A similar strategy has been undertaken to advance the child welfare work force. The following options are available in pursuit of Medicaid funding:

I. The first is to expand Graduate Medical Education (GME) and allied professional funding. Even though the federal *Centers for Medicare and Medicaid Services* (CMS), formerly known as Health Care Financing Administration (HCFA), has made it easier for states to test certain innovations under their Medicaid managed care programs, federal approval remains cumbersome for states that want flexibility and incentives to distribute GME payments to non-hospital training programs and to pay for training of non-physicians. CMS has no explicit guidelines on how state Medicaid programs should or could pay for GME (Henderson, 2000). Instead, CMS's response to states' request is based largely on its rules linking reimbursement to Medicaid service use and policies governing Medicare GME payment (Henderson, 2000).

II. The second is to explore access to Medicaid funding based on a strategy, which compliments the maximization of IV-E to fund Social Work education for public child welfare practice. To access Medicaid administrative support for university based training of individuals intending, or already working with the elderly, public universities would enter into interagency agreements with the state Medicaid agency, describing the health related education being offered. For example, masters or undergraduates in social work for students specializing in geriatric social work could be funded. In this process, public universities would provide their federally approved indirect rate as part of the total cost of the training or educational program spelled out in the interagency

agreement. The Medicaid agency would reimburse the university for the federal share of the Medicaid portion of the program. The Medicaid federal share would be determined by calculating the proportion of the educational program reasonably related to the Medicaid program. This calculation is usually based on the proportion of Medicaid clients the student is or will be serving upon completion of the health related course of training.

Case example:
If the direct cost of the training program were $100,000 and the federally approved university indirect rate was 40%, the total cost of the training would be $140,000. If students would be working with a geriatric population that was 70% Medicaid eligible, the federal Medicaid program's proportionate share of the program would be $98,000. Federal Medicaid funding would be available for half of that cost, or $49,000. In this instance 49% of the direct cost of the training would be supported with federal Medicaid funds.

III. The third is to explore access based on a strategy that would fold the cost of training into the Medicaid rate being paid for medical service. If the rate of federal financial participation for Medicaid supported services in the state was 60%, and 70% of the clients being served by the program were Medicaid eligible, as in the above illustration, the federal participation for a training program costing $140,000 would be $58,800. States having a federal financial participation rate for Medicaid supported services in excess of 50% should consider this option.

II. Department of Veteran Affairs

(http://www/ahrq.gov/fund/funding.htm)

A. *Veteran's Administration Office of Academic Affiliations* (http://www.va.gov/oaa/AHE_EdOpportunities.asp)

Title 38 mandates the VA to assist in the training of health professionals for its own needs and those of the Nation. Approximately 45,000 students and trainees in associated health education programs at the undergraduate, graduate and post-graduate levels, receive clinical experience at the VA facilities. Student funding support of $38.8 million is provided each year. For additional information contact the Education Office or the Clinical Discipline Office at the desired VA facility.

1. Forty five Geriatric Assessment Stipends of 500 hours each
2. Three hundred forty MSW student stipends at VA centers annually
3. Five hundred fifty seven stipends for MSW programs @ $4,112 each

B. *Post Masters & Pre-doctoral Fellowships & Funded Programs* (http://www.va.gov/oaa/AHE_EdOpportunities.asp

1. Geriatric & GRECC Expansion Program

This program provides training grants targeted to the 16 Geriatric Research, Education and Clinical Centers (GRECC) hosted at 18 VA Centers.

2. Pacific Center for Post-Traumatic Stress Disorder
   Funding support for doctoral students with clinical and research expertise in this area. Fellowship takes place at the Honolulu, Hawaii VA Center

3. Social Work Pre-Doctoral Fellowship
   Training support for two students at $17,000 for one fiscal year, who have completed their advanced course work and are at the dissertation stage of their doctoral studies. Dissertation topics must be in the area related to the VA patient population.

4. Substance Abuse Clinical Fellowship
   Interdisciplinary approach for substance abuse treatment models to develop knowledge and competencies to meet the needs of veteran patients; to develop, implement, and evaluate substance abuse treatment models that result in positive patient outcomes; and to provide leadership in developing an educational model which emphasizes an interdisciplinary approach for the care and treatment of substance abuse patients. Funding supports eight one-year graduate fellowships at two VA centers in Dallas, TX and Seattle, WA.

5. Summer Traineeships
   Concentrated clinical experience at VA hospitals; 500 hours @ $6.00 per hour

6. Primary Care Education Program for Associated Health Trainees (PRIME)
   Conduct research related to planning, organization, staffing, financing, management, utilization and evaluation of VA health services delivery. Sixty nine VA centers have received funding support for medical residents and associated health students

C. ***Translating Research into Practice (TRIP) Program Announcement (PA)* (http://www/ahrq.gov)**
This is a collaborative effort between Health Service Research & Development Service (HSR & D) within the VA and AHRQ. Applicants are invited to conduct research and evaluation projects related to the translation of research findings into measurable improvements in quality, patient safety, health care outcomes and cost, use and access. An explicit focus on testing effective strategies for translating research into practice is a priority for PA sponsors.
PA Number: PA-02-066

D. ***VA funded Research & Capacity Building Program***
(**http://www.hsrd.research/funding/application/guidelines/ch1.cfm**.)
This program funds a Nursing Research Initiative (NRI) that could be a model for social work funding; based upon scientific merit review and program relevance.

E. ***Interdisciplinary Team Training Program (ITTP)***
(http://www.hsrd/research/va.gov/for_healthcare_professionals/
This multidisciplinary approach studies the effect of social factors, organizational structures and processes, technology and human behavior on healthcare access, quality, costs and outcomes. How to organize, deliver and finance healthcare that is effective to meet the needs of Veterans and to ensure that their healthcare system provides the highest quality of care.

Three funding mechanisms:

1. Investigator-Initiated Research (IIR): enables social scientists to pursue career goals while advancing HSR & D research and contributes to the quality, effectiveness, efficiency of VA healthcare.

2. Special Solicitations: posted on HSR & D's web page that refer to particular research priorities and opportunities within the IRR program

3. Services-directed research: posted on HSR & D's web page to address specific research and development identified in VA Central Office

F. ***Handbook 1200***
(**http://www.hrsa.research/funding/application/guidelines/ch1.cfm**.)
Handbook 1200 presents the policies and procedures regarding investigator requirements, application procedures and review policies.

III. Health and Human Service (HHS) Grants:

(http://www.hhs.gov/grantsnet/roadmap/index.html)

Note: All HHS press releases, fact sheets and other press materials are available at **http://www.hhs.gov/news.**

There are several divisions and departments that offer funding opportunities within this federal government office. Mechanisms for retrieving information are as follows:

Federal Grant Retriever

(http://www.idimagic.com/htmls/grants/93824)
Access to government grants and loans through the Basic/Core AHEC

(http://www.fedmoney.org/grants/93969-00/html)
Grants for Geriatric Center Education Center to support the development of collaborative arrangements involving several health professions schools and health care facilities

(http://www.hrsa.gov/bhpr/grants2002)
A free online resource on all government student financial aid programs
Detailed information about 130 loans and grants for education

The Grant Application Form (PHS-398) is available online from the National Institutes of Health Grants Web site at the following URL:

http://grants.nih.gov/grants/funding/phs398/phs398.html

What follows is a description of HHS resource opportunities by department.

A. ADMINISTRATION ON AGING (AoA)

(http://www.aoa.gov)
Title IV of the Older Americans Act of 1965 authorizes funds to train personnel in the field of aging, improve knowledge of the problems and needs of the elderly, and to demonstrate better ways of improving the quality of life for the elderly. Funds may be used to increase the availability and accessibility of training and education programs in the field of aging and to conduct activities for the development of knowledge to improve the circumstances of the elderly. Grants may be made to any public or private nonprofit agency, organization or institution. Project funding is estimated at $22,000,000. The range of financial assistance is from $50,000 to $800,000 with an average award of $200,000.

Mail: Office of Program Development
Administration on Aging
Department of Health and Human Services
330 Independence Avenue, SW
Wilbur Cohen Building Room 4737
Washington, DC 20201
202-619-3032

1. National Family Caregiver Support Program (NFCSP)

These grants support states that work with area agencies on aging and community service providers to better serve caregivers who are struggling to care for their loved ones while holding jobs and juggling other responsibilities. Services provided include information and assistance, counseling, support groups and training, respite services so that the caregiver can get a short break when needed, and supplemental services that complement care provided by informal caregivers. The program also assists grandparents raising grandchildren and older individuals providing care to children with mental retardation and developmental disabilities.

The grants are part of the National Family Caregiver Support Program, which is administered by HHS' Administration on Aging (AoA). Created in 2000 under the Older Americans Act, the program also provides grants for innovative caregiving programs and support for Native American elders. For fiscal year 2002, the program received an appropriation of $141.5 million, a $16.5 million increase from the previous year's funding.

In fiscal year 2001, HHS released the first grants to states under the National Family Caregiver Support Program, and awarded $6 million for 34 innovative

caregiver grants and $5 million for a new program to serve caregivers of Native American elders. AoA also is developing a national awareness campaign on the increasing role that caregivers play in the lives of all Americans and to inform them of services available in their communities through this important program.

The chart below shows the list of state and territorial allocations under the grant program for fiscal year 2002 for the National Family Caregiver Support Program. More information on this program is available at *http://www.aoa.gov/carenetwork/default.htm*.

National Family Caregiver Support Program
FY 2002 Funding Allocations for States

State / Territory	Allocation	State / Territory	Allocation
Alabama	$1,981,897	Nevada	710,033
Alaska	639,540	New Hampshire	639,540
Arizona	2,320,088	New Jersey	3,945,892
Arkansas	1,293,789	New Mexico	703,918
California	12,565,808	New York	8,617,843
Colorado	1,418,946	North Carolina	3,302,337
Connecticut	1,696,988	North Dakota	639,540
Delaware	639,540	Ohio	5,318,148
District of Columbia	639,540	Oklahoma	1,574,594
Florida	10,010,315	Oregon	1,566,744
Georgia	2,640,289	Pennsylvania	6,922,703
Hawaii	639,540	Rhode Island	639,540
Idaho	639,540	South Carolina	1,634,941
Illinois	5,306,083	South Dakota	639,540
Indiana	2,642,469	Tennessee	2,400,144
Iowa	1,582,515	Texas	7,036,233
Kansas	1,280,796	Utah	654,210
Kentucky	1,733,057	Vermont	639,540
Louisiana	1,775,420	Virginia	2,708,331

Maine	641,505	Washington	2, 338,463
Maryland	2,074,464	West Virginia	967,450
Massachusetts	3,097,579	Wisconsin	2,504,545
Michigan	4,283,931	Wyoming	639,540
Minnesota	2,122,742	American Samoa	79,943
Mississippi	1,180,697	Guam	319,770
Missouri	2,646,862	Northern Marianas	79,943
Montana	639,540	Puerto Rico	1,399,720
Nebraska	831,605	Virgin Islands	319,770
		Total:	**$127,908,000**

The AoA is the federal agency dedicated to policy development, planning and the delivery of supportive home and community-based services to older persons and their caregivers through the national aging network of state and local agencies on aging, tribal organizations, service providers and volunteers.

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- **For further information, contact: Moya Benoit Thompson or Chris Rhatigan (202) 401-4541**
    - **Requests for information about aging issues and programs should be directed to http://www.aoa.gov/aoa/aoamail.html.**
    - **Comments about the AoA Web Site may be directed to http://www.aoa.gov/aoa/sgmail.html.**
    - **Access: Assistance for Persons with Disabilities in Accessing this web site**

Other Important Features of NFCSP:

The Older Americans Act Amendments of 2000 also establishes the Native American Caregiver Support Program, with $5 million of the $125 million designated to assist caregivers of Native American elders who are chronically ill or have disabilities. In addition, $6 million of the $125 million will be used to fund competitive innovative grants, grants of national significance, conferences and training, to further develop comprehensive and effective systems of support in family caregiving. AoA will issue a request for proposals in the Spring of 2003.

The National Aging Network:

Under the authority of the Older Americans Act, AoA works closely with the national network of aging organizations to plan, coordinate, and provide home and community-based services to meet the unique needs of older persons and their caregivers. AoA's aging network includes: 56 State Units on Aging, 655 Area Agencies on Aging (AAA), 225 Tribal and native organizations representing 300 American Indian and Alaska Native Tribal organizations and 2 organizations serving Native Hawaiians, plus thousands of service providers, adult care centers, caregivers, and volunteers.

Who to Contact for Help:

The local AAA is one of the first resources a caregiver should contact when help is needed. Almost every state has one or more AAA, which serves local communities, older residents, and their families. (In a few states, the State Unit or Office on Aging serves as the AAA.) Local AAA's are generally listed in the city or county government sections of the telephone directory under "Aging" or "Social Services."

For more information on the implementation of the NFCSP in a particular state, contact the State Unit on Aging. Contact information for State Unit on Aging staff is available at: http://www.aoa.gov/aoa/pages/state.html.

B. AGENCY FOR HEALTHCARE RESEARCH & QUALITY (AHRQ) (http://www.ahrq.gov/fund/grantix.htm)

AHRQ's research projects examine the availability, quality, and costs of health care services; ways to improve the effectiveness and appropriateness of clinical practice, including the prevention of disease; and other areas of health services research, such as services for persons with HIV infection. AHRQ uses mechanisms of grants, cooperative agreements, and contracts to carry out research projects, demonstrations, evaluations, and dissemination activities.

AHRQ also supports small grants, conference grants, and training through dissertation grants and National Research Service Awards to institutions and individuals. AHRQ provides an on-line database of funded grants (GOLD) http://www.gold.ahrq.gov

The vast majority of AHRQ grants and cooperative agreements are investigator-initiated. Areas of specific interest for grants and cooperative agreements are announced in the *NIH Guide for Grants and Contracts*. These may be areas of ongoing interest identified in program announcements (PAs) or targeted one-time activities identified in requests for applications (RFAs).

Financial Mechanisms

Public and private nonprofit entities and individuals are eligible to receive AHRQ grants (and both nonprofit and for-profit organizations may apply for cooperative agreements). A grant is a financial mechanism for providing discretionary funds and/or direct assistance to carry out approved research activities.

When a grant is awarded, no substantial Federal involvement with recipients is anticipated during performance of the research activity. A cooperative agreement is a type of grant; however, with this mechanism, a substantial Federal scientific and programmatic involvement with the awardee(s) is anticipated during performance of the project.

Grants Process

AHRQ announces research grant opportunities through program announcements (PAs) and requests for applications (RFAs). A PA is a formal statement that invites applications on new or ongoing research activities, usually with multiple application receipt dates. An RFA is a formal statement that invites grant or cooperative agreement applications in a well-defined scientific area, with one application receipt date.

Grant applications are reviewed for scientific and technical merit by a peer review group with appropriate expertise. Funding decisions are based on the quality of the proposed project, availability of funds, and program balance.

Select for a list of current AHRQ Research Grant Opportunities (PDF file, 14 KB), including program contacts. Potential applicants should refer to the relevant announcement(s), or contact the appropriate program contact, for information such as eligibility requirements, mechanism of support, research objectives, application procedures, and review considerations.

The AHRQ Grants Management Officer is responsible for all aspects of business management related to the award and administration of research grants. Inquiries should be directed to:

Mable L. Lam
Grants Management Officer
Telephone: (301) 594-1844

AHRQ awards disability and minority supplements to ongoing grants that have at least 2 years of committed support remaining in the project period. These supplements are used to train and provide health services research experience to persons with disabilities or to minorities, or to work on minority health issues. For more information, principal investigators should contact their Federal project officer, or the Grants Management Officer.

Information and Applications

The Grant Application Form (PHS-398) is available online from the National Institutes of Health Grants Web site at the following URL:

http://grants.nih.gov/grants/funding/phs398/phs398.html

PHS 398 forms and instructions are available in Adobe® Acrobat® (PDF) format.

AHRQ grant application kits, including all currently active requests for applications (RFAs) and program announcements (PAs), may be obtained from the AHRQ Publications Clearinghouse:

AHRQ Publications Clearinghouse Telephone: 800-358-9295
P.O. Box 8547
Silver Spring, MD 20907-8547
AHRQ grant announcements are available from AHRQ's InstantFAX, a fax-on-demand service that operates 24 hours a day, 7 days a week, and is accessible to anyone using a fax machine equipped with a touch tone telephone handset. Call (301) 594-2800, push "1," and then press the fax machine's start button for instructions and a list of currently available announcements.

AHRQ grant application kits, including all currently active RFAs and PAs, may be obtained from the AHRQ Publications Clearinghouse. E-mail: ahrqpubs@ahrq.gov

C. CENTERS FOR MEDICARE & MEDICAID (CMS)

(formally the Health Care Financing Administration) administers the Medicare and Medicaid programs, which provide health care to America's aged and indigent populations, about one in every four Americans.

1. REAL CHOICE SYSTEMS CHANGE GRANTS

http://www.cms.hhs.gov/realchoice

These systems change grants represent a major new initiative to promote the design and delivery of home and community-based services that support people with a disability or long term illness to live and participate in their communities. Congress and the Administration have made $50 million available for this initiative.

Medicaid home and community-based services play an increasingly critical role in enabling individuals of all ages who have a significant disability or long term illness to live fuller, more self-directed lives in their own homes and communities than ever before. Despite continuing progress on this front, however, States

wishing to improve the availability and quality of these services still face significant challenges. Accordingly, Congress and the Administration have envisioned a new grant program to assist States and the disability and aging communities to work together to find viable ways to expand such services and supports. The new grant funds are meant to be used to bring about enduring system improvements in providing long-term services and supports, including attendant care to individuals in the most integrated settings appropriate to their needs.

The "Starter Grants" represent the first grant opportunity under the Real Choice Systems Change initiative. Details of the "Starter Grants" and the four future grant solicitations, that we collectively refer to as the "Systems Change" grants, are further described in the Questions and Answers document.

Background on Systems Change Grants

http://www.cms.hhs.gov/systemschange/background.asp

On May 22, 2001, CMS invited proposals from States and others in partnership with their disability and aging communities, to design and implement effective and enduring improvements in community long term support systems. Grant applications were due in July 2001.

Federal Register Notice of Grant Opportunities. HCFA-2125-N "Medicaid Program: Infrastructure Grant Program to Support the Design and Delivery of Long Term Services and Supports That Permit People of Any Age Who Have a Disability or Long Term Illness to Live in the Community"-- Published in the Federal Register on May 22, 2001 PDF 354KB

These grants are intended to foster the systemic changes to enable children and adults of any age who have a disability or long-term illness to:

a. Live in the most integrated community setting appropriate to their individual support requirements and their preferences;

b. Exercise meaningful choices about their living environments, the providers of services they receive, the types of supports they use and the manner by which services are provided; and

c. Obtain quality services in a manner as consistent as possible with their community living preferences and priorities.

In this invitation States and other eligible entities competed for four different types of grants.

- "Nursing Facility Transitions" grants: To help States transition eligible individuals from nursing facilities to the community. Two types of grants were offered: State Program grants to support State program initiatives;

"Independent Living Partnership" grants to selected Independent Living Centers (ILCs) to promote partnerships between ILCs and States.

- "Community-integrated Personal Assistance Services and Supports" grants: To improve personal assistance services that are consumer- directed and/or offer maximum individual control. Personal assistance is the most frequently used service that enables people with a disability or long term illness to live in the community.
- "Real Choice Systems Change" grants: To help design and implement effective and enduring improvements in community long term support systems to enable children and adults of any age who have a disability or long term illness to live and participate in their communities.
- "National Technical Assistance Exchange for Community Living" grants: This national technical assistance initiative will provide technical assistance, training, and information to States, consumers, families, and other agencies and organizations.

Additional background information on the Systems Change Grants is also available on the CMS web site at: http://cms.hhs.gov/realchoice

D. HEALTH RESOURCES AND SERVICE ADMINISTRATION (HRSA)

http://hrsa.gov/releases/2002releases/geriatrics.htm

The Health Resources and Services Administration (HRSA) has announced new grant awards of $5.3 million to improve the ability of health professionals to better diagnose and treat elderly Americans. The grants are funded under two programs administered by HRSA's Bureau of Health Professional.

http://www.hrsa.gov/grants.htm

1. Bureau of Health Professionals (BHPr)

(http://www.bhpr.hrsa.gov)

HRSA Bureau of Health Professions programs help to assure access to quality health care professionals in all geographic areas and to all segments of society. BHPr puts new research findings into practice, encourages health professionals to serve individuals and communities where the need is greatest, and promotes cultural and ethnic diversity within the health professions workforce.

The Bureau of Health Professions has validated two approaches to health professions training that significantly increase the number of graduates choosing careers caring for underserved people:

- Increase the diversity of health professions students

- Focus on the primary care disciplines and expose students early and throughout their training to clinical practice in underserved areas.

2. National Health Service Corps

Awards 89.4 million in scholarships and loan repayments to students who take jobs in rural underserved areas

1. 900 Loan repayment awards
2. 400 continuing scholarship awards

How to apply:
(http://www.bhpr.hrsa.gov/nhsc)
or call: 1-800-221-9393

Who We Are
A unique group of dedicated and caring clinicians providing primary health care to adults and children in the communities of greatest need across the Nation.

Why We Are Here
Approximately 53 million people live in communities without access to primary health care.

At NHSC, we are working to change this by helping medically underserved communities recruit and retain primary care clinicians, including dental and mental and behavioral health professionals, to serve in their community.

The **NHSC Opportunities List** provides information on communities that are currently recruiting primary care clinicians. The identification of sites and vacancies is an ongoing process for the NHSC. The Opportunities List is updated on a weekly basis. *This list is not exclusive to individuals participating in the NHSC Scholarship and Loan Repayment Programs.*

- Are you an NHSC Scholar?
- Are you interested in the NHSC Loan Repayment Program?
- Are you interested in employment opportunities in a community that needs your help?

NHSC Loan Repayment Program

The 2002 application cycle for the NHSC LRP is now closed. Applications received by the NHSC, with a postmark on or before March 29, 2002 will be reviewed and those applicants notified of their status. These notifications are

expected to be mailed in July. To view a list of sites (with HPSA scores) that will be used in determining awards for the 2002 NHSC LRP and to learn more about the process, visit the 2002 NHSC LRP page.

You can learn more about the NHSC and our LRP by visiting the Get Involved section of the web site. You can also access the Fiscal Year (FY) 2002 Applicant Information Bulletin (AIB) for information on this year's award process. Please note that the FY 2002 AIB only describes the policies and procedures in place for FY 2002. Information on next year's eligibility, application and award process will be available by October 2002. Check this Web site for updates.

NHSC Scholars

NHSC Scholars are required to serve their commitments in health professional shortage areas (HPSAs) of greatest need. Therefore, not all NHSC vacancies are approved practice sites for NHSC Scholars. If you are an NHSC Scholar looking for an approved practice site, you must select the "NHSC Scholarship Opportunity" option. This will display only the approved practice sites for NHSC Scholars. The words "this site eligible for a NHSC Scholar" will appear in red on the site data form that appears when you click on a vacancy.

The identification of NHSC approved practice sites for NHSC Scholars is an ongoing process, and the listing is updated weekly. However, NHSC Scholars should pursue employment at sites that interest them immediately because there will be fewer sites from which to choose as the cycle progresses.

The sites on our list are not exclusive to NHSC Scholars. The sites are on our list because they have a vacancy to fill. Scholars should be aware that they are competing for these opportunities with non-NHSC clinicians. Information on how to conduct an effective interview/site visit can be found in the Career Information section of the NHSC Online Resource Manual.

NOW AVAILABLE:

- FY 2002 Practice Selection and Assignment Bulletin For Physicians
- FY 2002 Rolling Practice Selection and Assignment Bulletin for Physician Assistants, Certified Nurse-Midwives, and Nurse Practitioners

Looking for employment opportunities in underserved communities?

The NHSC Opportunities List is not exclusive to NHSC Scholars and those interested in the NHSC Loan Repayment Program. They are on our list because they are looking to recruit health professionals dedicated to serving underserved populations. Please contact these sites directly if you have an interest.

3. Geriatric Education Center (GEC)

GEC grants are made to accredited health professions schools, programs that train physician assistants and schools of allied health. Since 1985, 375,000 health professionals have received training in geriatrics through the Centers. Geriatric Education Centers:

- Improve the training of health professionals in geriatrics
- Provide geriatric residencies, traineeships and fellowships
- Develop and disseminate curricula on the treatment of health problems in elderly individuals
- Train and re-train faculty to provide instruction in geriatrics
- Support continuing education for health professionals who provide geriatric care
- Provide clinical geriatrics training in nursing homes, chronic and acute care hospitals, ambulatory care centers and senior centers

Geriatric Education Centers provide services to and foster collaborative relationships among health professions educators (organizations and institutions that sponsor formal and informal educational programs and activities for faculty, students and practitioners) within defined geographic areas (states, counties, metropolitan areas or portions thereof). Geriatric Education Centers strengthen multidisciplinary training of health professionals to diagnose, treat and prevent disease and other health problems that older people face.

Funding History
In FY2000, 34 Geriatric Education Centers were awarded a total of $7.4 million. The average first year award averaged $100,000 for a single institution; $150,000 for a consortium of three or more institutions.

Program Links
Find links to Geriatric Education Center Web sites and contact information at the National Association of Geriatric Education Centers (not a federal site).

FY 2001 GEC Directory includes program addresses and contact information (Adobe Acrobat - Get the free Reader)

Publications
***A National Agenda for Geriatric Education: White Papers*.** (Adobe Acrobat - Get the free Reader)

Guide to Resources of the Geriatric Education Centers. A list of written materials, electronic multimedia resources and presentation packages developed by the 26 Geriatric Education Centers supported by HRSA Bureau of Health

Professions grants. Section I includes resources listed alphabetically by topics, ranging from Adult Education and Advocacy through Nutrition and Oral Health to Substance Abuse and Women's Health. Section II includes resources listed by the Centers at which they were developed. (Adobe Acrobat - Get the free Reader)

Pipeline, monthly national newsletter of Geriatric Education Centers (not a federal Web site)

4. The Community Access Program (CAP)

http://www.bphc.hrsa.gov/CAP
Background
Several Federal grant programs increase access to health services for vulnerable populations, place health care professionals in underserved communities, and provide support services for people with specific health needs. Few resources, however, are available to help health care providers coordinate these "safety net" services for uninsured and underinsured Americans.
Some forward-looking communities have begun to reorganize their health care delivery systems to provide better coordinated, more efficient care for uninsured residents. These models of service integration have:

- created networks to share uncompensated care more fairly among local health providers;
- linked hospital and clinic services through state-of-the-art data systems that share information and create seamless transitions for uninsured patients; and
- funded managed care networks for the indigent through local tax increases.

CAP builds on these existing models of service integration to help health care providers develop integrated, community-wide systems that serve the uninsured and underinsured. CAP grants are designed to increase access to health care by eliminating fragmented service delivery, improving efficiencies among safety net providers, and by encouraging greater private sector involvement. Many CAP models provide for integration of substance abuse and mental health treatment into the primary care model and have as collaborative members social and human services organizations as well as the faith community. A majority of CAP grants fund the development and implementation of disease and case management protocols. *Promoters* or community health workers play a key role in health promotion, outreach, enrollment, and case management. Underscoring all CAP efforts is the vision and reality of providing "better health for more people for less cost." System efficiencies are supported and enhanced with improvements to Management Information Systems while disease and case management methods serve to reduce inappropriate and costly utilization of Emergency Rooms and redirect patient care into more appropriate settings. Creative financing, insurance products and next generation MIS are just samplings of the diverse and complex CAP projects. Currently, CAP grants support 136 communities in urban and rural areas and on tribal lands.

5. Area Health Education Centers (AHEC)

(http://www.hrsa.gov/grants.html.)

Program Objectives:

To assist schools to improve the distribution, supply and quality of health personnel in the health services delivery system by encouraging the regionalization of health professions schools. Emphasis is placed on community based training of primary care orientated students, residents and providers.

The AHEC program assists schools in planning, developing, and operation of AHEC's to initiate education system incentives to attract and retain health care personnel I scarcity areas. By linking the academic resources of the university health sciences center with local planning, educational services to students, faculty and practitioners in underserved areas and ultimately, to improve the delivery of health care in the service area. The program embraces the goal of increasing the number of health professions graduates who ultimately will practice in underserved areas.

Eligibility Categories:

1. Community Development
   - Planning and research
2. Education:
   - Health Education and Training
   - Resource Development and Support in General and Special Interest Organizations
3. Health
   - Education and Training
   - Program Development
   - Specialized Health Research and Training
4. Social Services
   - Training Assistance
   - Private non-profit institutions
   - General Public
   - Health & Education professionals
   - Student/Trainees
   - Graduate Students
   - Researchers

Who Can Apply:

1. Institutions of higher education
2. Public non-profit institution/organizations
3. Private non-profit institution/organizations

How to Apply:

Department of Health and Human Service Administration
(http://www.hrsa.gov/grants.htm)

Email: hrsagac@hrsa.gov
Telephone: 1-877-HRSA-123

Or contact the Federal Register:
The publication for Rules, Proposed Rules and Notices of Federal Agencies and Organizations: (http://www.access.gpo.gov/su_docs/aces/aces140.html)

6. Health Careers Opportunities Program (HCOP)

Federally funded grants that provide opportunities for disadvantaged students interested in health professions. Distributed through individual universities, generally through Schools of Public Health. Contact your local Financial Aid Office.

7. Community Integrated Personal Assistance Services and Supports Grants

http://www.cms.hhs.gov

Maximizing consumer choice and self determination for the elderly. These grants are distributed to states. For example:

Indiana Family and Social Services Administration (FSSA) serves as a local agency to create an enduring infrastructure to support consumer invested personal assistance services http://www.in.gov/fssa/servicedisabl

New York and Massachusetts Real Choices Systems Change Grant to improve the delivery of services to disadvantaged or at risk populations to enhance community based services.
http://www.ncsl.org/programs/health

8. Center for Healthcare Strategies: Community Integration Initiatives (CHCS)

http://www.chcs.org/ConsumerAction/olmsteadgrants.html

Grant opportunities to assist states in their implementation of the Olmstead Decision:

Nursing Home Transition Grants
Community Personal Assistance Services
Expanding home and community based services (HCBS)
http://www.hcfa.gov/medicaid/olmstead/olmshome.htm

9. National Long Term Care Ombudsman Resource Center

http://www.ltcombudsman.org

E. NATIONAL INSTITUTES OF HEALTH (NIH)

(http://www.nih.gov)

Each week the NIH transmits via LISTSERV, the table of contents (TOC) information for that week's issue of the NIH Guide for Grants & Contracts. To subscribe, send email to:
listserve@list.nih.gov

1. National Institute on Aging (NIA)

(http://www.nia.nih.gov/funding/grants)

The National Institute on Aging (NIA) supports research and research training related to aging. The Institute supports basic biological, neuroscientific, behavioral and social research on aging as well as intervention studies and clinical geriatric research. It does not support provision of services. Although the NIA's Intramural Research Program conducts research in its own laboratories in Bethesda, Maryland, and at the Gerontology Research Center in Baltimore, Maryland, the largest part of NIA's funding for research is extramural. (See NIA's Extramural Programs). This funding goes to research institutions, e.g., universities, hospitals, or similar organizations. Information on NIH's overall extramural research programs is available at the Home Page for the NIH - Office of Extramural Research.

Submitting a Grant Application

Institutions submit grant applications to the Center for Scientific Review (CSR), NIH, and those within the mandate of NIA are assigned to NIA for funding consideration. CSR assigns the initial review of the application either to one of its own review groups, or assigns the responsibility for review to NIA. The type of grant application is a major determinant of whether it is assigned to CSR or to NIA for review. Like other NIH

institutes, NIA is responsible for reviewing program project, center, research career, small grant, and institutional training grant applications. In addition, the Institute generally reviews applications that are submitted in response to Requests for Applications. Similar review procedures are followed regardless of whether the review is conducted by CSR or the Institute.

Awards

Less than one-third of recommended applications are awarded. A program administrator is responsible for managing awards and for interacting with the principal investigator to facilitate achievement of the scientific goals of the project and to ensure that all necessary policies and procedures are adhered to. A grants management specialist also is assigned to the award and is responsible for fiscal management of the award and for assuring compliance by the awardees institution with government policies. The grants management specialist is knowledgeable about allowable costs, various budgetary authorities, and fiscal accountability. The grants management specialist, review staff, and scientific program staff function as a team to make the initial award and to manage it during the award period.

F. SUBSTANCE ABUSE & MENTAL HEALTH SERVICE ADMINISTRATION (SAMHSA)

(http://www.samhsa.gov/grants/grants/html)

SAMHSA has funding available through:
Conference grant program
Center for mental health services
Community action grant program
Targeted capacity expansion program

SAMHSA's Office of Policy & Program Coordination, Division of Extramural Activities, Policy, and Review, has developed a technical assistance booklet that describes the process of applying for a SAMHSA grant. This booklet, *Tips for SAMHSA Grant Applicants*, contains the same material provided in Grant Writing Workshops presented by the Agency early in the grant-publishing period each year.

"Part I—Programmatic Guidance" of the Guidance for Applicants (GFA) gives information about specific funding programs. Part I details the material necessary to include in a responsive application for an individual grant announcement. The SAMHSA Website provides brief descriptions of the Grant Funding Announcements and links to copies of the full GFA in downloadable Wordperfect© 6/7/8 and Adobe© Acrobat© formats.

Community Action Grants for Service Systems Change support the adoption and implementation of exemplary practices related to the delivery and organization of services for children with serious emotional disturbance or adults with serious mental illness, and those with co-occurring disorders. Awards range from a minimum of $50,000 to a maximum of $150,000 in total costs. Actual awards will depend on the availability of funds. The program is made up of two phases of one-year grant awards.
Phase I grants support the building of consensus among stakeholders to adopt an exemplary practice in their community or state. The practice must demonstrate effectiveness and replicability. Applications may be submitted by units of State or local governments, by tribal governments and organizations, and by domestic private nonprofit and for-profit organizations such as community-based organizations, provider and consumer groups, universities, colleges, and health care organizations. SAMHSA encourages applications from consumer and family organizations. Phase II grants support the actual implementation of the practice with funds for training and other non-direct services.

IV. U.S. DEPARTMENT OF AGRICULTURE (USDA)

http://www.usda.gov

A. Cooperative State Research, Education, and Extension Service (CSREES)

http://www.reeusda.gov
Expanded Food & Nutrition Education Programs (IFNEP)

B. National Research Initiative Program (NRI)

http://www.reeusda.gov
Innovative programs addressing common community problems with regard to nutrition and health

C. Public Service Scholarship (PSS)

http://www.hsfi.org
Hispanic scholarship fund Institute for food and nutrition services through the Center of Nutrition Policy and Promotion (bachelor’s level)

D. National Scholars Program

http://www.hsfi.org
USDA 1890 National Scholars Program for African American students (bachelor’s level)

V. Other Resources:

A. The Student Guide

The Student Guide is the most comprehensive resource on student financial aid from the U.S. Department of Education. It covers the Department's major aid programs, including

Pell Grants, Stafford Loans, and PLUS Loans. About 70% of all student aid comes from the programs discussed in the Guide. If you have any questions about the *Guide,* or wish to obtain additional information on student financial assistance, you may contact your high school guidance counselor, the financial aid officer at the postsecondary school you plan to attend, or call the Department's toll free student information hotline at 1-800-4-FED-AID**.** The Student Guide is Free.

If you paid for a copy of this publication, please write to the following address and give us the name and address of the organization that charged you.

Federal Student Aid Information Center
P.O. Box 84
Washington, DC 20044-0084

B. Data Book on the Elderly: A Statistical Portrait

http://www.aspe.hhs.gov/daltcp/reports/databkes.htm

C. Green Book: Overview of Entitlement Programs published by the House of Representatives Ways and Means Committee http://www.aspe.hhs.gov

Private Sector Loan Sources

A number of market rate loan programs are available to health professions students through the private sector. Some private sector programs are identified here as a service to health professions students seeking market rate educational loans. This information is neither an endorsement of any program nor a complete source listing of available programs.

Name of Program	Telephone Number
Alternative Dental Education Assistance Loan (DEAL)	(800) KEY-LEND
American Express Educational Loans	(800) 987-7770
AMSA Advantage Education Loan	(888) 282-5957
Chiroloans	(800) 252-2041
CitiAssist Loan	(800) 745-5473
MedAchiever	(800) KEY-LEND
MedCAP Alternative Loan (MAL)	(800) 633-2270
MedChoice Loan (Teri)	(800) 255-8374
MEDFUNDS	(800) 665-1016
Medical Access Loan	(800) 282-1550
MEDLOAN Alternative Loan (ALP)	(800) 233-7575
Nelli-Mae, Inc.	(800) 634-9308
Platinum Alternative Loan	(800) 252-2041

Signature Education Loan Program	(800) 695-3317
STILL LOAN$	(800) 626-5266

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