Aging Network News®

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The Resource for an Aging Society

View From The Hill

Editor's Note: At press time, there was very little evidence that the U.S. House and Senate would be able to agree on legislation to renew the Older Americans Act, which officially expires September 30, 1991. The House and Senate versions for extending the Act vary considerably; and no date has yet been set for a House/Senate conference on these differences. ANN will include a report on the Older Americans Act in the next issue.

Health Care Reform Becomes A 1992 Presidential Campaign Issue

Herbert P. Weiss

While the Bush administration claims a decisive victory over Iraq, Democrats charge lack of domestic policy vision on the homefront and seek to upstage the Republicans on the issue of health care reform before the 1992 presidential campaign.

Overhauling the nation's health care delivery system becomes a key 1992 election year issue for businesses and states because of skyrocketing health care costs. Health care spending will climb from 12.3 percent of the gross national product in 1990 to 16.4 percent by the year 2000, reports the Department of Health and Human Services. At the same time, Democrats frame it as a middle-class issue. About 34 million Americans have no health care coverage, and millions more have inadequate insurance coverage.

The First Salvo Fired

The Senate Democratic leadership moved quickly to shape the health care reform debate by throwing its own proposal into the legislative hopper.

The plan (S 1227), crafted by Majority Leader George J. Mitchell (ME), along with Senators Edward M. Kennedy

See Weiss page 7

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Commissioner's Corner

WEISS Continued from page 1

(MA), Donald W. Riegle, Jr. (MI) and John D. Rockefeller (W.VA) assures that the bill will be taken more seriously by Congress than other proposals currently being considered.

The proposal, phased in over five years, requires all employers to either provide private health insurance to their employees, or contribute to a public program which will provide coverage. Health benefits would cost about $1,680 per employee, with the employer paying for 80 percent of the amount. Use of managed care plans would reduce premiums by about 15 percent.

Employers would pay a tax, set by the Secretary of Health and Human Services, if they chose not to offer private health insurance coverage. The employer tax, plus other revenues to be specified later, would be used to create a new program called "AmeriCare." The program's cost is estimated to be $6 billion for the first year, increasing to more than $11 billion in its fifth year.

The federal and state program would replace the existing Medicaid program, except for long-term care. All persons who are not covered by either the employer-provided insurance or Medicare would receive health coverage. Low-income individuals would not pay a premium for enrollment.

Key House leaders are also taking an interest in health care reform. Rep. Dan Rostenkowski (D-IL), chairman of the House Ways and Means Committee, has recently introduced a proposal (HR 3205) similar to the one crafted by the Senate Democratic leadership. The Rostenkowski proposal would provide basic health benefits for all Americans, with an annual cost of $2,500 for an individual and $3,000 for a family.

The plan would also set mandatory price controls for health care systems, lower Medicare eligibility to age 60 and impose new taxes to help the government pay for a new program, similar to Medicare, covering anyone not employed or eligible for Medicare. By 1996, employers would be required to provide health insurance to their workers or pay a nine percent federal payroll tax to help finance the program.

GOP Proposal on Hold

While Senate Republican Leader Bob Dole (KS) acknowledged that the Senate Democratic leadership's proposal has begun to shape the health care debate, he notes that Republicans strongly oppose its costs to employers. The Democratic package "picks the pockets of small businesses," Dole charges, noting that the employer payroll tax is, in effect, "a heavy tax on jobs."

However, at press time, no Senate Republican leadership healthcare reform proposal has been introduced. The Republican leadership has introduced a long-term care reform bill (S1668) known as "Secure Choice." As proposed, Secure Choice would provide for expanded home and community based care to older persons with incomes below the federal poverty level.

An internal Health and Human Service task force is working out the Administration's broad health proposal to be released by mid-December, a task force official tells **ANN**. Before hammering out its final report, the group is looking at more than 50 health-related proposals, she says.

But don't expect the White House to move quickly on its own health care reform proposal. According to the *U.S. News and World Report*, White House chief of staff John Sununu framed the health care reform issues at a fall planning session as a "poison pill." The Bush Administration won't introduce its blueprint for health care reform before 1992, giving the Democrats the opportunity to pass their health care proposal, the magazine says.

This strategy would give Republicans an opportunity to attack the proposal as too expensive and intrusive. The magazine also predicts that the White House will offer a modest plan early next year focusing on private-public partnerships.

Herbert P. Weiss is a Washington, DC writer who specializes in aging and health care topics

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Strengthened Ombudsman Program In Older Americans Act Will Protect Vulnerable Seniors

By Herbert P. Weiss

Editor's Note: In a July interview, Senator Brock Adams, Chair of the Subcommittee on Aging of the Senate Labor & Human Resources Committee, a subcommittee with jurisdiction over the Older Americans Act (OAA), discussed highlights of the legislation with Herbert P. Weiss, former editor of **Aging Network News** *and current member of the Editorial Advisory Committee. The interview was first published in the August/September 1992 copy of* ***Long-Term Care Administrator****, a publication of the American College of Health Care Administrators. An edited version of Mr. Weiss' interview is reprinted below with permission of the College of Health Care Administrators.*

Weiss: The OAA reauthorization bill would create a new Elder Rights Title (Title VII). How does this new title change the ombudsman program? Various consumer groups call on the federal government to strengthen the ombudsman program. How will Title VII accomplish this?

Sen. Adams: As we moved to reauthorize the OAA, there were few areas of consensus—one was to strengthen the ombudsman program. In fact, most major aging organizations called for a new ombudsman title in the Act. The Elder Rights title evolved from this. I am delighted with the support for Title VII, and it may turn out to be the centerpiece of the 1992 OAA reauthorization bill.

The New Elder Rights title will strengthen the ombudsman program in two ways: first, this new title will place the ombudsman program in context with other client advocacy and service programs, such as legal assistance and elder abuse, in the OAA. It also sends a very clear message that elder advocacy services must protect vulnerable elders in their homes and in group and institutional settings. Under Title VII, states would be given marching orders and the tools to take a leadership role in protecting the rights and well-being of older Americans.

Senator Brock Adams

Second, Title VII redefines the provisions that govern the roles and responsibilities of ombudsmen The current set of amendments build upon the substantive changes made in the 1987 OAA amendments. It addresses potential conflicts of interest of those appointing ombudsmen and by ombudsmen themselves, access to records, advocacy on behalf of facility residents, ombudsman training, data collection on ombudsman activities and federal support to state ombudsman programs through the Administration on Aging at the Department of Health and Human Services.

Weiss: Currently, ombudsmen can examine medical and social records of nursing home residents. The OAA reauthorization bill expands access to administrative records. Is this not a duplication of OBRA survey and certification procedures and practices?

Sen. Adams: No, I don't see it that way at all. State ombudsmen have a broad federal mandate to investigate complaints of facility residents. Many of the complaints that they look into are cases that state licensing and certification officials infrequently, if ever, address. For instance, an ombudsman can follow-up a complaint that a guardian is not performing appropriately in his or her duties on behalf of a nursing home resident. Or the issue may concern a payment or contractual dispute between resident and facility—a conflict that may be handled by an ombudsman. These are situations in which administrative records may be crucial to understanding and successfully resolving the particular problem.

Congress created and empowered the ombudsman program to investigate complaints. Their ability to carry out this mandate may be severely hampered by a lack of access to key administrative records and other pertinent documents.

Weiss: In light of current fiscal constraints regarding appropriations for OAA Title III services, how can you justify the creation of an Associate Commissioner, a federal ombudsman position, within the Administration on Aging (AoA)? Why add a whole new layer of bureaucracy in the AoA when scarce fiscal resources could be used to fund new services?

Sen. Adams: One of the major criticisms to emerge during the 1992 OAA reauthorization debate was the agency's lack of support of the ombudsman program. AoA could tell us little about this program, and we heard from ombudsmen in the field that they were getting little support from the Bush Administration.

As to cost, I believe it is well worth the expense to protect America's most vulnerable population—the elderly. A federal official responsible for the ombudsman program would become a champion for nursing facility residents by representing them in interagency policy discussions and ensuring adequate representation for the program. The costs associated with the new position will be minimal at best. If this person is effective, he or she could become a powerful force in assisting the ombudsman program obtain additional resources.

Weiss: Currently the Research Triangle Institute (RTI) is conducting a study to explore the relationship between the quality of care provided by board and care facilities and the strength of state regulations. The OAA reauthorization bill calls for an Institute of Medicine study on quality of care provided by board and care facilities. Do you feel that this effort is a duplication of the RTI study? Is the OAA an appropriate legislative vehicle to fund studies or initiatives to develop regulations for long-term care providers?

Sen. Adams: I am quite familiar with the RTI study's purpose to look at the impact of state regulation on quality of care provided to residents of board and care facilities. In fact, my Subcommittee on Aging held a briefing for congressional staff about it.

As you mentioned, the OAA reauthorization bill calls for an Institute of Medicine (IOM) study on quality of care provided by board and care facilities. But I do not believe that the IOM study will be a duplication—as a matter of fact, it will nicely complement the RTI study.

The IOM study is designed to examine the overall environment for board and care as it relates to quality and federal regulations. Some other issues that it will examine are: financing and incentive issues, the role of the ombudsman in board and care facilities and how this type of facility should fit into the long-term care continuum. This approach is modeled on the 1986 IOM study on nursing home quality which proved to be a tremendous success.

Weiss: As you leave office in January 1993, tell us what you would like to be remembered for in your legislative efforts on aging and health care issues?

Sen. Adams: I have been Chairman of the Subcommittee on Aging for just two years, and I must admit that I'm somewhat amazed at the scope and diversity of aging issues we've handled. My Subcommittee has held a multitude of hearings—from the administration's recalcitrance in fully implementing OBRA '87 nursing home reforms to the lack of standards for equipment and personnel involved in mammography screening. We even held the first congressional review addressing menopause.

I am especially proud of providing leadership in the Senate in our effort to overturn the administration's ban on fetal tissue research—which has such a detrimental impact on Alzheimer's and Parkinson's disease patients. I am also pleased that the current OAA Authorization proposal helps low-income and minority seniors along with protecting other vulnerable elders through a new Title VII.

Herbert P. Weiss is a Maryland-based writer who specializes in aging and health care topics.

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ANN's Focus: Spirituality

The Graying Of The New Age Movement

Older Persons Seek Self Realization

Herbert P. Weiss

While millions of age 50+ adults turn to mainstream religions, such as Catholicism, Protestantism, and Judaism, for solace in their later years, others seek alternative forms of spiritual pursuit to reach "self realization"—they join the rank and file of the New Age Movement.

Researchers estimate that New Agers represent about 11% of the total American population. Some believe that seniors represent about half of this group.

For a growing number of seniors (a.k.a. Old Agers) seeking personal spiritual experiences becomes even more important than belonging to a particular religion or church. During their spiritual quest to directly perceive inner truth, Old Agers are attracted to a wide array of New Age spiritual disciplines and philosophies.

Many of these individuals are following techniques promoted by the human potential movement and are studying Eastern and Western esoteric and Shamanic traditions.

New lifestyle changes and patterns of behavior take hold when Old Agers put their New Age beliefs into action.

Some drop junk food, soft drinks, and coffee from their diets in favor of following microbiotic recipes, eating organically grown foods and drinking spring or distilled water.

Many also seek spiritual guidance from psychics, astrological charts, rune stones, I Ching coins, tarot card readings and channelers — even if they choose to consult with religious leaders at their neighborhood churches and synagogues.

Many Old Agers even combine traditional medical treatments with non-traditional forms of alternative healing practices (see box, page 6), including yoga and Tai Chi, meditation, crystal healing, visualizations, affirmations, biofeedback, body therapies such as massage and reflexology, and past life regression through hypnoses.

Graying of New Age Events

"If you attend the metaphysical churches or New Age events, you will end up seeing a lot of white hair,"

See NEW AGE page 6

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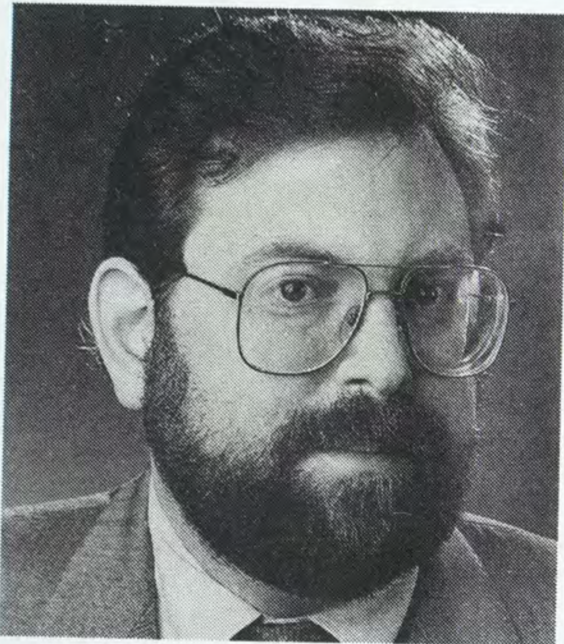
NEW AGE Continued from page 1



Herbert P. Weiss

observes Dr. Gordon Melton, Ph.D, of the Santa Barbara, California-based Institute for the Study of American Religion.

This should not be surprising, because alternative religions have been around since the 1880s, Melton says. "You have a lot of people who have grown up around alternative formats for most of their lives," he notes.

"While a minority of seniors become sticks in the mud, becoming older frees many from conventionality," Melton tells ***ANN***.

"They don't have anything to prove to anybody any more," he says.

Seniors want to make their final days count, Melton says. "Becoming older and wiser gives them a certain freedom to go exploring."

New Age philosophy also comes to Old Agers when they are confronted with a health crisis or go through a life change such as a divorce or death of a partner, says Jonathan Adolph, senior editor of *New Age Journal*, a national publication covering New Age issues. "Any of these life events that cause reflection can be a trigger for examining New Age beliefs and many of these life changes occur in later life," Adolph notes.

A Marketing Profile of An Old Ager

More than 50% of age 50+ adults are still entrenched in traditional religious practices, estimates John Garrett, director of marketing at SRI International's Value and Lifestyle Program. He puts these individuals, median age 55, into a marketing segment called Believers.

But Garrett notes that 25% of age 50+ adults fall into another marketing segment called Fulfilleds—these individuals, median age 48 and growing, are more likely to be open to nontraditional ways of doing things, he says.

Fulfilleds are more wholistic and open to the ideas of Eastern religion and are more likely to take a look at why we are here as people and ask questions about life after death, Garrett tells ***ANN***.

These individuals are also information oriented persons and intellectual religions are going to appeal to them much more than traditional religions, Garrett notes.

In order to continue to have their belief system, "they need lots of information to fuel their belief system," he says. "Any form of information is appealing to them. They are avid readers of books, magazines, and collectors of catalogues."

Even if Fulfilleds are not actively involved in New Age practices and philosophies, it is very important for them to be aware of and familiar with them, Garrett says. But if you compare Believers with Fulfilleds, the Believers may not even consider looking at any other traditional or alternative religions beside their own, he says.

As the millions of baby boomers age, it is not unlikely that they will expand the numbers of the New Age movement, Garrett predicts.

New Age Practices Beneficial

Age should be no barrier to a senior wanting to learn the art of meditation, says Dr. Jim Green, Ph.D., a 77-year-old retired sociologist and anthropologist and former State Department staffer, who teaches meditation and practices psychotherapy in Falls Church, Virginia.

In his 14 years of teaching meditation, Green's classes are always attended by retirees seeking to learn the techniques. His oldest student was age 82, he notes.

While many older people question whether they can learn to meditate and have doubts about their capacity to properly practice it, they always find out their limiting beliefs were wrong, Green observes.

"In fact, they have a greater capacity to learn because they can draw upon a whole life time of experiences," he says.

"For some people, there is a contemplative dimension to aging where one begins to pay more attention and notice things in one's own interior and in the world that was not noticed before," says Ray Studzinski, O.S.B., Ph.D., a monk of St. Meinrad Archabbey in Indiana, who is an associate professor at Catholic University of America in Washington, DC. As a result, "there is an openness to mystery, he says. "All of this can find a good fit in certain spiritual practices such as meditation and yoga."

"Sometimes meditation techniques can even bring about a sense of real integration or real harmony within one's self as well as offer ways to deal with some of life's hurts," Studzinski says.

But while meditative practices, visualization and the use of mantra-like affirmations may be beneficial to use for some individuals, "don't consider them to be like over-the-counter drugs," Studzinski warns. "They may work very well for some people but not well for others."

Herbert P. Weiss is a writer who specializes in aging and health care topics.

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Congress Puts Alternative Medical Therapies Under A Microscope

Herbert P. Weiss

Editor's Note: On July 28, in a front-page article, *The New York Times*, (Molly O'Neill) reported that Mutual of Omaha, the nation's largest health insurance company for individuals announced that it would "reimburse patients participating in a program that combines diet, meditation, exercise and support groups to reverse heart disease." The reversal program developed by the Preventive Medicine Research Institute's Dr. Dean Ornish, is the first "non-surgical, non-pharmaceutical therapy for heart disease" to be covered by an insurance company and, with the exception of chiropractic care, is the first "alternative" medical technique to be insured.

Alternative healing practices will come under new federal scrutiny since Congress has ordered the U.S. National Institutes of Health (NIH) to create an advisory panel to investigate the medical potential that exists in alternative medical practices.

This legislative initiative comes amid recent studies published by the *New England Journal of Medicine*, which reported that about 10 percent of Americans—roughly 25 million people—sought help of "unconventional" medical practitioners in 1990. *The Washington Post* noted that Americans spent about $10.3 billion for alternative medical care in 1990, compared to the $12.8 billion they spent on regular hospital bills—though the cost of in-hospital medical care was much higher, insurance companies paid for most of those expenses.

NIH defines alternative medical practices as diagnostic or therapeutic techniques that are presently considered "outside" the mainstream of scientific research. But for millions of Americans, a wide array of unconventional medical therapies—such as Ayurveda medicine, acupuncture, homeopathy, reflexology, visualization, hypnotism, hands-on healing and Chinese herbal remedies—have become part of their regular medical regimen.

Congress Gives NIH a Surprise Gift

Funding for NIH's new initiative to study alternative medical practices "was a pure gift to NIH from Congress," claims C. Scott Jones, president of the Vienna, Virginia-based Human Potential Foundation, a nonprofit group that is closely following NIH's new project.

Appropriations language written by the Senate Appropriations subcommittee on labor, health, and education, chaired by Sen. Tom Harkin (D-IA), to accompany the FY 1992 federal budget, directed NIH to spend at least $2 million to organize the Office of Alternative Medicine (OAM), formerly the Office for the Study of Unconventional Medical Practices.

Sen. Harkin became interested in studying alternative therapies because of the personal lobbying efforts of retired Iowa Congressman Berkley Bedell. Bedell's personal odyssey to find a cure for his serious illness would ultimately have larger implications—congressional prodding of NIH to formally study alternative medical practices.

Bedell, 71, left Congress in 1986 because of severe lethargy resulting from lyme disease. One year later, he was diagnosed as having prostrate cancer. Traditional medical treatments didn't cure Bedell's lyme disease, he says. But his medical problems were corrected with alternative medical practices, he claims.

Through Bedell's efforts to tell his friend Senator Harkin of his cure, NIH was given funding to scientifically study the outcomes of alternative medical practices.

Getting Off The Ground

Currently, 25 members—including Bedell, a Mescalero Apache medicine man, a Harvard Medical Professor—sit on OAM's Advisory Panel.

There has been a ground swell of support for OAM's efforts. The Office held its two-day kick off session at the NIH campus in suburban Bethesda, Maryland in June 1992. More than 200 people attended the sessions to listen to 85 alternative health care practitioners speak in general terms about their specific therapies. Public testimony at the sessions produced more than 500 pages of transcribed comments about alternative healing

See CONGRESS, page 10

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CONGRESS Continued from page 9

practices, including Ayurveda medicine, acupuncture, homeopathy, reflexology, visualization, hypnotism, hands-on healing and Chinese herbal remedies.

About 125 scientists, alternative physicians and healers gathered at an invitational conference in Chantilly, Virginia held in September 1992. The participants were asked to hammer out the OAM's goals and objectives to develop research protocols to evaluate alternative healing diagnostic and therapeutic techniques.

The meeting was really an "unusual and historical gathering," says Dr. Beverly Rubik, PH.D, director of the Center for Frontier Sciences at Temple University in Philadelphia, Pennsylvania, and a member of the Office's Advisory Panel.

"There was such a variety of people coming from different backgrounds—it was outstanding to see the federal government actually fund a conference like this," she says.

OAM is now staffed up to accomplish its Congressional mandate, says Director, Dr. Joseph Jacobs, M.D, a 46-year-old Yale trained pediatrician, whose mother was a member of the Mohawk tribe. His professional staff members hold advanced degrees with a knowledge of one or more alternative medical practices.

While some people want to see OAM evolve into a full-blown Institute, Jacobs believes that it is more critical to mainstream alternative therapies into NIH's research community. "It is important for us to not ghettoize it," he says. "You have to work collaboratively with other Institutes—there is no other way to get around that."

Capitol Hill supportive of alternative medicine

Currently, both the White House and Congress are closely monitoring OAM's efforts to evaluate alternative medical therapy outcomes, Jacobs observes. While President Clinton's Task Force on Health Care Reform solicited comments from mainstream medical and health care groups about their concerns, its members also wanted to hear also about OAM's activities, he notes. Jacobs was invited by the Task Force last April to address how alternative medical therapies "fit" into health care reform.

Even the Senate Appropriations subcommittee on labor health, and education, chaired by Sen. Harkin scheduled a June 24 hearing to highlight the benefits of alternative medical practices along with exercising its congressional oversight responsibilities on OAM's activities.

Wait and See

To be officially sanctioned by the scientific and medical communities, alternative medical practices will have to meet the same strict scientific criteria as conventional medical practices.

Alternative therapies are going to challenge the conventional way of clinical testing, Dr. Beverly Rubik predicts. "Alternative therapies are often tailored to each individual," she says. "Are they going to look at acupuncture from within its own tradition? Or are they going to squeeze it into a conventional mode of treating specific disease syndromes according to an established protocol?" she asks. But even with the problems of measuring outcomes, it will be the key to OAM's success. Scientifically-based information will help people make informed and intelligent choices, says Dr. Dean Ornish, M.D., of the University of California, San Francisco.

"Many alternative approaches have value and others don't—some have value under some circumstances and not in others," Ornish says. Medical groups are generally supportive but some express skepticism about whether anything meaningful will come out of NIH's efforts to study alternative healing therapies—especially with limited funding.

"NIH won't be able to do too many studies with a funding level of only $2 million," says Roy Schwarz, senior vice president for medical education and science at the American Medical Association. "There are so many alleged alternative therapies we will never have the money to investigate them all," Schwarz says. To succeed, "NIH must prioritized and look at the unconventional medical therapies that seem to have the most promise."

But people in the alternative healing community see great things ahead and even more acceptance of alternative medical practices by the medical community in the future, even with only a couple of million dollars in OAM's budget.

While only $2 million was allocated to fund OAM activities, "the federal government wouldn't have put $20 into the project ten years ago, says Dr. Bernard Siegel, M.D., author of the best-selling book *Love, Medicine and Miracles*. This reflects a change in the federal government's thinking about alternative medical practices, he notes."

Herbert P. Weiss is a former editor of **Aging Network News.** *Today, he is a Rhode Island-based writer who covers health care issues. Weiss can be reached at 401- 351-9519.*

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The Resource for an Aging Society

Regional WHCoA Participants Call For Changes In The LTC Delivery System

Herbert P. Weiss, N.H.A.

Marlborough, MA—Today's long-term care delivery system, driven by reimbursement and budget considerations, must give way to a more "person centered" and "user friendly" system. One that allows individuals to live independently at home as long as possible, if that is their choice.

This major policy recommendation was among scores of others put on a policy wish list by more than 400 seniors and aging advocates from six New England states who attended a regional mini-White House Conference on Aging (WHCoA) held on Dec. 6-7. Over 85 percent of these individuals were age 60 and older, the remainder representing human service and health care agencies.

During the two-day regional Conference, concurrent workshops were held to address the policy issues of economic security, long-term care, and elder abuse. The New England region's WHCoA report, containing a summary of these issues and proposed policy recommendations, will be placed before the WHCoA delegates in Washington, DC next May 2-5. Delegates to the White House Conferernce will consider them for inclusion into the final Conference report.

At press time, over 150 reports have been received by the 1995 WHCoA staff. Over 20,000 participants attended over 250 pre-WHCoA events, 26 state and 18 regional conferences. More than 12,000 of these individuals are age 55 and older.

"The 1995 WHCoA will be the single most important forum to discuss issues affecting seniors in our country," said Phil Johnston, New England Health and Human Services regional director, one of many federal officials to attend the event. Its report will influence the aging policy debate over the next ten years, he noted.

See WEISS, page 3

A Message From The Editor

Older Learners Focus Of February ANN

Aging Network News' "Directory of Resources for Living" has become so large it is necessary to break it up. Therefore, the February issue features programs and resources for the **older learner**. The March issue will feature programs and resources for the **older volunteer**, in addition to a current list of state units on aging and members of the Leadership Council of Aging Organizations.

For the February issue, we are very pleased to be able to share with subscribers an up-to-date list of the expanding number of Learning in Retirement Centers, SeniorNet Learning Centers, OASIS Centers, as well as information about Elderhostel, Senior Ventures, Museum One, American Library Association, and the National Council on the Aging's Arts and Humanities programs.

The growing importance of the older learner in the field of aging has been underscored recently by the fact the American Society on Aging (ASA) has created a new

See EDITOR, page 6

INSIDE

Museum One	Page	2
Of Special Interest To Women	Page	5
ANN on Compuserve	Page	6
List of SeniorNet Learning Centers	Page	7
List of OASIS Centers	Page	11
List of Institutes for Learning in Retirement (ILRs)	Page	15
Calendar	Page	22

WEISS Continued from page 1

Growing Need for LTC Services

Rep. Joseph P. Kennedy II, urged federal policy makers to prepare for the soaring demands and rising costs of long-term care services.

According to Kennedy, the number of people needing costly nursing home care will jump from 7 million today to about 14 million by 2010. Today, many seniors are forced to pay over $35,000 per year for costly nursing home care.

Rep. Joseph P. Kennedy

Kennedy predicted that the nation's health care crisis won't be solved until Congress seriously addresses the need for long-term care and prescription drug coverage.

But with a Republican majority in Congress, Kennedy conceded that passage of legislation creating a new community and home-care benefit and prescription drug coverage will be unlikely next year—but he pledged to continue to push for enactment of such initiatives.

"The bottom line is that without long-term care coverage, no family has security against devastating costs of serious illness or disability," Kennedy told the audience. He pointed out that long-term care is an intergenerational issue and should not be considered just an elderly issue.

Long-Term Care Issues Addressed

According to Anne Harrington, Ph.D., an Arlington, Massachusetts-based consultant in aging issues and LTC workshop facilitator, many workshop participants called for "individual choice and preference, autonomy, dignity, independence and personal rights" to be reflected in any newly developed long-term care delivery system. In addition, they wanted any long-term care setting to promote the individual's highest level of functioning, she added.

Many persons in the workshop said that long-term care has to encompass more than nursing home care. They suggested that the term be expanded to include medical, nursing, rehabilitative, preventive, social, mental health, and supportive services provided in home and community-based settings as well as in institutional settings.

Workshop participants also voiced strong concerns that the current long-term care system is confusing and overly complex for many seniors to negotiate and access appropriate services. To fix this access problem, they recommended a one-stop shopping, single entry to long-term care information and service, Harrington said.

"There was strong support for a national publicly-funded social insurance system that provides universal coverage for health and long-term care," said Harrington. But she stated that participants disagreed about how to implement such a system—whether there should be a single payer system, regional health alliances, or some other funding approach. People were willing to supplement this system through private contributions to be paid into a program similar to Medigap insurance, she noted.

A full array of home and community based options (e.g., home care, home health care, day care, transportation, respite care, and assisted living, etc.) are not always available in many local communities, the work participants charged. Even when they are available, high costs, program eligibility restrictions, and limited public funding, reduce access to these services. Many believed that a national social insurance system could help seniors live at home longer.

Consistent with the ideal of a person-centered long-term care system, participants said that quality indicators should include the individual's own definition of quality. This subjective assessment can be measured by customer satisfaction surveys and other techniques, Harrington told LTCA.

"The world is changing and older persons want to stay at home as long as possible," Harrington said. After listening closely to her workshop group, she noted that nursing homes must change the way they do business—it has become more important for facilities to become active in developing alternative services to institutional care.

Administration on Aging Regional Administrator Thomas L. Hooker added, "We are pleased with the recommendations and strong support for community-based long-term care services emerging from our Regional Conference. He noted that long-term care is one of AoA's major initiatives to keep older people independent and at home.

Reprinted with permission from the Long-Term Care Administrator *28 (9), January/February 1995. Herbert P. Weiss, N.H.A. is a Providence, RI-based writer who covers health care and aging issues. He was founding editor of* **Aging Network News.**

ANN

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New Federal Program To Attack Medicare And Medicaid Fraud And Abuse

Herbert P. Weiss, N.H.A.

Washington, DC—Using the 1995 White House Conference on Aging as a backdrop, President Clinton recently launched a national anti-fraud campaign in five states to crack down on Medicare and Medicaid fraud and abuse, particularly in home health agencies, nursing homes, and suppliers of durable medical equipment.

In 1993, Medicaid spent $25 billion for services to 1.6 million Medicaid patients in nursing facilities and $5.5 billion for home health services provided to homebound patients. This year, Medicare payments will total $16 billion, up from $7.1 billion in 1992.

The project, "Operation Restore Trust," will initially focus in five states with the highest Medicare expenditures—New York, Florida, Illinois, Texas, and California. Nearly 40 percent of all Medicare and Medicaid beneficiaries live in these states.

The Clinton administration's anti-fraud campaign is targeting home health care and nursing facilities because past federal investigations have shown them to be particularly susceptible to fraud and abuse. Fraud and abuse in the home health care setting includes: billing for excessive services or for services not rendered, the use of unlicensed or untrained staff, falsified plans of care, forged physician signatures, and kickbacks.

In nursing homes, areas most susceptible to fraud and abuse include inappropriate payments and overuse of services. Wherever it occurs, it increases the financial burden on beneficiaries and the Medicare and Medicaid programs.

It's a win-win project

"The project is a win-win situation for everybody except those who try to cheat the system," said HHS secretary Donna E. Shalala. She predicted that the Medicare and Medicaid programs will save six to eight million dollars in reduced spending on up-front billings for fraudulent and wasteful practices and from the monies received from court awards.

"We need to weave fraud control deeper into the fabric of our programs, and we need our beneficiaries and our private sector partners to help us," Shalala said.

A major component of the project will be a voluntary disclosure program that allows home health agemcoes and nursing homes to come forward with evidence of fraud or errors within their own organization, in consideration for possible reduced penalties, according to Judy Holtz, spokesperson for the Health and Human Service Office of the Inspector General (OIG).

According to Holtz, the $8 million dollar anti-fraud project will involve the OIG, the Health Care Financing Administration and the Administration on Aging along with an intergovernmental team comprised of federal and state personnel.

Other project activities include:

• Financial audits by OIG and HCFA.

• Criminal investigations and referrals by OIG to appropriate law enforcement officials.

• Civil and administrative sanctions and recovery actions by OIG and law enforcement officials.

• Studies and recommendations by OIG and HCFA for program adjustments to prevent fraud and reduce waste and abuse.

• Issuance of Special Fraud Alerts to notify the public and the health care community about schemes in the provision of home health services, nursing care and medical equipment and supplies.

To report a fraud or abuse incident, contact the Department of Health and Human Services hot line at 1-800-447-8477.

Herbert P. Weiss, NHA, is a former editor of **Aging Network News**. *He is now a Providence, Rhode Island-based writer who covers health care and aging issues.*

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The Resource for an Aging Society

Bringing The Spiritual Moment To Persons With Dementia

Herbert P. Weiss, N.H.A.

Boston, MA—Spiritual connectedness is a vital part of every relationship and this universal experience does not end with cognitive impairment or dementia, said Rabbi Sam Seicol, of the Boston-based Hebrew Rehabilitation Center for Aged, to more than 1,600 professionals attending the July 1995 Alzheimer's Disease Education Conference.

According to Seicol, helping persons with dementia to create spiritual connectedness and enhancing their spiritual wellness requires providers to recognize that all people are spiritual beings and to understand how Alzheimer's disease changes one's perception of time.

"Do not confuse spirituality with religiosity," Seicol warned the audience, because religion is only one pathway to creating a sense of spiritual relations and supporting the personal sense of spiritual self. While religion may be different for each individual, spiritual needs are essentially the same for every one, he noted. However, the ways in which these needs are met will be different for each person.

Internal vs. external factors

Seicol told the crowd that a sense of personal identity, such as finding meaning, purpose and value in one's life, and the external interaction to the outside of the self can result in spiritual wellness.

"Internal and external influences and the connections to the spirit lie within each of us," he said, stressing that spiritual connectedness can be derived through alternative routes that each person might choose to take. As illustrated by the "Wheel of the Human Spirit", (Figure 1 on page 4) when dementia limits a person's accessibility to spirit through the cognitive pathway, the individual can still find other paths to spirit," Seicol said. For example, each person has physical, emotional, and cognitive facets, and loss in one area can be compensated for through alternate "internal or external" routes.

See WEISS, page 4

ANN's Focus: Spirituality

HOPE:
The Keeper Of Spirit

Sr. Josephine Bryan, RN, MSN

We are beings facing the future, and no matter how tight you close your eyes, it continues to come. The motivating factor that energizes human beings to be open to the future is hope. The individual who lacks hope perceives no prospect of change or improvement in his/her life, neither does the person perceive a solution to problems or a way out of difficulties.

Our total life is the process of coming to be. When this process is frustrated, and the individual perceives self as inadequate to act, hopelessness ensues. In a personal letter from Hans Selye, he described hopelessness as a condition which was largely due to the individual's lack of faith in his own code of behavior and motivation. Meissner (*Journal of Religion and Health*, Vol.12, 1973) describes hopelessness as a negative sense of self that permeates the rest of the individual's experience and activity. Karen Horney (*Our Inner Conflicts*, W.W. Norton, New York, 1945) writes that as people grow older and one hope after another fades, they are

See HOPE, page 4

INSIDE

View from Academe	Page	2
Of Special Interest To Women	Page	5
View from the Hill	Page	7
Earn CEUs In Art Appreciation	Page	9
Managed Care: Part Two	Page	13
Calendar	Page	18
Research Review	Page	19

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HOPE Continued from page 1

forced to take a good look at themselves as a possible source of their distress. When one is hopeless there is not only a loss of hope for goals but there is likewise concurrent loss of hope in one's competence.

Growing older, the loss of one's job, the inability to find another job or the community not having an available position connotes rejection, and when this is compounded by having to move to another location, or a senior's residence, in the mind of the beholder it signifies the end, for which there is nothing more to hope.

Hope is the candle of light, as Menninger described it (*The American Journal of Psychiatry*, 1959), that enables the individual to continue to strive, to accept diminishment in the physical self and cope with the numerous losses. The flame of hope is the individual but the protection of the flame from overwhelming winds of stress comes from a confident self, whereas the continual supply of oxygen to keep the flame burning comes from other human beings who confirm one as a person.

One of our Sisters was diagnosed with terminal cancer. We were ever delighted and surprised as she took on new treatments against all odds, and bounced back to participate fully even on our general council. What we didn't realize is how much hope she had placed in her doctor, and the most nauseated experience could be tolerated for an expectation of a few more years, months or days. When her doctor came into her hospital room, and said, "Sister, there is nothing more I can do for you," she died.

A.H. Schmale, a noted psychologist who has done research on psychosomatic disease, suggests that when goals (gratifications) that are highly valued are assumed to be lost, be it real, threatened or symbolic, and the individual feels she is unable to cope with the loss, that the affective response of giving up tends to precede the onset of exacerbations of a disease. According to Schmale these giving up experiences are almost inevitably associated with the changes, including loss, required as persons go from one relationship or one stage of development to another.

When we relegate the elderly to the bleachers of not being needed to contribute as part of the family/commu-

See HOPE, page 6

WEISS Continued from page 1

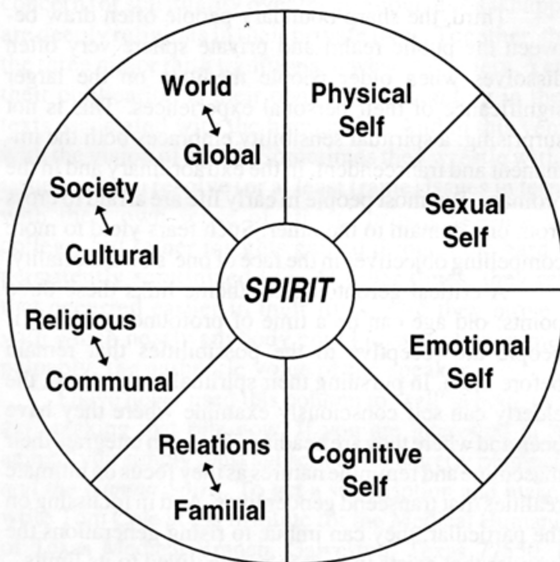

Figure #1: The Wheel of the Human Spirit

Time perception and dementia

It is all too common for people to say they live in the present. But most of the world is really viewed through the filter of our past and the future, Seicol said. Time perception is different for those patients advancing through the stages of a dementia, he noted.

"There is a significantly decreased capacity to maintain and utilize short term memories for persons with dementia," Seicol stated. These individuals can not relate to the present using recent memories nor can they tap into those memories from the more immediate past," he added.

Seicol said that persons with dementia also lose the normative sense of anticipation and expectation, both usually part of an interpersonal relationship. Additionally, dementia reduces the ability to recall and process what information does remain, he said.

The "present moment" is a compressed point between the immediate past and the soon to be future, Seicol said. Increasingly the person with dementia lives in this moment, but it is difficult for caregivers and family members to relate to this time frame because it really does not exist to them, he noted.

See WEISS, page 10

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New Director Of NICA/NCOA Appointed

Washington, DC—Barbara P. Clemons is the new director of the National Interfaith Coalition on Aging (NICA), a constituent unit of the National Council on the Aging, Inc. (NCOA). Ms. Clemons follows John Evans who had been director since 1990.

Ms. Clemons is retired from the position of chief operating officer of Asbury Methodist Village, a continuing care retirement community in Gaithersburg, Maryland. She has a master's degree from Wesley Theological Seminary in Washington, with an emphasis on Ministry for and with Older Adults. She is a pioneer in studying the importance of reminiscence in the spiritual well being of older adults.

NICA objectives Ms. Clemons will pursue include: strategic planning for the future which will clarify and emphasize membership benefits and aims to increase membership; marketing of the National Clergy Leadership Project materials; and giving emphasis to the availability of Robert Wood Johnson Foundation/Faith in Action Grants for local agencies.

The National Clergy Leadership Project to Prepare for an Aging Society has developed methods, programs, and products that congregational clergy and leaders can use to educate themselves and others about aging and about serving the needs of older persons. The materials includes a 13 minute VHS video, a congregational leader's manual, a congregational resource book and articles covering such topics as changing attitudes and creating actions with and on behalf of older persons, working with congregations on understanding aging, programs for older people, etc. For further information contact Barbara P. Clemons at 202-479-6689.

NICA will sponsor a spirituality track of programs as part of the annual Washington meeting of the National Council on the Aging April 24 - 28, 1996. The keynote address will be given by Robert A. Raines, retired director of Kirkridge Center and author of *New Life in the Church*, who will speak on "Forward with Faith: Choices for Growth" on Saturday April 27 at 1:00 to 5:00 PM.

At 9:00-10:30 AM on April 27 the topic will be "Spirituality and Mental Health: Faith Development in Later Life." The speaker will be Harold G. Koenig, M.D., assistant professor Psychiatry and Internal Medicine; Director, Program on Religion, Aging and Health at the Center for Aging, Duke University Medical Center. He is author of *Aging and God: Spiritual Pathways to Mental Health in Mid Life and Later Years.* **ANN**

WEISS Continued from page 4

Dementia and the Spiritual Moment

Caregivers and family members are in a sense "visitors" into another world when caring for persons with dementia, Seicol said, placing the burden of the relationship primarily on them, he noted. Combining a person's spiritual needs with the challenges of relating to a person of dementia in the context of the "present moment" creates a "spiritual moment."

There are many opportunities for spiritual support and care by this "visitor" to a person with dementia in the created "spiritual moment," Seicol said. If the cognitive pathway to spirit is blocked other options for creating spiritual well-being remain, he noted. We can utilize the knowledge that memory of emotion, music, movement and ritual are better retained. For instance, the physical self can easily respond and celebrate through rhythmic movement, sensory stimulation and use of religious objects, including rosary beads, taking communion, or wearing of a yarmulke and prayer shawl. In addition, music, art, non-verbal stimuli, and the use of long-learned poems, and religious literature, can be crucial for maintaining connections and relationships in the "spiritual moment."

Seicol urged family members and caregivers to focus on this "moment" of connectedness, and not expect to be "remembered" or "anticipated" in a cognitive sense; however, the emotion and spiritual imput is likely to be remembered. Even after the "visitor" is long gone their gift of spiritual uplift still provides strength and spiritual nourishment to the person with dementia.

Herbert P. Weiss, NHA is a Providence, Rhode Island-based writer on health care and aging. He is the founding Editor of **Aging Network News**.

For more information about spirituality and dementia, contact Rabbi Sam Seicol, Hebrew Rehabilitation Center for Aged, 1200 Centre St., Boston, MA 02131; 617-325-8000, ext. 386. **ANN**

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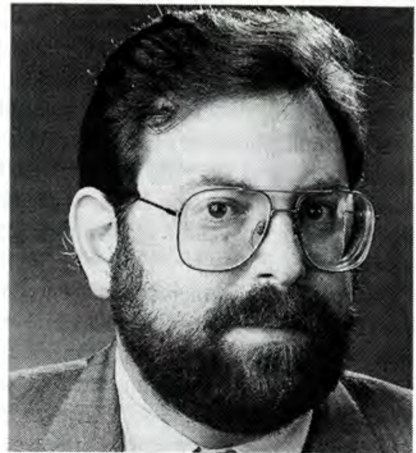
Viewpoint:

New Report On Nursing Homes: Mental Health's Forgotten Constituency



Herbert P. Weiss, N.H.A

Herbert P. Weiss, N.H.A.

The principal authors of a new report on mental health in nursing homes charge that cutbacks in Medicare and the block granting of Medicaid will have a disproportionately large impact on the funding of mental health treatments. The report, *Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care*, which this writer co-authored, calls mentally ill residents long-term care's "forgotten constituency."

According to Nancy Emerson Lombardo, one of the new report's authors, mental health experts worry that the situation for mentally impaired elders may worsen if proposals are passed by the 104th Congress to drastically cut Medicare, dismantle the Medicaid program, and repeal essential features of the Nursing Home Reform Act.

Big Battle Looms

Lombardo emphasized in an interview that, given present efforts in Washington, "It will take a big battle to restore mental health funding even to the inadequate levels of a few years ago, let alone bring it up to par with payments for treating other medical problems." She said that adding to the difficulties facing mental health advocates is evidence that many managed care programs taking over Medicare benefits for elders have greatly reduced mental health services.

She and other mental health advocates hope that the report will bolster their efforts in Washington, DC. It notes that reductions are coming at a time when we are learning more and more about the effectiveness of mental health treatments. Evidence has mounted in recent years, some from federal investigators, that physical illnesses of people, especially frail elders, cannot be treated separately from mental illness.

The report quotes a 1982 Government Accounting Office report that stated, "Left undiagnosed and untreated, mentally ill residents have limited prospects for improvement, and their overall conditions may decline more rapidly and ultimately place greater demands on the health care system."

Achieving Mental Health... was published in June by the nonprofit Hebrew Rehabilitation Center for the Aged's (HRCA) Research and Training Institute in Boston, in conjunction with the Mental Health Policy Center (MHPRC) in Washington, DC. It is based on a 1993 invitational conference that brought together more than 130 experts in mental health and aging.

The report enumerates a variety of obstacles to the provision of appropriate mental health services. These include a shortage of mental health professionals trained in geriatric medicine; lack of in-service training in nursing homes to teach facility staff to treat behavior and functional consequences of mental illness or dementia; and inadequate Medicaid and Medicare payments and reimbursement rules that do not reflect the relative costs of preferred treatments.

Model Programs, Recommendations

The report notes that, in spite of these hurdles, model mental health programs do exist in some nursing homes; they are funded by an array of federal and state agencies, nonprofit foundations and even by some of the facilities themselves, drawing upon nonfederal funds. The issue brief recommends that such programs be identified, cost-benefits calculated, and the results widely disseminated to nursing homes for replication.

However, mental health experts involved in the issue brief agree that progress is slow and good mental health care in nursing homes is still the exception rather than the rule. Key recommendations in the report include:

- Additional funding for research, staff training, and consumer education initiatives
- Improved Medicare and Medicaid reimbursement to pay for psychiatrists to train nursing home staff members in mental health services
- The "unbundling," or separating, of mental health services from nursing home per diem rates, so that

See VIEWPOINT, page 12

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VIEWPOINT Continued from page 11

funding intended for such assistance cannot be buried in lump-sum reimbursement for care and forgotten

- Full implementation of all federal nursing home reform mandates passed in 1987 and 1989, such as those requiring training for nursing home staff and strictly limiting the use of psychotropic drugs and physical restraints with residents
- Increasing the percentage of mental health services paid for by Medicare and other federal and private insurance to match that paid for other medical services.

Further, the report recommends that reimbursement incentives be redirected to recognize behavioral methods and de-emphasize "medication-only" treatment.

The report's authors added that Washington has failed to recognize cost-effective but humane alternatives to wholesale budget cuts. For example, given the current anti-regulatory mood in Congress, report cards for consumers can be one solution to assist family members in choosing a nursing home that provides adequate mental health training to its staff, said one of the report's authors, Gail K. Robinson, deputy director of the MHPRC.

She suggested, "With such ratings, consumers and their families can be more selective in choosing a nursing home that provides better quality mental health care. Moreover, the facility could use the ratings to identify their weaknesses and correct them."

According to Lombardo, there are less costly ways to improve mental health services than obtaining psychiatric specialists care for most residents. For example, she said, "The facility's in-service training budget could easily be used to bring in experts to teach staff how to care for residents with mental illness or behavioral problems." This redirection of funds would allow specialists to serve as trainers and troubleshooters, rather than as consultants for individual residents.

Lombardo also called on nursing home administrators to support single changes in their in-service training philosophies. "Administrators must realize that the actions of every staff member in their facilities affect the mental health of residents, either positively or negatively. Therefore, every person should attend training on mental and behavioral issues."

To order a copy of *Achieving Mental Health of Nursing Home Residents: Overcoming Barriers to Mental Health Care*, by Nancy Emerson Lombardo, Barry S. Fogel, Gail K. Robinson and Herbert P. Weiss, contact the HRCA Research and Training Institute: 617-325-8000, ext. 391. The cost is $5 to cover the cost of the publication, mailing and handling each copy.

Herbert P. Weiss, a certified nursing home administrator, is a Providence, Rhode Island-based writer and founding editor of **Aging Network News.**

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ANNouncement

Minority Leadership Development Program Seeks Applicants

The Gerontological Society of America (GSA) seeks applicants for its 1996 Minority Leadership Development Program in Aging. Ten minority predoctoral students interested in research careers will be selected to attend GSA's Annual Scientific Meeting in Washington, DC, November 17-21, 1996, and a special program of sessions and events. Students will also participate in a National Institute on Aging-sponsored workshop in the summer of 1997. Expenses for travel, lodging, meals, and registration fees will be provided by the program.

The Minority Leadership Program in Aging was initiated by the Gerontological Society in 1993 to attract minority students to gerontological research careers. The 1996 program is supported by a grant from the AARP Andrus Foundation.

Applications must be postmarked by September 24, 1996. Selection will be made in early October. For application information contact Linda K. Harootyan, The Gerontological Society of America, 1275 K Street NW, Suite 350, Washington, DC 20005-4006, telephone (202) 842-1275, e-mail: geron@geron.org

The program invited 10 students in 1993 and 11 in 1994.

The Minority Leadership Program in Aging focuses on mentoring and leadership development of minority researchers who are already enrolled in a doctoral program. It also provides them with an opportunity for professional socialization, to develop linkages with the professional community.

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